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The Effects of Self Stigmatization on the Functionality and Attitudes toward Mental Illness

Maria Topi [1], Olga Velentza[2], Efseveia Arvaniti[3], Anastasia Topi[4], Argyris Argyriadis[5]

[1,2]Eginitio Hospital, Athens, Greece

[3]G.H.A, G.Gennimatas, Athens, Greece

[4]Tzaneio Hospital, Athens, Greece

[5]MD PhD Psychiatrist, GCPN WHO

ABSTRACT

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Background: Self-stigma significantly affects the outcome of mental illnesses as it affects the individual on a physical, functional, psychological, and emotional level. Attitudes towards mental illness are common indicators of social stigma.

Aim: The main purpose of the present study was to investigate the relationship between self-stigma, functionality, and attitudes toward mental illness, among mentally ill persons.

Material and methods: A quantitative cross-sectional study conducted, and questionnaires used to collect data. Specifically, the ISMI, ASMI and WHODAS scales used. The sample consisted of 130 participants with some mental illness, aged 18-65 years located in three Public Psychiatric Hospitals of Attica.

Results: The 40% of participants were high school graduates, 69.2% were unemployed, while 62.3% lived with family or friends. living status (p 0.008), experience of discrimination (p 0.021) and resilience to stigma (p 0.002) were significantly associated with high rates of total disability. Accordingly, stereotype internalization (p 0.003) was significantly related to desire for social distance from temporary relationships. Female gender (p=0.044) was associated with optimism about the outcome of mental illnesses. Participants who lived alone (p=0.018) had less favorable coping with mental illness. Experiencing discrimination (p=0.031) was associated with understanding more negative perceptions of mental illness.

Conclusion: Self-attribution and reproduction of stereotypical perceptions, as well as low functioning create greater rates of social stigma among people with mental illnesses. The findings above highlight the power of social stereotypes over scientific documentation and emphasize the necessity of awareness, information, and psychoeducation programs.

KEYWORDS:
Attitudes, disability, functionality, mental illness, self-stigmatization

1. INTRODUCTION

The concept of self-stigma has its origin in the 1950s, with the term "self-fulfilling prophecy". In the 1990s, Link and Phelan, through their work, introduced the concept of "public stigma" to describe the negative attitudes and beliefs of society towards mental illness. The term "self-stigma" refers to the internalization of public stigma. By internalizing all those negative stereotypes and perceptions, individuals may believe that they are responsible for their mental health condition, reproducing thoughts and feelings of self-reproach (Corrigan, 2004).

Through the literature review, it has been seen that multiple factors contribute to the development and maintenance of self-stigma. One of them is the role of shame and guilt. The above feelings can lead individuals to social withdrawal and isolation, making it difficult or impossible to seek help and participate in activities that promote well-being. An additional factor is the identification process. The struggle of individuals to integrate the diagnosis into their sense of self leads to uncertainty and identity confusion. Finally, lack of social support is an additional factor that

Corresponding Author: Maria Topi

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increases the burden of internalized stigma on individuals (Corrigan & Rao, 2012).

The impact of self-stigma on the mentally ill manifests itself on several levels. Specifically, it can lead to a reduction in treatment-seeking behaviours and more severe symptoms. People who internalize negative social attitudes about mental illness are less likely to seek treatment for their symptoms. Studies have shown that internalizing negative social attitudes and perceptions about mental illness leads to the emergence of negative emotions, depressive symptoms, and anxiety disorders. In addition, it can lead to low self-esteem, reduced quality of life, social isolation, low levels of self-care and functioning, and an overall worse prognosis of their disease. Avoidance of social interactions and isolation can intensify feelings of loneliness, depression, and anxiety and make access to social support infrastructure more difficult (Livingston & Boyd, 2010).

The concepts of functionality and disability remain fluid and difficult to define. Nevertheless, some approaches have been made for their definition by various institutional and legal frameworks of states around the world. Specifically, the World Health Organization (2001), approached these concepts through the biopsychosocial model, which explains how the concept of disability, is inextricably linked to that of functionality because of interaction between health conditions. Based on the above, human functionality is categorized into three levels: the physical level, the individual level, and finally, the level of the individual as a member of a social group. Disability, on the other hand, includes dysfunction at the level of physical structures, at the level of activities, and limitation in participation (Vornholt et al., 2017).

