

Relationship between internalized stigma and treatment efficacy in mixed neurotic spectrum and depressive disorders

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Abstract

OBJECTIVE: Many psychiatric patients suffer from self-stigma. One consequence of these internalized prejudices is decreased treatment efficacy. Much has been written about the effects of self-stigma in patients with severe mental disorders. However, individuals with minor psychiatric disorders also suffer from self-stigma. It is therefore necessary to explore the effect of self-stigma on treatment efficacy of neurotic patients.

METHOD: Aim of our study was to investigate relationship between self-stigma, severity of symptoms, and presence of comorbid disorder and treatment outcome in neurotic patients. Patients were treated by combined psycho and pharmacotherapy. Level of self-stigma was measured by Internalized Stigma Of Mental Illness scale. Severity of anxiety and depressive symptoms was assessed by Beck Anxiety Inventory, Beck Depressive Inventory and Clinical Global Impression Scale.

RESULTS: Level of self-stigma was significantly correlated with the levels of anxiety, depression and global evaluations of a mental state on the beginning of the therapy. Up to our results patients with higher level of self-stigmatization had lower improvement after combined treatment in respect to perceived anxiety symptoms.

CONCLUSION: Self-stigma seems to be an important factor influencing efficacy of combined treatment. More researches focused on self-stigmatization should be done to find an optimal therapeutic strategy for patients with higher level of self-stigmatization.

INTRODUCTION

Stigmatization of psychiatric patients is a social process through which individuals get labeled because of having mental disorders. After obtaining a label, others start to avoid the patients and might discriminate them (Goffman 1986; Finzen 2000). Stigma can be divided into several subgroups – social, structural (institutional), and internalized (in other words self-stigma) (Livingston and Boyd 2010). Internalized stigma develops when patients apply prejudices on themselves. It has been shown that internalized stigma brings the most serious impact on psychiatric patients, as compared to social or structural stigma (Corrigan *et al.* 2011).

The consequences of self-stigma are various – individuals, who stigmatized themselves, experience more dysphoric emotions, lower self-esteem and quality of life. They tend to isolate themselves and might show other potentially maladaptive behavior, such as alcohol abuse. In extreme cases, internalized stigma might lead to a change of identity (Schulze & Angermeyer 2003).

Self-stigma also influences engagement in treatment and treatment efficacy. Individuals with mental health problems issues, who stigmatize themselves, tend to avoid psychiatric or psychotherapeutic treatment (Vogel *et al.* 2006). This often leads to chronification of mental disorders or exacerbation of their symptoms. Sirey *et al.* (2001) study of older depressive patients showed, that patients who perceive stigma drop from treatment earlier. Ritsher and Phelan (2004) stated that self-stigma is related to a lower adherence to a treatment, more serious symptomatology, and worse prognosis. Patients with internalized stigma show poorer treatment participation than those who do not stigmatize themselves so extensively (Tsang *et al.* 2010). These relationships might be partially explained by the connection between internalized stigma and self-esteem and self-efficacy. Patients, who stigmatize themselves, often lose their self-esteem. In the study of Rüscher *et al.* (2006) self-stigma predicted decrease of self-esteem level in women with social phobia or borderline personality disorder. The relationship remained significant even when the factors of depression and shame-proneness were considered. There are two possible associations between self-stigma and self-efficacy – self-stigma leads to the decrease of self-efficacy, and “premorbidly” lower self-efficacy predicts the higher level of self-stigma (Okhakume 2012). According to Corrigan *et al.* (2009), self-stigma is related to a concept similar to self-efficacy – empowerment. Empowerment then serves as a mediator between self-stigma and patients’ behavior during the treatment. Thus, when the patient remains confident in spite of experiencing the relaps of the mental disorder and possible stigmatizing behavior from his environment, he is more active in treatment and shows better treatment adherence. Such perception about one’s ability to control his own life, own abilities and self-worth predicts better therapeutic outcomes.

Corrigan *et al.* (2009) stated that it is internalized stigma what influence that relationship between empowerment or self-efficacy and treatment participation and possibly also the treatment outcomes. However, while the current research offers some explanations about the relationship between self-stigma and treatment outcomes of patients with serious mental disorders, little is known about the impact of internalized stigma on treatment efficacy of patients with neurotic disorders.

METHODS

The purpose of this study was to clarify the relationship between internalized stigma, severity of symptoms, presence of comorbid disorder and treatment outcome after combined treatment of neurotic patients with or without comorbid depression.

