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Kelvin M.T. Fung, Hector W.H. Tsang, Patrick W. Corrigan, Chow S. Lam and Wai-ming Cheng

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MEASURING SELF-STIGMA OF MENTAL ILLNESS IN CHINA AND ITS IMPLICATIONS FOR RECOVERY

KELVIN M.T. FUNG, HECTOR W.H. TSANG, PATRICK W. CORRIGAN, CHOW S. LAM & WAI-MING CHENG

ABSTRACT
This study translated and validated the Chinese Version of the Self-stigma of Mental Illness Scale (CSSMIS), which may be used to measure self-stigma of mental health consumers in China. We also examined its correlation with self-esteem, self-efficacy and psychosocial treatment compliance. A cross-sectional observational study was implemented. Some 51 males and 57 females who suffered from severe mental illness were recruited from psychiatric settings in Hong Kong. They were required to complete the Chinese Version of the Self-stigma of Mental Illness Scale, the Rosenberg Self-esteem Scale and the Self-efficacy Scale. Their level of compliance during psychosocial treatment and their demographic information were recorded by their case managers. Exploratory factor analysis revealed two homologous factors for the four subscales of the CSSMIS. Factor 1 was related to the negative beliefs and consequences of having mental disorders, whereas Factor 2 was related to positive beliefs. The perceived stigma subscale and the three self-stigma subscales were strongly inter-correlated. Significant correlations were also found between almost all subscales of the CSSMIS and the remaining scales. The psychometric properties of the CSSMIS are statistically acceptable. The results also suggest that stigma played a detrimental role in undermining self-esteem, self-efficacy and psychosocial treatment compliance. Implications for recovery of mental health consumers are discussed.

Key words: measurement, psychosocial treatment compliance, self-efficacy, self-esteem, stigma

INTRODUCTION
The lives of many mental health consumers are seriously impeded by stigma (Link et al., 1987; Schumacher et al., 2003), which obstructs them from social integration and recovery (Page, 1995). There is a lot of public stigma in both the Western world (Hamre et al., 1994; Link, 1987; Phelan et al., 2000) and Chinese societies (Tsang et al., 2003; Yang & Pearson, 2002). Mental health consumers frequently face difficulties in seeking employment (Link, 1987; Tsang et al., 2003), leasing apartments (Alisky & Iczkowski, 1990; Page, 1983; Tsang et al., 2003), and accessing social opportunities (Holmes & River, 1998).
Apart from public stigma, self-stigma (or internalized stigma) is believed to worsen one’s recovery (Corrigan et al., in press; Ritsher et al., 2003; Ritsher & Phelan, 2004). In response to the negative attitudes and discriminatory actions from the public, mental health consumers may generate an internalized reaction to act against themselves (Corrigan & Watson, 2002), which may prevent them from seeking professional assistance (Meltzer et al., 2003).

Self-stigma is a three-level process which consists of stereotype agreement, self-concurrence and self-esteem decrement (Corrigan et al., in press). In the initial phase of self-stigmatization, mental health consumers agree with the perceived negative stereotype towards mental illness. They then further internalize this general agreement and concur with the public stereotype specifically applied to them. Finally, personal qualities are contaminated via the internalization process, and their self-esteem is eventually impeded (Corrigan et al., in press). This process of self-stigmatization leads to a drop in their self-esteem. Unfortunately, the egregious consequence of self-stigma is most prominent among those with low self-esteem and low self-efficacy (Corrigan & Watson, 2002). Self-esteem in fact would be eroded by self-stigma under a vicious cycle. Less emotional disturbance is noticed among those who do not internalize the negative stereotype to their own circumstances (Ritsher & Phelan, 2004).

The psychological mechanism of self-stigmatization in undermining the recovery of mental health consumers could be explained according to the concepts of self-esteem and self-efficacy decrement. Self-stigmatized mental health consumers always show lower self-esteem and self-efficacy. Attributing negative circumstances to their own cause is the common attributional style for those with low self-esteem (Crocker et al., 1988; Weiner, 1995). Individuals with low self-efficacy frequently possess the feeling of incapability, and demonstrate avoidant behaviors for required tasks (Bandura, 1986). They give up more easily because of their frustrated personal beliefs and identities. Undoubtedly, self-stigma would impede their recovery (Ritsher & Phelan, 2004) by obstructing their participation in and utilization of pharmacological and psychosocial interventions (Corrigan, 2004; Watson & Corrigan, 2001). Self-stigmatized consumers are likely to have poor recovery because treatment compliance is essential for them to acquire positive therapeutic outcomes (Ludwig et al., 1990). Under the influences of Confucian values and the related concept of fate (Nagayama Hall, 2002), this internalization process of public stigma into self-stigma is thought to be more obvious among Chinese mental health consumers. These relationships are illustrated in Figure 1.