People who experience functional limitations, such as limited mobility or cognitive impairment, may have difficulty participating in self-care activities, with a negative impact on their overall health and well-being (Santos et al. 2017). Mental illness, and the stigma that accompanies it, often seem to have a negative impact on individuals' physical health and functioning outcomes. The stigma of mental illness often affects the quality of care provided to the mentally ill, as health professionals integrate and reproduce negative attitudes and perceptions toward them (Druss et al., 2010).

People with mental illness often face barriers to accessing healthcare facilities. Some of the reasons include economic difficulties, exclusion and stigmatization, insufficient training of health professionals and inadequate infrastructure, difficulties in commuting, and insufficient psychoeducation. The above barriers can keep people with mental illnesses away from receiving appropriate and timely health care (Thornicroft et al., 2019). An additional important factor affecting the levels of functioning or disability of these individuals is the side effects of psychiatric drugs, which have multiple effects on their physical health such as weight gain or the risk of developing diabetes and cardiovascular diseases (Vancampfort et al., 2015).

The concept of attitudes was recorded at the beginning of the 20th century, defining how one evaluates anything that can be a field of thought (object, idea, person) guiding one's readiness and reaction towards them. International literature studies have focused on recording the attitudes and perceptions and consequently the stigmatization of the mentally ill by various social categories of the general population (Angermeyer et al., 2013).

Lack of contact with the mentally ill appears to be a considerable factor perpetuating negative attitudes towards mental illness. A study in Greece recorded more stereotypical views and less favourable attitudes toward serious mental illness

s compared to men. Also, the inhabitants of Attica had less stereotypical perceptions than the inhabitants of the rural areas. Informing and providing knowledge about mental illness recorded more positive attitudes towards mental illness (Madianos et al., 2012).

Women in the literature appeared to have less negative and stigmatizing attitudes than men and a more optimistic attitude about the treatment of mental illness. In addition, they record more positive attitudes and perceptions towards the mentally ill, especially younger women (Holzinger et al., 2012 ; Schroeder et al., 2020).

Another factor seems to be age. In a study by Bradbury, it appeared that people >40 years old had more positive attitudes than teenagers 16-18 years old. In another study, young people 18-24 had more negative attitudes but could raise more awareness. Residents of rural areas had more negative and stigmatizing attitudes towards mental illness than residents of urban areas. Lower educational and socioeconomic backgrounds were associated with more negative attitudes toward mental illness. Even rural health professionals in a study in China showed a greater desire for social distancing from the mentally ill. Finally, higher educational levels showed more positive coping with mental illness and less stigmatizing perceptions. Lower levels of education and Christian and Muslim beliefs were positively related to the desire for social distance (Bradbury, 2020 ; Henderson et al., 2014 ; Wong et al., 2018).

Negative attitudes towards mental illness led to significant prejudices with an impact on the lives of the mentally ill and the provision and receipt of adequate health care services. A significant percentage of negative attitudes and perceptions of various groups of health professionals towards mental illness has been recorded with great frequency, through various studies worldwide. Some professionals record how they often avoid involvement in mental health service provision infrastructures, due to the stigmatization even of these specialties. Even among medical school students, it seems that psychiatry is not a popular choice because of the stigma. Lien et al. documented a significant impact of health professionals' attitudes on providing care to the mentally ill. Specifically, stigmatizing views were considered a key obstacle to the provision of

health and mental health services to individuals. More recent studies of medical students show a shift to more positive attitudes toward mental illness, as do nursing and biology students (Hapell et al., 2018 ; Lien et al., 2019).

Diversity seems to be one of the main elements that contribute to social exclusion. The stigmatization of mental illness is a phenomenon of social injustice and at the same time a challenge to the ideals of a society that wants to be called just, humane, and privileged. Equally important are the effects on the social and family environment of people with mental illness, as well as on their therapists and carers.

The main purpose of this study is to investigate for the first time in Greece how people with mental illnesses internalize and reproduce stigmatizing perceptions of other mentally ill people and the parameters that lead to the phenomenon.

For this objective, there was investigated the relationship of internalized stigma with levels of functioning, attitudes towards mental illness, and the desire for social distance towards people with mental illnesses.