Patients

Patients suffering from neurotic spectrum disorders, referred to an intensive psychotherapeutic inpatients program, were enrolled in the study. Inclusion criteria were:

1. Age 18–75 years
2. Neurotic and anxiety spectrum diagnosis according to ICD-10 (1996)

Excluded were patients diagnosed with bipolar disorder, schizophrenia and other psychotic disorders, organic disorder, and those who were severely physically handicapped, were not included. Patients with mild or moderate depression and patients with comorbid personality disorders were included.

The diagnosis, according to the research criteria of ICD-10 (1996), was confirmed by 3 independent psychiatrists: an outpatient psychiatrist, who firstly assessed patient, a psychiatrist at psychotherapy department, and a senior psychiatrist, who supervised the department. The diagnosis was confirmed by an evaluation with structured interview M.I.N.I conducted by an experienced psychologist (Lecrubier *et al.* 1997).

Methods of evaluation

After patients signed an informed consent, they filled out several scales and questionnaires. The following ones were completed at the start and in the end of the treatment:

BAI (Beck *et al.* 1988) – Beck Anxiety Scale consists of 21 items based on a four-point Likert scale in which patients choose, which of the described anxiety symptoms they perceived in a last week.

BDI-II (Beck *et al.* 1996) – Beck Depression Inventory, second edition, consists of 21 items in which patients choose, which of the described depressive symptoms they perceived in a last week.

CGI (Guy 1976) – Clinical Global Impression is a global evaluation of severity of psychopathology. The sources of the evaluation are two. The first presents a

complex evaluation by a physician (objCGI) about the severity of the disorder; the second one is a self-evaluation done by patients on a scale 1–7 where every point of the scale has described its unique characteristics (subjCGI).

The following method of evaluation was used only at the start of the treatment:

ISMI (Ritsher *et al.* 2003) – Internalized Stigma Of Mental Illness consists 29 items with statements and a four-point scale measuring a level of an agreement with them. The scale focuses on five elements of internalized stigma – alienation, perceived discrimination, stereotype endorsement, social withdrawal, and resistance to stigma. The scale was standardized in Czech by Ociskova *et al.* (2014 in press).

Methods of treatment

All patients underwent a group therapy (CBT or short psychodynamic) while hospitalized on the psychotherapeutic department of the University Hospital Olomouc. The program consisted of 30 group sessions and 5 individual sessions. Medication was accustomed to the algorithms of treatment of neurotic disorders. Statistics were calculated by using the Prism (GraphPad PRISM version 5.0; <http://www.graphpad.com/prism/prism.htm>). Demographic data and average scale scores were processed by descriptive statistics; means, medians, standard deviations, and character of data distribution were also identified. Differences in the scores during the treatment were calculated by pair t-tests. Differences in the declines of the scale scores in patients with and without a comorbid depression were calculated by ANOVA. Relations between the categories were evaluated through correlations and a linear regression. It was agreed that a 5% level of statistical significance would be accepted in all tests. The research was conducted in accordance with the latest version of the Helsinki Declaration and the Guideline for Good Clinical Practice

(EMEA 2002). The study was approved by the local ethical committee. All patients signed informal consents.

RESULTS

Subjects

There were 76 patients included in the study, 58 females and 18 males, during the period from 12 November 2012 to 21 June 2013. Another thirteen patients admitted to the department were not interested in participation. The mean age was 40.20 ± 12.85 years. Eleven patients (14.7%) passed elementary school, 22 (29.3%) had an educational level of skill workers, 33 (44%) passed secondary school, and 8 (10.7%) university. One patient did not finish elementary school and one did not fill in her education level. Twenty-six patients (34.2%) were unemployed, 38 (50.0%) were working as employees or were self-employed, 4 (5.3%) were taking rent, and 4 (5.3%) were taking old age pension. Twenty-six patients (34.2%) were single, 32 (42.1%) married, 17 (22.4%) divorced, and 1 widow.

The diagnostic spectrum in the patients participating on the study was wide. The primary diagnosis was a neurotic disorder in 59 patients (77.6%) and a depressive disorder in 17 patients (22.4%). 52 patients (68.4%) were diagnosed with comorbid disorders (Table 1). 23 patients (30.3%) had a comorbid personality disorder.