![Figure 1. The simplified process of self-stigmatization on impeding recovery](image-url)
The psychological well-being of the self-stigmatized individuals is found to be persistently affected, even though their symptoms and functioning have been ameliorated by the interventions (Link et al., 1997). In view of its importance, a specific measure of self-stigma for mental health consumers based on the above three-level process model is urgently needed among Chinese, who constitute a quarter of the world’s population.

With a better understanding of its disruptive mechanism, intervention strategies to improve consumers’ treatment compliance, reduce their self-stigma, and thus enhance their treatment outcomes and recovery may be formulated. As there is a lack of validated scale for use among Chinese, the Self-stigma of Mental Illness Scale (SSMIS; Corrigan et al., in press) was adopted, translated and validated to ensure that this scale is applicable to Chinese-speaking mental health consumers. The Self-stigma of Mental Illness Scale (Corrigan et al., in press) consists of four subscales. The first subscale measures stereotype awareness, which represents perceived discrimination of the mental health consumers. The remaining three subscales are stereotype agreement, self-concurrence and self-esteem decrement, which represent respectively the three-level process of self-stigma. Each subscale contains the same 15 items in random order with different introductory clauses. Table 1 illustrates an example of the introductory clauses for each SSMIS subscale. To facilitate our comparison with Corrigan et al.’s study (Corrigan et al., in press), we used the same instruments for measuring self-esteem and general self-efficacy in this study.

The relationship between self-stigma with self-esteem, self-efficacy and psychosocial treatment compliance for Chinese mental health participants was examined to see whether it is consistent with the literature that self-stigma is related to low self-esteem and self-efficacy (Corrigan, 2004; Corrigan & Watson, 2002; Corrigan et al., in press; Ritsher & Phelan, 2004; Watson & Corrigan, 2001), and poor treatment compliance (Corrigan, 2004: Watson & Corrigan, 2001). Implications for the recovery of the mental health consumers are discussed.

**METHOD**

**Development of the CSSMIS**

The Self-stigma of Mental Illness Scale was translated from English to Chinese by a qualified translator so that the Cantonese-speaking respondents could understand the scale. The translated Chinese version was then back-translated independently to English by another qualified translator. Discrepancies in semantic meaning between the original English version and the back-translated version were identified by two postgraduate candidates with expertise in mental health research. The discrepancies were further examined by two doctoral-level researchers who are experts in

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Introductory clause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stereotype awareness</td>
<td>I think the public believes most persons with mental illness…</td>
</tr>
<tr>
<td>Stereotype agreement</td>
<td>I think most persons with mental illness are…</td>
</tr>
<tr>
<td>Self-concurrence</td>
<td>Because I have a mental illness, I…</td>
</tr>
<tr>
<td>Self-esteem decrement</td>
<td>I currently respect myself less because I…</td>
</tr>
</tbody>
</table>

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Minor amendments were made to the Chinese version so as to reconcile the differences based on their comments. The amendments included improving item presentation and correcting some mistranslated words.

Participants
One hundred and eight mental health consumers (47.2% males and 52.8% females) were recruited. They were inpatients (42.6%), day patients (46.3%), outpatients (3.7%) or other service recipients (7.4%) recruited from Kwai Chung Hospital, which is one of the major mental hospitals in Hong Kong, and Lai Kwan Day Training Centre of Baptist Oi Kwan Social Services. On average, they were 38.47 ± 8.13 years old. Their medical records showed that they were diagnosed with schizophrenia (79.6%), depressive disorder (6.5%), bipolar affective disorder (8.3%), schizoaffective disorder (3.7%) or delusional disorder (1.9%) by psychiatrists. They had received at least primary education, and most of them were single (76.9%). Individuals with developmental disabilities, dementia, substance misuse and hearing impairment were excluded.