The individual objectives were:

• Investigating the relationship of participant socio-demographics and self-stigma to functioning and disability.
• Investigating the relationship of participants' socio-demographic data and self-stigma with attitudes towards mental illness.
• Investigating the relationship of participants' socio-demographics and self-stigma with social distance.

2. METHODS

2.1 Studys' sample

The target population of the study was people with some diagnosis of mental illness, in the absence of active psychopathology, aged 18-65 years, from three Psychiatric public hospitals of Attica, their community structures, and their psychosocial rehabilitation units. The final sample consists of 130 individuals, whose characteristics are reported in the results.

2.2 Data collection / Ethical considerations

The study was conducted after written permission was requested and given from the Ethics and Ethics Committee of the Nursing Department of the National and Kapodistrian University of Athens, as well as from the Scientific and Administrative Council and the Nursing Service Directorate of the hospitals.

Questionnaires were distributed to all individuals in the target population, while those who consented from the included hospitals. Specifically, the questionnaires were distributed to people with a mental illness in the psychiatric clinics, as well as the psychosocial rehabilitation units, the daycare units as well as the hostels for people with mental illness in the three public psychiatric hospitals of Attica.

The total response rate was 180 questionnaires of which 130 were validly returned. Data collection was completed over a period of 15 months.

The data collection package included by a questionnaire of demographics questionnaire, the self-stigma rating scale, the social distance scale, the Attitudes Towards Serious Mental Illness Questionnaire, and the WHODAS 2.0 Disability Rating Scale. Along with the questionnaires, it was distributed a form in which it was mentioned the aim of the study, the center of origin of the researcher (National and Kapodistrian University of Athens, Department of Nursing), the voluntary nature of the participation, the safety and anonymity of the participants were assured, as well as data confidentiality. The distribution of the questionnaires was carried out by the researcher who personally informed the managers and supervisors of each department and unit about the purpose of the study and the data collection process, while the researcher provided an information sheet that included the contact details for both the update as well as for any resolution of questions and clarifications.

The participants completed the questionnaire themselves, based on the instructions given. The completed questionnaires were being placed in an opaque envelope, which the researcher received sealed from the heads of the departments. The maximum time limit for completing the questionnaires in each hospital was set at three months. During this time, the researcher visited each hospital at least once a week, while also communicating by phone on the days in between. On the days he was in the respective hospital, the questionnaires were completed and received at the time of the stay.

2.3 Criteria for participation in the study

The selection of the study sample was made based on the following entry and exclusion criteria:

Study entry criteria:

1. People who have received a diagnosis of a mental illness according to ICD10
2. Aged 18-65 years
3. Not to show active symptoms
4. Good knowledge of the Greek language
5. To have Greek citizenship

Exclusion criteria from the study:

1. People who declare that they do not wish to participate in the study.
2. People who do not want to complete the interview process and answer the study questionnaires.
3. Persons placed under judicial support.

3. RESULTS

The sample consists of 130 people with a mental illness diagnosis and a mean age of 48.2 years (SD=13.1 years). Below is the table with the demographics of the participants.

Table 1: Sample characteristics (N=130)

		N	%
Gender	Men	67	51,5
	Women	62	47,7
	Other	1	0,8
Age, Mean (SD), Median		48,2 (13,1)	47,5 (39,0 -57,0)
Family status	Unmarried	75	57,7
	Married	24	18,5
	Divorced	18	13,8
	Widowed	5	3,8
	In a relationship	8	6,2
Living status	Alone	45	34,6
	With friends/family	81	62,3
	In care unit	4	3,1
Siblings	No	30	23,3
	Yes	99	76,7
Children	No	91	70,0
	Yes	39	30,0
Educational level	None	0	0,0
	Primary school	10	7,7
	Middle school	20	15,4
	High school	52	40,0
	University	43	33,1
	MSc/ PhD holder	5	3,8
Employed	No	90	69,2
	Yes	40	30,8