Medication

Patients were treated by using standard dosages of antidepressants, mostly the same ones they were using when referred; there were no other changes in pharmacotherapy. The numbers of patients using a certain type of a medication at the start and in the end of treatment are shown in Table 2. There was no significant difference between average doses of antidepressants in patients with and without a comorbid depressive disorder at the start of the treatment (60.00 ± 38.24 mg

Tab. 1. A primary diagnosis and comorbidities.

Primary diagnosis	Number	Comorbidities (number of patients)				
		Without	1 dis.	2 dis.	3 and more dis.	PD
Depressive disorder	17	3	3	7	4	4
Neurotic spectrum	59	21	22	13	3	19
Panic disorder/ agoraphobia	16	6	5	4	1	4
OCD	9	4	3	1	1	3
GAD	6	4	1	1	0	0
Mixed anxiety-depressive disorder	7	3	4	0	0	4
Adjustment disorders	4	0	2	2	0	4
Social phobia	7	1	4	2	0	2
Dissociative/somatoform disorder/neurastenia	10	3	3	3	1	2

Dis = disorder; PD = a personality disorder

Tab. 2. Primary diagnosis, medication and their combinations.

Primary diagnosis	Number	Medication mg and numbers of treated patients at the start / at the end of treatment					
		AD	ANX	AP2	Comb 2 meds	Comb 3 meds	Without meds
Depressive disorder	17	72.00 mg (15) / 61.88 mg (16)	1.19 mg (8) / 0.31 mg (4)	1.90 mg (5) / 2.10 mg (5)	6 / 3	3 / 3	2 / 0
Neurotic spectrum	59	43.33 mg (51) / 42.91 mg (55)	1.03 mg (16) / 0.60 mg (8)	1.33 mg (10) / 1.30 mg (16)	15 / 16	5 / 4	7 / 4
Panic disorder/ agoraphobia	16	43.08 mg (13) / 35.63 mg (16)	1.17 mg (6) / 0.58 mg (4)	0.67 mg (3) / 0.75 mg (3)	3 / 7	3 / 0	3 / 0
OCD	9	60.00 mg (7) / 55.00 mg (8)	0 / 0.5 mg (1)	5.5 mg (1) / 2.67 mg (3)	1 / 2	0 / 1	2 / 1
GAD	6	51.67 mg (6) / 54.17 mg (6)	0.75 mg (3) / 1.00 mg (1)	0 / 0.5 mg (2)	4 / 1	0 / 2	0 / 0
Mixed anxiety-depressive disorder	7	56.67 mg (6) / 37.14 mg (7)	0.33 mg (3) / 0.25 mg (1)	1.00 mg (3) / 1.75 mg (3)	1 / 2	2 / 1	0 / 0
Adaptation disorders	4	46.67 mg (3) / 73.33 mg (3)	0 / 0	0 / 0.5 mg (1)	0 / 1	0 / 0	1 / 1
Social phobia	7	31.43 mg (7) / 34.29 mg (7)	0.75 mg (1) / 0	1.00 mg (1) / 1.00 mg (2)	2 / 2	0 / 0	0 / 0
Dissociative/somatoform disorder/neurasthenia	10	27.50 mg (8) / 38.13 mg (8)	1.83 mg (3) / 0.75 mg (1)	0.88 mg (2) / 0.88 mg (2)	5 / 1	0 / 1	2 / 2
Average dose converted to an index drug (paroxetine, alprazolam, risperidon) in mg per day at the start of treatment		50.62 mg (65)	1.08 mg (24)	1.52 mg (15)			
Average dose converted to an index drug (paroxetine, alprazolam, risperidon) in mg per day at the end of treatment		47.18 mg (71)	0.50 mg (12)	1.49 mg (21)			

AD = antidepressants – equivalent of paroxetine; AP2 = antipsychotics of second generation – equivalent of risperidone; ANX = anxiolytics; Comb = combination

versus 46.73 ± 34.54 mg of paroxetine equivalent, Mann Whitney test: $M-W U=326$; n.s.). However, the mean antidepressant dose was significantly higher in patients with a comorbid depressive disorder compared to patients without depression at the end of the treatment (64.71 ± 40.94 mg versus 41.64 ± 28.01 mg of paroxetine equivalent, Mann Whitney test: $M-W U=307.5$, $p < 0.05$). There were no significant differences of mean doses of anxiolytic or antipsychotic between patients with and without a comorbid depression at the start or at the end of treatment.