Instruments
Perceived discrimination and self-stigma of the mental health consumers were assessed by the Chinese version of the Self-stigma of Mental Illness Scale (CSSMIS) described earlier. Participants were required to fill in this instrument based on a nine-point Likert scale assisted by a qualified assessor. Higher scores represent a higher level of perceived discrimination and/or self-stigma. The four original subscales have demonstrated satisfactory internal consistency (from 0.64 to 0.87) and test–retest reliability (from 0.62 to 0.75) (Corrigan et al., in press). Construct validity was well established via the convergent validation with the Rosenberg Self-esteem Scale (Rosenberg, 1965) and General Self-efficacy Scale (Sherer & Adams, 1983). Global self-esteem was assessed using the 10-item Rosenberg Self-esteem Scale (Rosenberg, 1965). It is rated using a four-point Likert scale, with a higher score representing higher expected self-esteem for the participants. General self-efficacy and social self-efficacy were measured by the 23-item Self-efficacy Scale (Sherer et al., 1982). Each item is scored from 1 to 14, with a higher score indicating higher general/social self-efficacy. The Rosenberg Self-esteem Scale and the Self-efficacy Scale were translated from English to Chinese by qualified and independent translators. Their content validity and cultural relevancy were ensured by means of an expert panel.

Psychosocial treatment compliance of the mental health consumers was measured by using the 17-item Psychosocial Treatment Compliance Scale (PTCS; Tsang et al., in press). The PTCS was developed and validated in Hong Kong by our team earlier. Two subscales of ‘Participation’ and ‘Attendance’ based on factor analysis were used in assessing compliance, with a higher score indicating better adherence. Respondents were required to answer this scale based on a five-point Likert scale from ‘Never’ to ‘Always’. Excellent internal consistency and good test–retest reliability were obtained for the subscales.

Data collection
Before data collection, research assistants who were certified occupational therapists explained the general information of this study to participants and obtained their written consent. The research assistants then interviewed the participants to complete the CSSMIS, the Rosenberg Self-esteem Scale and the Self-efficacy Scale. The demographic information sheet and the PTCS of participants were filled in by the respective case managers. The demographic data were obtained from
the participants’ medical records. The PTCS was filled in by the case managers, who were experienced occupational therapists, because they were key persons in providing psychosocial treatment to the participants. All of them had participated in a training session on the use of the PTCS. This was to ensure that reliable data were gathered. To examine the test–retest reliability of the CSSMIS, the first 31 participants had to complete the CSSMIS again within one to two weeks of the first administration. One-time assessment was administered for the remaining participants.

Data analysis
The Statistical Package for the Social Sciences version 11.0 was used to analyze the data. Descriptive statistics were used to compute participants’ demographic information. The coefficient alpha was used to assess the internal consistency of each subscale of the CSSMIS. The intraclass correlation coefficient was used to test the stability of the CSSMIS at two different time intervals. Exploratory factor analysis was conducted to test the factor structure of the subscales of the CSSMIS. It was inappropriate to group all the subscales together for factor analysis because the four subscales contained the same 15 items. The adequacy of data set for exploratory factor analysis was assessed by the Kaiser–Meyer–Olkin (KMO) Measure of Sample Adequacy (Kaiser, 1974), and Barlett’s Test of Sphericity (Bartlett, 1954). Kaiser’s criterion (eigenvalues greater than 1) and Cattell’s scree test (Cattell, 1966; plot of eigenvalues versus factor numbers) were used to assess the number of factors for extraction (Gorsuch, 1983). Orthogonal rotation using varimax was applied for better interpretation of factor structures. The bivariate correlation between perceived stigma, self-stigma, self-esteem, self-efficacy and psychosocial treatment compliance was investigated by using Pearson coefficient of correlation. The overall heterogeneity of correlations across different levels of stigma with self-esteem, self-efficacy and compliance was tested using a chi-square test, which is based on Fisher’s Z transformation (Meng et al., 1992). The post-hoc pair-wise comparisons were then followed to examine their pattern of differences. The pattern of scores of self-esteem, self-efficacy and psychosocial treatment compliance across the chain of stigmatization was verified according to the chi-square test and post-hoc test. The intensified negative effect of stigmatization from stereotype awareness to self-esteem decrement was then justified.

RESULTS
The internal consistency of the subscales of the Chinese Version of Self-stigma of Mental Illness Scale was excellent. The internal consistency was 0.82 for stereotype awareness, 0.85 for stereotype agreement, 0.90 for self-concurrence and 0.88 for self-esteem decrement respectively. Good test–retest reliability, ranging from 0.71 to 0.81, was also garnered for the four respective subscales of the CSSMIS.