Table 2: Descriptive statistics of WHO-DAS, ISMI and ASMI subscales

	Minimum	Maximum	Mean (SD)	Median	Cronbach's a
ASMI					
Stereotypes (Elimination)	11,0	44,0	26,5 (8)	26 (21 ─ 31)	0,77
Optimism	0,0	24,0	15,9 (5,5)	16 (12 ─ 20)	0,72
Coping	6,0	28,0	21,9 (4,9)	23 (19 ─ 25)	0,71
Understanding	4,0	24,0	14,2 (4,9)	14,5 (11 ─ 17,5)	0,76
ISMI					
Alienation	6,0	22,0	13,3 (4,2)	13 (10 ─ 16)	0,83
Stereotype Endorsement	7,0	24,0	14,4 (4,1)	15 (12 ─ 17)	0,78
Discrimination Experience	5,0	19,0	11,3 (3,6)	11 (8 ─ 14)	0,82
Social Withdrawal	6,0	24,0	13,5 (4,3)	13,5 (10 ─ 17)	0,83
Stigma Resistance	5,0	17,0	11,2 (2,4)	12 (10 ─ 13)	0,80
WHO-DAS					
Motor ability	0,0	83,3	33,5 (21,2)	33,3 (16,7 ─ 50)	0,82
Participation & cognition	0,0	75,0	33,6 (22,4)	37,5 (12,5 ─ 50)	0,77
Self-care	0,0	91,7	20,2 (23,5)	8,3 (0 ─ 33,3)	0,88
Total disability score (WhoDas)	0,0	75,0	29,8 (19,7)	27,1 (14,6 ─ 45,8)	0,92

Table 3: Spearman correlation coefficients of WHO-DAS subscales with ISMI and ASMI subscales

		Motor ability	Participation & cognition	Self-care	Total disability score (Who Das)
Stereotypes (Elimination)	Rho	-0,17	-0,10	-0,18	-0,14
	P	0,061	0,246	**0,045**	0,107
Optimism	Rho	-0,16	-0,17	-0,19	-0,17
	P	0,061	0,055	**0,030**	0,055
Coping	rho	-0,25	-0,16	-0,24	-0,22
	P	**0,005**	0,071	**0,006**	**0,012**
Understanding	rho	0,32	0,29	0,11	0,30
	P	**<0,001**	**0,001**	0,224	**0,001**
Alienation	rho	0,53	0,51	0,46	0,53
	P	**<0,001**	**<0,001**	**<0,001**	**<0,001**
Stereotype Endorsement	rho	0,53	0,50	0,45	0,55
	P	**<0,001**	**<0,001**	**<0,001**	**<0,001**
Discrimination Experience	rho	0,54	0,50	0,44	0,55
	P	**<0,001**	**<0,001**	**<0,001**	**<0,001**
Social Withdrawal	rho	0,52	0,49	0,41	0,53
	P	**<0,001**	**<0,001**	**<0,001**	**<0,001**
Stigma Resistance	rho	0,19	0,24	0,17	0,20
	P	**0,029**	**0,007**	0,052	**0,023**

Table 4: Multiple linear regression analysis results with ASMI subscales as dependent variables

	β+	SE++	b*	P
Stereotypes (Elimination)				
Living alone (Yes vs No)	-0,052	0,025	-0,179	**0,044**
Stigma Resistance	-0,014	0,005	-0,237	**0,006**
Optimism				
Gender (Women vs Men)	0,075	0,037	0,189	**0,044**
Coping				
Living alone (Yes vs No)	-0,051	0,021	-0,222	**0,018**
Understanding				
Discrimination	0,015	0,007	0,359	**0,031**

4. DISCUSSION

In the present study, the relationship between self-stigma, functioning, and attitudes was investigated in a sample of 130 people with some psychiatric diagnosis in 3 public psychiatric hospitals in Attica. All participants were taking some psychiatric medication (mainly antipsychotics, antidepressants and anxiolytics). These patients were either undergoing psychosocial rehabilitation or were at the end of their hospitalization after a relapse of the disease and the need for pharmaceutical regulation.

The main criteria for participation in the research were the absence of active psychopathology, as well as not being under judicial support. The presence of active psychopathology, specifically in the case of schizophrenia negative compared to positive symptomatology, appears to lead to significant cognitive dysfunction and significant functional deficits (Heydebrand et al., 2004 ; Velligan & Miller, 1999).

