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Exploring Internalized Stigma, Self-Esteem, and Symptom Severity in Depression: A Comparative Study of Active and Remitted Phases

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Abstract

Objective

Internalized stigma, which refers to the internalization of negative attitudes and beliefs towards persons with mental illness, significantly impacts their self-perception and overall well-being. This research examines the correlations among internalized stigma, the severity of symptoms, and self-esteem in individuals diagnosed with major depressive disorder (MDD), specifically comparing those currently experiencing active depression with those who are in remission.

Material and Method

Participants were selected from a psychiatric outpatient unit based on their diagnosis of MDD. Participants provided sociodemographic information and completed assessments measuring the severity of depression, level of anxiety, self-esteem, and internalized stigma.

Results

Participants experiencing active depression exhibited elevated levels of depression severity, anxiety severity, and internalized stigma, while also reporting diminished self-esteem in comparison to those who were in a state of remission. Strong positive relationships were observed between the severity of depression and internalized stigma where self-esteem was negatively correlated with the stigma. The results of the regression analysis showed that there was a significant relationship between the severity of depression, self-esteem, and internalized stigma in the group of individuals with active MDD.

Conclusion

This study underscores the impact of depression severity and self-esteem on internalized stigma in individuals with MDD. The findings indicate the need to implement comprehensive treatment techniques that address psychological and social variables like self-esteem and internalized stigma in addition to symptom management. Future studies should investigate the long-term connections and assess the efficacy of interventions in reducing the obstacles caused by stigma in the process of recovering from depression.

Keywords: Anxiety, depression, internalized stigma, self-esteem, symptom, remission

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Introduction

Internalized stigma, sometimes referred to as self-stigma, is a kind of stigma that manifests alongside other forms such as personal (1), public stigma (attitudes towards others with mental illnesses) (2), perceived stigma (perceived attitudes of others towards mental illness), enacted stigma (experienced stigma), and treatment stigma (negative attitudes and beliefs about receiving treatment) (3). If a person agrees with stigmatizing beliefs and acts, they then proceed to internalize the stigma, which has a long-lasting and deep impact on them (4). An individual's preexisting social identity, which is determined by their positions within the community such as being a son, brother, sister, friend, employee, or possible lover, is gradually substituted with a diminished and stigmatized perception of oneself (5).

The presence of stigma related to mental diseases has been identified as a significant obstacle to maintaining treatment for depression (6) and may lead to reduced self-esteem (7) where negative thoughts may become a barrier to recovery (8). Studies have reported that higher depression symptoms predicted higher self-stigma, suggesting that those with higher depression hold more stigmatized views of themselves (9). Individuals who experience depression are often stigmatized as being unable to be cured, lacking strength, and having difficulty communicating (3). Therefore, individuals who experience depression may internalize stigmatizing judgments that make them feel unlovable, imperfect, and inadequate (10). Upon examining the literature, some studies found a significant relationship between depressive symptoms and internalized stigma among depressive disorder patients (6,10,11), anxiety and psychotic disorders (6), somatoform pain disorder patients (12), bipolar disorder patients (6,13) and the general public (9).

In addition, individuals may attribute responsibility to themselves and experience feelings of guilt for lacking the resilience to overcome their condition or feel a sense of humiliation over their sickness. Ultimately, it results in a substantial decline in one's self-esteem, to be more precise (3,14). Self-esteem is the personal assessment of one's ideas and emotions. Self-esteem may be seen as a cognitive framework that serves as a mechanism by which external information can impact mood and behaviour, either in a good or negative manner. Numerous studies have highlighted low self-esteem as an important risk factor for depression, where the link between self-esteem and depression is bidirectional, with self-esteem having a higher impact as a risk factor for depression (the vulnerability model) compared to depression's impact on self-esteem (the scar model) (15). Self-stigma is found associated both with harming self-esteem (16) and is negatively correlated with self-esteem in numerous studies which is in line with one of the definitions that conceptualize internalized stigma as “the loss of self-esteem and self-efficacy that occurs when people internalize the public stigma” (17).