Changes in the scales scores in the patients with and without a comorbid depression

The mean overall scores of BAI, objCGI, and subjCGI did not significantly differ at the start of the treatment in the patients with a comorbid depressive disorder and the patients without it, but there was statistically significant difference between depressed and non-depressed group in BDI-II scale (Table 3). Both groups differed in the change of the BAI and objCGI scores, but not in subjCGI scores (Table 3).

Changes in the scales scores in the patients with and without a comorbid personality disorder

Average overall scores of all scales were higher in the patients with a personality disorder at the start of the treatment. However, the difference was statistically significant only in the BDI-II and objCGI scores (Table 3). At the end of the treatment, the group of patients with a comorbid personality disorder scored statistically higher in BAI, BDI-II, and objCGI. When comparing changes during the treatment in both groups, the only significant difference was in the objCGI score (Table 3).

A relationship between internalized stigma, depressivity and personality disorder

The average score of ISMI was statistically higher among patients with depression than in the non-depressive group (Table 4). The patients without a depressive disorder scored significantly lower in most subscales of ISMI (alienation, stereotype agreement, social withdrawal) except for the stigma resistance subscale which was significantly higher. It seems that the depressive individuals with neurotic disorders stigmatize them-

Tab. 3. The mean overall scores in the scales at the start and in the end of the treatment in all patients, the patients with and without a comorbid depressive disorder, and the patients with and without a comorbid personality disorder.

	BAI-before	BAI-after	BDI-II-before	BDI-II-after	Subj CGI-before	Subj CGI-after	Obj CGI-before	Obj CGI-after
All patients	23.64±11.96	20.61±11.59	25.18±11.47	19.51±12.60	4.589±1.223	2.986±1.379	4.733±1.031	2.568±1.008
Pair t-test ^P or Wilcoxon signed rank test ^W	t=2.094 df=73; p≤0.05^P		t=4.840 df=73; p≤0.001^P		W=1686; p≤0.001^W		W=2688; p≤0.001^W	
With a depressive disorder n=17	22.88±12.24	21.81±10.55	31.38±11.12	26.31±12.53	4.813±0.75	3.563±1.413	4.706±0.849	2.882±0.858
Without a depressive disorder n=52	23.85±11.98	20.28±11.92	23.50±11.06	17.64±12.06	4.526±1.324	2.821±1.336	4.741±1.085	2.474±1.037
Unpaired t-test ^T or Mann-Whitney ^M	t=0.2868 df=73; ns ^T	t=0.4670 df=72; ns ^T	t=2.523 df=73; p≤0.005^T	t=2.526 df=72; p≤0.05^T	U= 383.5; ns ^M	U= 300; p≤0.05^M	U= 485; ns ^M	U= 350.5; ns ^M
With a depression compared to without a depression: interaction during the time	Two way RM ANOVA: F= 2.424 Df=16; p≤0.005		Two way RM ANOVA: F= 3.548 Df=23; p≤0.01		Two way RM ANOVA: F=0.7367 Df=16; ns		Two way RM ANOVA: F= 0.2143 Df=17; p≤0.0001	
With a personality disorder n=21	26.57±13.51	26.81±12.75	30.71±10.94	27.67±12.90	4.905±1.338	2.950±1.305	5.429±1.121	3.200±1.005
Without a personality disorder n=55	22.50±11.22	18.15±10.21	23.03±11.03	16.28±11.02	4.462±1.163	3.000±1.414	4.463±0.863	2.333±0.911
Unpaired t-test or Mann-Whitney	t=1.331 df=73; ns	t=3.059 df=72; p≤0.005	t=2.716 df=73; p≤0.01	t=3.816 df=72; p≤0.0005	U=441; ns	U=511; ns	U=302; p≤0.005	U=298; p≤0.005
With a personality disorder compared to without a personality disorder: interaction during the time	Two way RM ANOVA: F=1.588 Df=21; ns		Two way RM ANOVA: F=2.270 Df=21; ns		Two way RM ANOVA: F=0.517 Df=21; ns		Two way RM ANOVA: F=1.414 Df=21; p≤0.05	

Tab. 4. ISMI – the mean scores of the whole group and comparisons of the depressive and non-depressive and with a personality disorder and without a personality disorder subgroups.