Studies from the international literature have highlighted the fact that both stigma in all its manifestations and forms – social stigma, internalized stigma – is second nature to mental illness (Brown et al., 2010). In addition, mental illness, according to the World Health Organization (2016), emerges as the third leading cause of disability and general burden

after cardiovascular disease and cancer. The stigma that accompanies mental illness concerns not only the patient himself, but also his family network, with results such as reduced social activity and reduced social network for both the individual and the whole family. In Greece, a country in which the role of the family and the wider social network continues to play an important role in supporting or rejecting and excluding a person with mental illness, the study of stigma parameters seems to be important in determining the outcome of the disease itself, the functioning of the individual and finally, social inclusion or exclusion (Mittal et al., 2012 ; Rusch et al., 2009).

Functioning as a concept includes the ability to perform the activities that people enjoy at work, at home, and in social life, self-care, maintaining interpersonal relationships, and social adjustment (Schnettler et al., 2022). The gender differences between the survey participants appeared to be insignificant. Most of them continue to live with people from their family environment, do not have a partner and have not created their own family, confirming in a way the framework of previous studies on the difficulty of maintaining interpersonal relationships and adaptation. Also, the educational level and studies of the participants seemed to be in line with the results of previous studies. Specifically, 66 out of 100 were elementary, middle and high school graduates, while 29 continued in tertiary education and only 5 continued at postgraduate or doctoral level. Both cognitive deficits created due to the disease and social exclusion due to stigma seem to be a significant obstacle to the education, professional and psychosocial rehabilitation of these people. All the above is confirmed in this study, as only one in four reported working in some context.

The results show that greater alienation, internalization of stereotypes about mental illness, existence of some experience of discrimination and social withdrawal, lead to significantly greater impairment of functionality and consequently greater rates of disability. Of all mental illnesses, schizophrenia is the one with the most significant cognitive, emotional and functional deterioration (Clark, 2016). Similar studies, such as that of Clark, refer to low rates of functioning and maintenance of daily life skills and social roles in people with schizophrenia and other psychotic spectrum disorders (Vaskinn et al., 2015). Among the factors affecting functioning, symptoms of the disease appeared to be, as well as social, cultural, social and environmental factors, including stigma and self-stigmatization (Capar & Kavak, 2019). In the current study, ephemeral relationships, within a context of socialization and interaction between people, appeared to be associated with lower rates of disability in contrast to stable relationships, which did not seem to play a significant role in participants' functioning.

Educational attainment seemed to contribute to lower rates of disability in terms of social participation and cognitive ability. Educational attainment was associated with higher social functioning and better disease outcomes in people with mental illness (Xiang et al., 2010). A study among people with schizophrenia found that higher educational attainment was associated with the absence of negative symptoms and consequently higher functionality. Finally, McGurka & Meltzer, (2000) who also found in their study a positive correlation between higher educational attainment and higher functioning, explained the fact that high academic level delayed the onset of the disease, so functioning skills were already at a high level, helping these individuals to remain socialized to a significant extent (Erol et al., 2015).

In terms of gender, women recorded significantly greater disability compared to men. Greater internalization of stereotypes was also associated with greater disability. The results of the study are consistent with those of Capar & Kavak, (2019) with women showing lower rates of functionality. On the contrary, Erol et al., (2015) found no statistically significant differences in the functioning of mentally ill people between the sexes.

Participants with siblings and therefore a direct family support framework recorded significantly lower rates of disability relative to self-care levels. In contrast, participants who experienced greater alienation and isolation recorded greater disability.

There is a substantial body of research supporting that gender plays an important role beyond the occurrence of mental disorders and in disparities in diagnosis and help-seeking behaviours such as treatment and recovery in mental disorders. Social gender roles, such as masculinity in men and the need for dominance and power, lead men to avoid seeking help for mental health issues and consequently, the inability to prevent or early diagnosis and treatment for a better outcome. Disease (Smith et al., 2018). Also, health professionals are often consciously or unconsciously influenced by beliefs about gender and mental health, where women are stereotypically seen as more emotionally susceptible than men, while the latter expresses any mental distress through behaviours such as abuse of psychoactive substances, with the adverse effect of overdiagnosis in women and underdiagnosis in men (Boyd et al., 2015 ; Kuehner, 2017).