Over the past two decades, the concept of internalized stigma has received significant scholarly attention. This is reflected in the substantial increase in both qualitative and quantitative research on the topic, highlighting its growing importance. Despite this wealth of research, there remain inconsistent findings regarding the relationships between sociodemographic factors, diagnostic categories, symptom severity, and internalized stigma (18). Considering the potential associations between internalized stigma, self-esteem, and depression, the previous research emphasized the importance and the need for cross-cultural studies and they acknowledged the present relationship may vary according to the clinical diagnosis and different phases of the illnesses (3,5,6,18). This study aims to address these inconsistencies by examining these associations across different diagnostic groups and sociodemographic settings. Accordingly, the primary goal of this research was to compare the internalized stigma, self-esteem, and symptom severity between individuals experiencing active phases of depression and those in remission, providing insights into how these constructs vary across different stages of the disorder. Additionally, the research sought to identify associations between internalized stigma, self-esteem, and symptom severity, illuminating the intricate interactions between these elements in the context of active depression. We hypothesize that individuals with active depression have higher levels of internalized stigma and lower levels of self-esteem compared to remitted depression patients. Moreover, there would be significant associations between symptom severity, self-esteem and internalized stigma. We acknowledge that by explaining the dynamics of internalized stigma, self-esteem, and symptom severity, this study may contribute to the creation of targeted therapies aimed at reducing the burden of depression and improving the well-being of affected persons.

Material and Method

Participants and Procedure

The patient cohort was drawn from individuals seeking assistance at the psychiatric outpatient unit of Celal Bayar University Hospital between January 2012 and March 2012, specifically selected if they met

the diagnostic criteria for MDD through DSM-IV-TR structured clinical interviews. The inclusion criteria for patients were: (i) to be between 18 and 65 years old, (ii) to have a diagnosis of MDD (iii) to not have any alteration in treatment regimen within the preceding month before the study. The exclusion criteria were: (i) Presence of any comorbid psychiatric disorders other than MDD, and (ii) the presence of psychotic symptoms, mental retardation, Substance Use Disorder /Alcohol Use Disorder, and neurocognitive disorder which may affect the responses of the participants, and (iii) presence of current hospitalization. Initially, 100 patients were recruited; however, 27 individuals were excluded due to the presence of psychiatric comorbidities other than MDD. Consequently, the patient group was divided into 2 subgroups including active MDD patients (n=50) and patients who are in remission (n=33). At the time of the study, all patients were undergoing regular antidepressant treatment.

Sociodemographic Form

The participants' demographic characteristics (e.g., age, education, disease duration, treatment duration, suicide attempt) were documented with the sociodemographic form prepared by the researchers.

Hamilton Depression Rating Scale (HDRS)

The Hamilton Depression Scale (HDRS) was developed to assess symptom severity in depression. The scale was revised by the same researcher in 1967 and given its final form with some modifications. In this study, we used the last modified version which includes 17 items (e.g. depressed mood, feelings of guilt, suicide, agitation) with a score from 0 to 4 or 0 to 2, depending on the severity. The scores are then summed up to obtain a total score, which can range from 0 to 53, with higher scores indicating more severe depression. The validity and reliability study for the Turkish population was carried out by Akdemir et al. (19) and the internal consistency coefficient was found to be .76.

Hamilton Anxiety Rating Scale (HARS)

The Hamilton Anxiety Rating Scale (HARS) consists of 14 items about somatic and psychological symptoms, including anxious mood, depressed mood, tension, insomnia, somatic symptoms, problems in the intellectual, sensory, cardiovascular, respiratory gastrointestinal, genitourinary, or autonomic systems, and the behaviour observed at interview (fidgety, restless, etc.). Each item is scored on a scale from 0 (not present) to 4 (very severe), with a total score range of 0-56. A total score <17 indicates mild anxiety whereas scores >25 or higher refer to moderate and severe anxiety. Yazıcı et al. (20) conducted the validity and reliability research among the Turkish population and the Cronbach alpha value was found to be .72.

Rosenberg Self-esteem Scale (RSES)

The Rosenberg Self-esteem Scale (RSES) was developed to evaluate an individual's self-esteem. The 4-point Likert-type scale consists of 10 items. The high scores obtained from the Rosenberg Self-Esteem Scale indicate low self-esteem. The responses to the items in this scale receive score values in the range of 0-6. In interpreting the scores; those scoring 0-1 are considered to have "high" self-esteem, those scoring 2-4 are considered "moderate," and those scoring 5-6 are considered to have "low" self-esteem (21). Cronbach Alpha coefficient for reliability was found to be .81.