	Overall score	Alienation	Stereotype agreement	Perceived discrimination	Social withdrawal	Stigma resistance
All group mean	66.78 ± 13.71	15.58 ± 4.33	13.88 ± 3.47	10.53 ± 2.95	13.79 ± 3.97	11.00 ± 2.80
Depressive (n=17)	75.18 ± 8.77	17.65 ± 3.353	15.65 ± 2.805	11.82 ± 2.531	16.24 ± 3.364	9.412 ± 2.093
Non-depressive (n=59)	64.18 ± 13.97	14.95 ± 4.424	13.36 ± 3.493	10.14 ± 2.975	13.05 ± 3.858	11.48 ± 2.828
Depressive – not depressive: un-pair t-tests	t=3.056 df=70; p≤0.005	t=2.316 df=70; p≤0.05	t=2.470 df=73; p≤0.05	t=2.107 df=71; p≤0.05	t=3.062 df=71; p≤0.005	t=2.789 df=71; p≤0.01
With a personality disorder (n=21)	72.70 ± 12.12	18.00 ± 3.95	14.48 ± 3.47	12.05 ± 2.72	15.00 ± 2.96	10.45 ± 2.86
Without a personality disorder (n=55)	64.50 ± 13.70	14.65 ± 4.14	13.65 ± 3.47	9.96 ± 2.85	13.34 ± 4.22	11.21 ± 2.78
Un-pair t-tests	t=2.345 df=70; p≤0.05	t=3.111 df=70; p≤0.005	t=0.9276 df=73; ns	t=2.825 df=71; p≤0.01	t=1.613 df=71; ns	t=1.030 df=71; ns

selves more than the non-depressive ones and are also less resistant against internalized stigma.

The mean overall score of ISMI was statistically higher in the patients with a comorbid personality disorder compared to the patients without a personality disorder (Table 4). The subscales, which contributed to the difference most significantly, were alienation and perceived discrimination. Both of them were noticeably higher in the patients with a personality disorder. Therefore, patients with a personality disorder stigmatize themselves more than the individuals

without a personality disorder and it is connected to feelings of being alienated from others and discriminated by them.

Internalized stigma and its relation to the severity of the symptoms and depression

The internalized stigma level was significantly positively connected to the level of anxiety symptoms measured by BAI in the end of the treatment (Pearson $r=0.45$; $p\leq 0.05$) and it was also connected to the depressive symptoms measured both at the start (Pear-

son $r=0.44$; $p \leq 0.05$) and in the end of the treatment (Pearson $r=0.48$; $p \leq 0.05$) (Table 5).

The results show that the more patients had stigmatized themselves at the start of the treatment, the higher scores they achieved in all scales. Thus, the level of self-stigma was significantly positively associated with the levels of anxiety (BAI) and depression (BDI-II) and both subjective and objective evaluations of a mental state (subjCGI and objCGI) at the start of the treatment (Table 4).

Internalized stigma and its relation to the therapeutic change

The relationship between self-stigma and the change during the treatment was rather interesting. There was a significant negative correlation between a subjective evaluation of the change of the anxiety symptoms (BAI relative) and objective evaluation of the severity of the disorder (objCGI) during the treatment and internalized stigma (Table 5). It means that the more patients stigmatize themselves, the less they benefit from the treatment in respect to perceived anxiety symptoms (Figure 1). However, this relationship did not persist in the subjective overall evaluation of one's mental state

(subCGI) changes during the treatment. The connection between internalized stigma and the change of the depression symptoms (BDI-II) was not proven either.

DISCUSSION

Although there were published numerous studies focusing on the relationship between internalized stigma and treatment efficacy and prognosis, they were mostly related to psychoses and affective disorders (Yanos *et al.* 2008; Barney *et al.* 2006). Little is known about the impact of self-stigma on the treatment efficacy and development of minor psychiatry disorders, specifically neurotic disorders. Thus, the goal of this study was to find out if internalized stigma significantly contributes to the treatment efficacy of neurotic disorders.

One result of this research confirmed findings of previously published studies topic (e.g. Ritsher *et al.* 2003; Ritsher & Phelan 2004; Vauth *et al.* 2007) that found moderately strong connection between internalized stigma and depression.

As for the impact of internalized stigma on the combined pharmacological and psychotherapeutical treatment efficacy, we found an inverse relationship. The strong significant correlation between self-stigma and the change of the mental state during treatment evaluated by a physician supports the hypothesis that patients, who highly stigmatize themselves, improve noticeably less during treatment than patients with lower levels of self-stigma. The more individuals agree with prejudices about psychiatric patients and apply them on themselves, the less they improve their anxiety symptoms. However, the correlation connecting the internalized stigma to the depressive symptoms change was not significant. There are many possible explanations clarifying this phenomenon. One of the explanations might be that the objective evaluation (objCGI) overestimates the extent of the improvement during the treatment, other explanation might be that this non-significance was caused by the relatively small number of the participants.