Serious mental illnesses, as in the case of schizophrenia, are chronic and difficult for individuals to recover from, resulting in high rates of permanent disability. Also, the presence of negative symptoms of schizophrenia appeared to be associated with greater disability than the presence of positive symptomatology. Disability due to mental illness, particularly in the case of schizophrenia, prevents individuals from practicing daily self-care activities (Akinsulore et al., 2015 ; Korkmaz et al. 2022).

Internalized stigma seems to predict help-seeking behaviours for dealing with mental health problems, greater rates of self-stigma prevent the person from seeking help or dealing with their mental disorder. A study in India found that increased rates of self-stigma led to greater disability and

reduced self-care behaviours. Psychoeducation in individuals and families appears to reduce both the severity of psychopathology and the rates of disability in people with mental illnesses. In Vietnam, social isolation of the mentally ill was found to reduce the social functioning of these individuals (Coriggan et al., 2016 ; Jennings et al., 2015 ; Martensen et al., 2018).

Many studies came to confirm the findings of the present research, where high rates of self-stigma in people with mental illness led to low rates of medication compliance, which are included in the context of self-care. The same appeared to be true of internalizing negative social stereotypes of mental illness (Hajda et al., 2015 ; Yılmaz & Okanlı, 2015).

Therefore, both from the results of the present study and from the already existing literature, investment in education for better medication compliance of people with mental illnesses, as well as social inclusion, destigmatization, and professional and educational inclusion, is recorded as an unmet need. Also, the care and support of the family and the environment of the individual contribute so that them either maintain or regain satisfactory levels of self-care (Essau et al., 2019 ; Sartorius, 2018).

Important findings of this study concern the correlation of attitudes towards mental illness with self-stigma. The more alienation, internalization of mental illness stereotypes, discrimination, and social isolation experienced by the individual, it appeared to entail more stereotypic perceptions, less coping effort, and less optimism. The international literature includes studies concerning the attitudes towards mental illness from various social groups. Some of them, in addition to the general population, are health professionals, mental health professionals, and health school students. A study in Canada and Hungary among psychiatrists showed low rates of stigma-positive attitudes and less social distance toward mental illness. In contrast, however, if the mental problem concerns psychiatrists themselves, lower rates of seeking mental health help were recorded, reflecting internalized perceptions and stereotypes about the incapacity of the mentally ill. Professionals who had sought help for personal mental health problems reported less social distance from the mentally ill (Ori et al., 2022; Stefanovics et al., 2016).

From the correlation of the functioning-disability scale (WHODAS) with the scale of internalized stigma (ISMI scale) it was found that the participants who lived alone and were able to support the needs of independent living and the participants who worked somewhere, recorded less motor difficulty, with work being the most important factor of greater functionality in this area.

Those who lived alone also reported greater participation in activities of daily living and lower scores on the total disability scale. Participating in community activities and maintaining or reinstating a social role are among the most important factors in the recovery of functioning in the mentally ill (Russinova et al., 2023). Accordingly, people with mental illness who were married reported lower rates of stigmatizing perceptions compared to people who were divorced or people who lived alone, a possible explanation seems to be the fact that single or divorced people faced more discrimination from family or other social groups (Rans et al., 2018).

Medication adherence, which is an important indicator of functioning and adequate self-care, has been shown to reduce stigma scores. Educational level and work profile also seem to influence the rates of internalized stigma, a fact interpreted as better education and the possibility of working, giving the person an extra push for awareness and sensitivity about their disease, thus reducing the stigmatizing perceptions and their internalization (Szcześniak et al., 2018).

Mental illness remains a disproportionately important factor in long-term work-related abstinence and disability. The percentages of mentally ill people who work remain high to a significant extent, unchanged over the years, and are associated with significant costs on social and personal levels (Campellone et al., 2016). Some of the reasons that contribute to this condition are feelings of hopelessness, inadequacy, and self-stigma. Modern studies also posit a new concept of defeatism, explaining all those overgeneralized negative thoughts about a person's abilities to achieve a task (Kiwanuka et al., 2014).

From the review of the literature, severe mental illnesses, including schizophrenia, bipolar disorder, and major depressive disorder have high rates of disability. Functional disability refers to interpersonal relationships, self-care, and participation in community activities (McFarlane et al., 2015).