Internalized Stigma of Mental Illness Scale (ISMI)

The Internalized Stigma of Mental Illness Scale (ISMI) is a self-report measure that includes 29 items within the framework of five subscales titled alienation, confirmation of stereotypes, perceived discrimination, social withdrawal, and resistance to stigma. The scale assesses people's subjective stigmatization experiences. The items are rated on a four-point Likert scale which ranges between strongly disagree (1) and strongly agree (4). For our research purposes, we only utilized the overall score of the ISMI scale in the analyses. The overall ISMI score is calculated by summation of the subscale scores ranging from 4 to 116. Higher ISMI scores indicate that the person's internalized stigma is more negative and severe. Turkish validity and reliability study was performed by Ersoy et al. (22) and Cronbach's alpha was found .93.

Statistical Analysis

All analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 16.0 (IBM Corp., Armonk, NY). The normality of distribution was checked by skewness kurtosis and visual plots. To examine differences in sociodemographic variables and applied scales between MDD and remission MDD groups, chi-square tests and independent samples t-tests were performed. Pearson bivariate correlations were utilized to analyze the relationship between variables including HDRS, HARS, RSES, and ISMI in the active MDD group. Subsequently, a multiple linear regression analysis was run to identify potential associations between ISMI and related variables in the active MDD group. Cohen's f2 was calculated to define the effect size within the regression model. According to Cohen's guidelines, f2 values of ≥ .02, ≥ .15, and ≥ .35 represent small, medium, and large effect sizes, respectively. The level of statistical significance (p) was set at <.05.

Results

Characteristics of the Participants

The sociodemographic features of individuals with MDD and those in remission from MDD are shown in Table 1. In the active MDD group, mean age, disease duration, and treatment duration were comparable to those in the MDD remission group. Both groups had similar educational backgrounds and gender distributions. Marital status also showed no significant difference between the two groups. However, there was a significant difference in the place of residence, with a higher proportion of individuals with active MDD residing in the city center compared to those in remission from MDD. Psychiatric history in the family, keeping mental disorders secret, experiencing

Table 1 Sociodemographic features of the groups

	Group						Statistics
	MDD (n = 50)			MDD remission (n = 33)			
	M	SD	n (%)	M	SD	n (%)	
Age	39.66	11.98		44.64	11.14		t(81) = -1.82, p = .072
Disease duration (months)	66.14	51.28		82.12	70.99		t(81) = -.921, p = .360
Treatment duration (months)	21.38	28.72		33.88	40.53		t(81) = -1.64, p = .104
Education							
Primary			32 (64%)			23 (70%)	χ2(2) = .508, p = .913
High			11 (22%)			7 (21%)	
University			7 (14%)			3 (9%)	
Gender							χ2(1) = .825, p = .364
Male			8 (16%)			3 (10%)	
Female			42 (84%)			30 (90%)	
Marital status							
Married			36 (72%)			26 (78%)	χ2(2) = 5.10, p = .164
In relationship			11 (22%)			2 (6%)	
Single			3 (6%)			5 (16%)	
Psychiatric history in family							
Present			21 (42%)			11 (33%)	χ2(1) = .63, p = .427
Not present			29 (58%)			22 (67%)	
Keeping mental disorder secret							χ2(1) = 1.319, p = .250
Yes			23 (46%)			11 (33%)	
No			27 (54%)			22 (67%)	
Exposure to discrimination							
Yes			11 (22%)			4 (12%)	χ2(1) = 1.310, p = .252
No			39 (78%)			29 (87%)	
Suicide attempt							
Yes			7 (14%)			2 (6%)	χ2(1) = 1.296, p = .255
No			43 (86%)			31 (94%)	

M: mean; SD: standard deviation

discrimination, sharing mental disorders, and reporting suicide attempts did not differ significantly between the groups. Table 2 compares individuals with active MDD to those in remission from MDD across several measures. In the active MDD group, the HDRS score was significantly higher than in the remission group. Similarly, for the HARS, the MDD group had significantly higher scores compared to the remission group, however, for both groups the anxiety severity was negligible. Additionally, the RSES scores were markedly higher in the active MDD group compared to the remission group which showed that the active group has less self-esteem relative to remission group. Similarly, the ISMI showed higher scores in the MDD group compared to the remission group indicating active group has more internalized stigma.