The study has several limitations. The number of participants was relatively small and some of the patients did not fulfill all of the required items in the

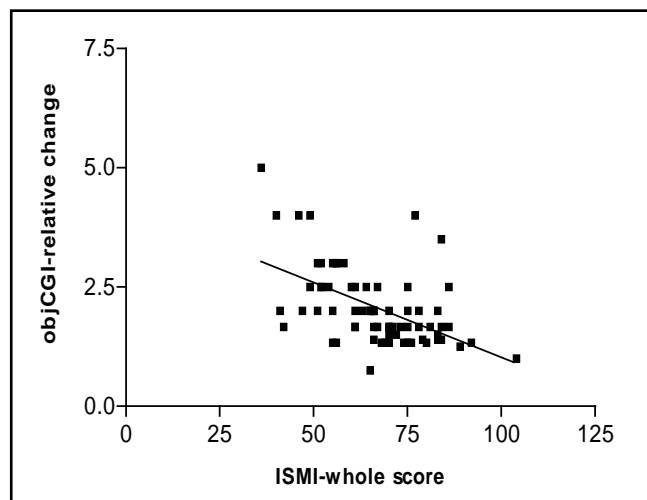


Fig. 1. A linear regression between ISMI and the relative change in objCGI. $F=26.31$ DFn, Dfd=1.000, 69.00; p -value: ≤ 0.0001

Tab. 5. The relationship between self-stigma and psychopathology.

	BAI-before	BAI-after	BDI-II-before	BDI-II-after	subj CGI-before	subj CGI-after	obj CGI-before	obj CGI-after
Correlation with ISMI-WS; Pearson ^P or Spearman ^S r	$r=0.30$; $p \leq 0.05$ ^P	$r=0.41$; $p \leq 0.0005$ ^P	$r=0.54$; $p \leq 0.0001$ ^P	$r=0.53$; $p \leq 0.0001$ ^P	$r=0.38$; $p \leq 0.005$ ^S	$r=0.32$; $p \leq 0.01$ ^S	$r=0.31$; $p \leq 0.01$ ^S	$r=0.60$; $p \leq 0.0001$ ^S
	BAI-relative change	BAI-absolute change	BDI-II-relative change	BDI-II-absolute change	subj CGI-relative change	subj CGI-absolute change	obj CGI-relative change	obj CGI-absolute change
Correlation with ISMI-WS; Pearson ^P or Spearman ^S r	$r=-0.32$; $p \leq 0.01$ ^P	$r=-0.10$; ns ^P	$r=-0.16$; ns ^S	$r=-0.04$; ns ^P	$r=-0.07$; ns ^S	$r=0.07$; ns ^S	$r=-0.52$; $p \leq 0.0001$ ^S	$r=-0.28$; $p \leq 0.05$ ^S

test battery. A certain limitation might pose the prevalent use of the psychological methods based on self-evaluation. The use of these scales is conditioned by the ability of introspection of probands and willingness to be honest in their statements. Another limitation presents a diffuse character of diagnoses which patients suffered from. The participants were diagnosed with various neurotic disorders and 1/4 of them suffered from a comorbid depressive disorder. The specific diagnostic groups might respond to the intensive therapeutic treatment differently. Because of the small numbers of the participants in the particular diagnostic units it was impossible to compare levels of internalized stigma among different disorders of neurotic spectrum. The patients differed in the diagnostic units that they suffered from but they were also treated with various medication. In spite of this diagnostic and treatment diversity, internalized stigma proves to be an important factor contributing to the treatment efficacy.

CONCLUSION

It seems to be useful to perform studies focusing on the internalized stigma and its impact on the treatment efficacy in particular anxiety disorders. Higher numbers of participants and their longer follow-up would be necessary conditions for such researches. Results of similar studies might be useful for the choice of an optimal therapeutic strategy for specific patients. Because the current methods of the treatment cannot help all patients and a lot of them remains resistant to treatment, it is necessary to search for alternative therapeutic approaches. Such approaches should be aimed especially on patients who suffer from high level of internalized stigma.

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