Exploratory factor analysis was used to examine the factor structures of the subscales of the CSSMIS. All subscales attained the KMO value > 0.60, and Bartlett’s test value < 0.05, which supported their adequacy for factor analysis. It has been confirmed by Kaiser’s criterion and Cattell’s scree test that each subscale should retain two factors. Factor 1 and factor 2 accounted for 31.14% and 10.90% of the total variance respectively for stereotype awareness; 36.42% and 12.09% for stereotype agreement; 46.36% and 9.91% for self-concurrence; and 40.64% and 14.11% for self-esteem decrement. The mean item score of the four subscales ranged from 2.45 to 6.90 ($SD = 1.80–2.65$).
Under the factor structure of self-esteem decrement, Item 7, ‘I have something that is contagious’, loaded evenly on factor 1 (0.540) and factor 2 (0.544). As factor 1 represented the negative attitudes and consequences of having mental disorders, Item 7 was allocated to this factor for consistency of meaning (Kim & Mueller, 1978). An amazing pattern of factor structure was revealed. The items for factors 1 and 2 were homologous among the four subscales. Thirteen items belonged to factor 1, which described the negative beliefs and consequences of having mental disorders. In contrast, factor 2 consisted of two items that were related to positive sides of having mental disorders. Their rating had been converted before the factor analysis procedure. It showed that these two items under factor 2 were still in the negative direction with respect to the items of factor 1. After removing the items of factor 2, the overall internal consistency improved slightly from 0.82 to 0.85 for stereotype awareness, 0.85 to 0.88 for stereotype agreement, 0.90 to 0.92 for self-concurrence, 0.88 to 0.92 for self-esteem decrement. It seems that the accuracy of measuring the same characteristic for each subscale was not affected by including the two positive items.

As presented in Table 2, significant correlations were found between the four subscales of the CSSMIS at $p < 0.01$ level. The three self-stigma subscales were strongly inter-correlated ($r = 0.639$ to 0.915), especially for the self-concurrence subscale and the self-esteem decrement subscale. They were also strongly associated with the stereotype awareness subscale ($r = 0.569$ to 0.754).

### Table 2

<table>
<thead>
<tr>
<th></th>
<th>Stereotype awareness</th>
<th>Stereotype agreement</th>
<th>Self-concurrence</th>
<th>Self-esteem decrement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stereotype awareness</td>
<td>1.000**</td>
<td>0.754**</td>
<td>0.612**</td>
<td>0.596**</td>
</tr>
<tr>
<td>Stereotype agreement</td>
<td></td>
<td>1.000**</td>
<td>0.658**</td>
<td>0.639**</td>
</tr>
<tr>
<td>Self-concurrence</td>
<td></td>
<td></td>
<td>1.000**</td>
<td>0.915**</td>
</tr>
<tr>
<td>Self-esteem decrement</td>
<td></td>
<td></td>
<td></td>
<td>1.000**</td>
</tr>
</tbody>
</table>

Significant correlation between the pairs: **$p < 0.01$**

### Table 3

<table>
<thead>
<tr>
<th></th>
<th>Stereotype awareness of CSSMIS</th>
<th>Stereotype agreement of CSSMIS</th>
<th>Self-concurrence of CSSMIS</th>
<th>Self-esteem decrement of CSSMIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in the PTCS</td>
<td>−0.180</td>
<td>−0.319**</td>
<td>−0.394**</td>
<td>−0.390**</td>
</tr>
<tr>
<td>Attendance of PTCS</td>
<td>−0.258**</td>
<td>−0.343**</td>
<td>−0.425**</td>
<td>−0.391**</td>
</tr>
<tr>
<td>Rosenberg Self-esteem Scale</td>
<td>−0.462**</td>
<td>−0.429**</td>
<td>−0.701**</td>
<td>−0.674**</td>
</tr>
<tr>
<td>Self-efficacy: General</td>
<td>−0.457**</td>
<td>−0.444**</td>
<td>−0.731**</td>
<td>−0.738**</td>
</tr>
<tr>
<td>Self-efficacy: Social</td>
<td>−0.369**</td>
<td>−0.444**</td>
<td>−0.519**</td>
<td>−0.514**</td>
</tr>
</tbody>
</table>

Significant correlation between the pairs: **$p < 0.01$**
Significant correlations were found between the four subscales of the CSSMIS with the scales of self-esteem, self-efficacy and psychosocial treatment compliance at the 0.01 level. The bivariate correlations are listed in Table 3. The negative correlations indicated that a higher level of perceived stigma and/or self-stigma was associated with poor self-esteem, self-efficacy and compliance. Stronger correlations were found in the self-concurrence and self-esteem decrement with the measures. The only exception is that there was no significant correlation between stereotype awareness of the CSSMIS and the participation subscale of the Psychosocial Treatment Compliance Scale.