Other studies, mainly in developed countries, associated disability in people with serious mental illness with demographics, male sex, older age, lower social classes, illness severity and duration, and finally, stigma (Harvey & Strassnig, 2012). In a study in Africa, high rates of reduced functioning and disability were associated with disease severity, increased age, and high rates of self-stigma. People with mental illness who were married or in a relationship reported lower rates of disability. The existence of a relationship appeared to help the individual, as it provides him with the necessary social support so that he is functional and involved in various social activities (Habtamu et al., 2018 ; Hanlon et al., 2016).

In the present study, high rates of self-stigma, and specifically the dimensions of alienation and alienation, appeared to be the second factor, after the work profile of the participants, that is also associated with greater mobility difficulty in individuals.

Also, the high rates of self-stigma were the primary factor affecting participation in everyday activities. Finally, people who had higher rates of self-stigma and had experienced more discrimination due to the disease had greater difficulty in self-care activities, but also overall

increased disability. Studies in Europe and Ethiopia found high rates of the alienation dimension, but lower agreement with stereotypes in people with mood disorders. Accordingly, the self-esteem dimension was high in individuals with high rates of self-stigma (Brohan et al., 2011 ; Girma et al., 2013).

The discrimination experienced in everyday life, both practical and interpersonal, seems to push the person to isolate and withdraw from socialization or self-service and self-care activities, due to disenfranchisement. Internalizing prevailing perceptions about the productivity of people with mental illness, who may not be able to live up to the criteria set by our existing social structuring system, pushes these people into a sense of alienation as their sense of belonging diminishes, as long as diversity in multiple areas of life (education, appearance, gender, race) is not tolerated and accepted.

Participants living alone reported stronger stereotypic perceptions compared to those living with immediate family or relatives. The living situation appeared to influence the treatment of mental illness, specifically, those who lived independently had a worse treatment of mental illness. The living situation, in addition to the functionality, often also concerns the economic situation and the social class of the people. Correspondingly, people from higher social classes and with greater economic income had reduced rates of self-stigma (Rusch ,2005).

In addition, those individuals with higher rates of self-stigma reported more stereotypical perceptions, a fact that is related to increased acceptance of stereotypical perceptions. People with high rates of self-stigma are associated with low levels of self-esteem, hope, empowerment, and quality of life (Livingston & Boyd, 2010). The internalization of discrimination and stereotyping that people with mental illnesses largely experience, seems to drive them to adopt and reproduce more stereotypical perceptions of other mental patients, especially in diagnostic categories that have experienced stigmatization to a much greater extent scale such as schizophrenia or bipolar disorder.

Female participants had higher scores on the dimension of optimism about having a mental illness than male participants. Although, as has been shown in other studies, women record higher rates of self-stigmatization than men, since in addition to mental illness they also face discrimination due to their gender, they have more optimistic attitudes towards its existence and outcome (Girma et al., 2013).

Also, people who had embraced more negative perceptions about mental illness reported the greatest discrimination. People with multiple hospitalizations and presumably greater severity and chronicity of the mental illness, refrain to a significant extent from participating in social events and are often stigmatized much more, and internalize all these stereotypical perceptions against them, reproducing the discrimination in others (Maharjan & Panthee, 2019).

These findings contrast with the findings of studies in the general population. Personal experience and contact with people with mental illness have been shown to reduce negative perceptions of the dangerousness or victimization of the mentally ill. Furthermore, the type of contact and the duration of the contact appeared to have a particular impact on reducing negative attitudes toward mental illness (Shumet et al., 2021).

Among nurses, those with the most negative attitudes toward mental illness were nurses who did not work on psychiatric wards with first responders in emergency departments. Also, nurses had more negative attitudes than doctors (Ghuloum et al., 2022). Educational level appeared to be related to nurses' attitudes towards the mentally ill. Specifically, the more qualified and trained the nurses were, the more positive their attitudes were. On the contrary, nurses who worked for 11-15 years presented more negative attitudes (Li et al., 2023 ; Porfyri et al., 2022).

However, it seems that the negative effect of stigma on mentally ill patients, beyond the high rates of self-stigma, has a great effect on their mental well-being. People who have experienced significant social, educational, and professional discrimination due to the disease end up with reactions ranging from anger to sadness, despair, and less trust in others. These experiences may be able to explain why these individuals report the greatest discrimination against other mentally ill people.