The associations between HDRS, HARS, RSES, and ISMI

The correlations among the main variables are illustrated in Table 3. According to the results of bivariate correlations, there was a positive correlation

Table 2 The comparison of mean values between groups

	Group						
	MDD (n = 50)			MDD remission (n = 33)			Statistics
	M	SD	n (%)	M	SD	n (%)	
HDRS	19.84	5.14		7.12	3.53		t(81) = 12.40, p < .001
HARS	7.42	5.33		2.82	2.05		t(81) = 4.72, p < .001
RSES	3.60	1.60		1.45	1.41		t(81) = 6.24, p < .001
ISMI	69.46	14.47		50.52	11.14		t(81) = 6.36, p < .001

Notes: HDRS: Hamilton Depression Scale, HARS: Hamilton Anxiety Scale, RSES: Rosenberg Self Esteem Scale, RSQ: Rosenberg Self-Esteem Questionnaire, ISMI: Internalized Stigma of Mental Illness Scale

Table 3 Correlational coefficients between HDRS, HARS, RSES and ISMI in the MDD group

Variable	1	2	3	4	5	6	7
1. Age	-	.17	-.32*	.09	-.01	-.14	-.13
2. Gender		-	.23	.02	.13	-.02	.10
3. Education			-	-.09	-.05	.06	-.23
4. HDRS				-	.49*	.17	.30*
5. HARS					-	.07	.19
6. RSES						-	.56**
7. ISMI							-

Notes: HDRS: Hamilton Depression Scale, HARS: Hamilton Anxiety Scale, RSES: Rosenberg Self Esteem Scale, RSQ: Rosenberg Self-Esteem Questionnaire, ISMI: Internalized Stigma of Mental Illness Scale
*p < .05, **p < .01

Table 4 The results of multiple linear regression analysis

Independent variables	Standardized βeta	t	p	R^2
HDRS	.365	3.129	.016	.53
RSES	.566	5.506	<.001	

Notes: Dependent variable: ISMI: Internalized Stigma of Mental Illness Scale; HDRS: Hamilton Depression Scale, RSES: Rosenberg Self Esteem Scale

between HDRS, RSES, and ISMI. However, there were no significant relationships found between age, gender, education, and HARS variables with ISMI. We executed multiple linear regression with the enter method to explore whether HDRS and RSES factors, which had significant associations in correlational analyses, were associated with the ISMI variable. In regression analysis, we included only a group of individuals which was referred to as an active patient group. The regression results revealed that both HDRS and RSES were associated with the ISMI ($F(2, 47) = 33.11$, $p < .001$) accounting for 53% of the variance which indicates a large effect size according to Cohen's guidelines. Coefficients are shown in Table 4.

Discussion

The study investigated the depression and anxiety symptom severity, self-esteem, and internalized stigma in patients with MDD, comparing individuals in active depression with those in remission. Additionally, we examined the associations between internalized stigma, symptom severity and self-esteem among individuals who have active depressive symptoms. Our results demonstrated that the active MDD group exhibited significantly higher scores on measures of depression severity, anxiety severity, and internalized stigma, along with lower self-esteem compared to the remission group. Moreover, our research revealed noteworthy associations between internalized stigma, self-esteem and the severity of depressive symptoms; that is, individuals with lower self-esteem and more pronounced depressive symptoms experienced a greater degree of internalized stigma.

Internalized stigma has become a significant focus of research, with a notable increase in related literature. Despite the extensive data, there are still conflicting findings in various diagnostic and sociodemographic contexts, such as different phases of mental disorders (23,24). Considering the need in this field, our study compared MDD patients who were in two distinct stages of the illness, and the results indicated that the patients who suffer from active depressive symptomatology bear higher internalized stigma when compared to the remission group. This finding corroborates the previous metanalysis findings that demonstrated mental disorder severity as a prominent risk factor in internalized stigma (3,5). Moreover, the studies including only depression samples demonstrated similar results that depression symptom severity poses a risk factor in internalized stigma (10,11,25). Although the anxiety scale was used to exclude its comorbid presence with depression in our study, we have included it in further analysis to examine the relationship. Our results showed no significant associations between anxiety and internalized stigma. In the literature, anxiety symptom severity was found to be positively correlated with internalized stigma among patients with anxiety disorders (5,26). This null finding could be attributed to the milder symptoms (<17 in HARS) of our sample which did not exceed the threshold to negatively affect the internalized stigma.

The sociodemographic variables including age, gender, and education were not related to the internalized stigma in our sample. Previous studies showed inconsistent findings and yielded mostly non-significant associations. In one systematic review, which explored the relationship between internalized stigma and socio-demographic characteristics, no consistent or strong correlation was found between internalized stigma and socio-demographic characteristics such as age, gender, education, employment, marital status, income, or ethnicity. In more detail, among the included studies in the review, 31 (81.6%) out of 38 studies reported no significant outcomes on gender and internalized stigma. Out of 35 age studies and 27 education studies, 24 (68.6%) and 22 (81.5%) reported non-significant results (17). These data suggest that the Turkish depression population also faces internalized stigma similarly regardless of socio-demographic factors.

While the prevailing body of research has linked self-stigma to diminished self-esteem, Livingston and Boyd's (17) investigation put forth the hypothesis that self-stigma could be predicted by individuals with mental illness who exhibited low self-esteem. One potential rationale for the association between low self-esteem and self-stigmatization is heightened vulnerability to stigmatizing concepts, additionally; low self-esteem is also considered to be a comorbidity with depression (27). Previous studies acknowledged self-esteem as a protective factor for internalized stigma. Particularly the researchers focused on solely depression samples and found out that higher self-esteem plays a noticeable role in decreasing self-stigma attitudes (28–30). Therefore, our study supports the earlier findings which again presented self-esteem's vital role in internalized stigma.

Study limitations: Although the research yielded valuable insights, it is imperative to acknowledge several limitations. Causal conclusions cannot be drawn from the cross-sectional design, and the findings may be difficult to generalize due to the relatively small sample size. Moreover, response bias may be introduced by the use of self-report measures, and the findings may not apply to the broader population of individuals with depression due to the exclusion of those with comorbid psychiatric conditions. Additionally, we did not include a control group in our study which may distort our perspective in reference scores of the healthy population.

Notwithstanding these constraints, the research enhances our comprehension of the intricate dynamics that exist among internalized stigma, severity of symptoms, and self-esteem in the context of depression. By incorporating participants in both the active depression and remission phases, significant insights can be gained regarding the varying effects of internalized stigma at distinct stages of the illness. Furthermore, our research conducted a comparative analysis of sociodemographic attributes (such as age, gender, education, and marital status) and psychosocial factors (including familial psychiatric history, secrecy regarding mental illness, encounters with discrimination, disclosure of mental disorder, and suicide attempts) between groups with active and remitted MDD. These variables were previously recognized as potential mediators in the development of internalized stigma. The absence of any discernible difference in these comparisons enhanced our ability to interpret our findings related to symptom severity, self-esteem and internalized stigma measurements. In active MDD patients, our research emphasizes the significance of two critical determinants of internalized stigma: depressive symptoms and self-esteem. This primary finding is consistent with one of the most recent systematic reviews, which identifies elevated self-esteem as a protective factor against internalized stigma and increased severity of depressive symptoms as a risk factor (3). The results emphasize the necessity of developing all-encompassing treatment strategies that tackle psychological and social determinants of depression in addition to alleviating symptoms. While the notion of stigma has persisted for several decades, curiosity and attention regarding its underlying causes, impact on mental health, and potential remedies have only emerged in recent times (24). Self-esteem and internalized stigma may be addressed through cognitive-behavioural techniques, peer support programs, and psychoeducation that seek to dispel negative beliefs and foster resilience (17). To mitigate internalized stigma and offer assistance and empowerment to individuals with mental illness, educational interventions that enhance their coping mechanisms and stigma management capabilities could be quite useful in clinical practice. Future research should explore longitudinal associations between internalized stigma, symptom severity, and self-esteem, and evaluate the effectiveness of interventions aimed at reducing stigma-related barriers to recovery in individuals with depression.

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Conflict of Interest Statement
The authors have no conflicts of interest to declare.

Ethical Approval
In our study, written consent was obtained from all the cases participating in our study, in accordance with the Declaration of Helsinki. Ethics Committee permission was obtained from Celal Bayar University Medical Faculty Clinical Research Ethics Committee with the decision dated 04.01.2012 and numbered 001.

Consent to Participate and Publish
Written informed consent to participate and publish was obtained from all individual participants included in the study.

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Availability of Data and Materials
Data is available on request from the authors.

Authors Contributions
PUA: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Writing-original draft.

EOT: Conceptualization; Project administration; Supervision; Validation; Writing-review & editing.

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