Empathy has also been shown to be an important factor related to functioning and self-care, especially cognitive ability and therapeutic adherence (hospitalization, drug therapy).

Schizophrenia, which is also the most severe category in terms of functioning and disability among psychiatric diagnoses, has high rates of disability. The symptoms of schizophrenia lead to cognitive impairment and social and professional dysfunction. Residuality due to the above leads to reduced actions of daily self-care.

Disability and low functioning are in the same vicious circle as stigma and self-stigma in people with mental illness. Because of their disease, they are in a condition of marginalization, and neglect by society, its relationships, and functional benefits. The perception of disability and deficient functioning appears to be related to several negative representations in individuals, such as lack of acceptance and respect, low self-esteem, maltreatment, isolation, intolerance, and indifference (Cairns et al., 2005).

Our findings appear to be more in line with several studies where participants who had experienced stigma and discrimination due to mental illness referred to themselves with the label of mental disability. High rates of self-stigma are predictive of medication adherence, psychological distress, and relapse, which are fundamental domains of both self-care and functioning. In addition to medication compliance, increased rates lead to poorer treatment compliance and consequently a worse prognosis of the

disease. This fact is linked to the low rates of self-esteem and self-efficacy resulting from the high rates of self-stigma. The effort of people with mental illness to avoid discrimination and prejudice, hide the disease and the diagnosis, and avoid treatment. This is a schema that explains how internalized stigma leads to low self-care in terms of treatment and compliance, which gradually pushes the individual into low levels of functioning (Livingston et al., 2011).

5. STRENGTHS AND LIMITATIONS

However, this research has some limitations. The sample is not representative for the entire Greek population, as it concerns a population of people living in the capital. Social stereotypes and prejudices in the province of Greece as well as gender segregation are much more pronounced in small societies. Thus, this sample concerns people in an urban area in which the possibilities for support and psychosocial rehabilitation and care may be much greater than in the province, but also there is even a rudimentary mitigation of stereotypes and discrimination that apply to mental illness. It is important to explore an even larger part of the Greek population both in the big cities and in the province as the framework of support to the community is not so extensive there. In addition, the sample includes people with different psychiatric diagnoses and different levels of functionality. Therefore, this makes it difficult to be able to help more especially in each disease category according to its needs. This is because each category of mental illness has a different prognosis, different stigma and therefore different needs.

Limitations of the study, also include the response reliability of the self-report assessment questionnaires. Furthermore, participants' perceptions of attitudes toward mental illness, as well as levels of functioning, self-care, and self-stigma, may vary over time due to personal and social circumstances. If so, better treatment adherence or attending psychoeducational programs may have modified the levels of self-stigma, as well as the perceptions and attitudes towards other people with psychiatric illnesses. Finally, the functionality of these individuals may have improved or worsened about the time in which they were recorded.

An important limitation of the study is the absence of investigation of the onset of the disease, which may have affected the participants' cognitive ability, but also the time of exposure to social exclusion, professional and social disability, and social stigmatization. It was also not examined the medication they were receiving and how any adverse effects might affect the functionality of the participants.

6. CONCLUSIONS

Social discrimination, stigmatization, and internalization continue to make the daily life and the outcome of the disease of people with mental illnesses difficult. Stigma and self-stigma remain important factors of reduced functioning and self-care, but also an important factor in the reproduction and perpetuation of negative attitudes towards mental illness by the individuals in the mentally ill group themselves.

A social context, which sets criteria of normality, in a world of diversity and specificity, cannot but reproduce inequalities, separations, discrimination, and isolation of all those who cannot be included in its criteria. Mental and physical illness cannot be separated, but after all, they are not a choice in any case, just like other manifestations of diversity. Despite this, people are under crisis and isolation due to the individual characteristics of a whole that constitute each personality and entity.

In conclusion, the present study confirms and highlights the power of social stereotypes and representations against scientific documentation and information. In the world of the 21st century, attitudes and perceptions towards diversity should not be determined by the social perceptions of individuals, their social and economic status, and education, but by the universal human right to equality. As health and mental health professionals, we must assume our responsibility, through our interventions and actions, so that people with mental illnesses do not need the law and the respective rights observatories, to be able to exist without their existence, their value, and the right to dignity and equal living in the social context is abused.

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