Further steps were taken to explore how the correlation coefficients differed significantly among the four subscales of the CSSMIS with the self-esteem, self-efficacy and psychosocial compliance scales. The chi-square test indicated that a higher level of perceived stigma and/or self-stigma was associated with poor self-esteem, self-efficacy and compliance. Stronger correlations were found in the self-concurrence and self-esteem decrement with the measures. The only exception is that there was no significant correlation between stereotype awareness of the CSSMIS and the participation subscale of the Psychosocial Treatment Compliance Scale.

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Further steps were taken to explore how the correlation coefficients differed significantly among the four subscales of the CSSMIS with the self-esteem, self-efficacy and psychosocial compliance scales. The chi-square test indicated that significant differences in correlation existed in participation of the PTCS ($\chi^2(3) = 9.77, p = 0.021$), self-esteem scale ($\chi^2(3) = 29.38, p = 0.000$), and general self-efficacy scale ($\chi^2(3) = 43.08, p = 0.000$) among the four subscales of CSSMIS. Post-hoc comparisons demonstrated significant differences between stereotype agreement and self-concurrence for self-esteem ($Z$-score $= -4.33$, $p = 0.000$) and general self-efficacy ($Z$-score $= -4.71$, $p = 0.000$). The overall results in testing the heterogeneity of correlated correlations are shown in Table 4.

### DISCUSSION

This study aimed to assess the psychometric properties of the Chinese Version of Self-stigma of Mental Illness Scale. Excellent internal consistency of the subscales of the CSSMIS suggests that the items of each subscale measure the same underlying construct. The promising test–retest reliability shows that acceptable temporal stability is noted across the implementation of the CSSMIS.
Two identical factors are explored for the four subscales of the CSSMIS. After recoding the reversed items, inconsistency in pattern is still noted for factor 2. The appropriateness of the two positive items for measuring stigma is doubtful. This intriguing finding may be because of the poor agreement among the participants that mental health consumers are geniuses or unusually artistic. Most of the non-stigmatized participants simply held the belief that having mental disorders should not disable them. This was shown by the high mean scores of these two items in the subscales, and by the feedback of participants when they answered the questionnaires. The retention of these items for further study of perceived stigma and self-stigma of the mental health consumers should be considered. Fortunately, the overall internal consistency of each subscale did not violate the retention of these two positive items. Our results supported that the four 15-item subscales are reliable in measuring perceived stigma and self-stigma.

Significant inter-correlations among the three self-stigma subscales have been demonstrated in our study and the previous research done by Corrigan et al. (in press). The correlation between stereotype agreement and self-concurrence suggests that mental health consumers consented to the public stereotype and thus internalized it. The strong association between self-concurrence and self-esteem decrement suggests that decrease in self-esteem then automatically occurred after the self-internalization process (Corrigan et al., in press). However, one obvious difference was found between this study and the one reported by Corrigan et al. (in press). Our study illustrated significant correlations between the perceived stigma subscale and the three self-stigma subscales, whereas the study done by Corrigan and colleagues (Corrigan et al., in press) did not. This may imply that there was a cultural difference between Chinese and American consumers in transforming perceived public stigma to self-stigma.

This disparity is theoretically in step with our earlier thought that Chinese are more ready to concur with public stigma under the influences of the Confucian values and the concept of fate (Nagayama Hall, 2002). The prominence of collectivistic ideas held in Chinese culture (Philipchalk, 1995) turns individuals’ focus more on to their social identity and value (Lord, 1997). For instance, the influence of collectivism in Hong Kong is stronger than that in the United States. Mental health consumers in Hong Kong should therefore be more easily affected by social influences, which included agreeing with the public stereotype of mental illness and hence turning it into their self-stigma. Although this explanation is largely hypothetical, it provides us with the insight to include cultural factors in our further research on understanding the stigmatization process towards people with mental illness.

Our findings also dovetailed the previous claim that self-stigma is related to low self-esteem and diminished general self-efficacy (Corrigan, 2004; Corrigan & Watson, 2002; Watson & Corrigan, 2001). Contrary to the study done by Corrigan et al. (in press), we found a significant association between stereotype agreement and self-esteem/self-efficacy. It seems that the self-esteem and self-efficacy of mental health consumers would be negatively affected if they were aware of public stigma against them. Apart from self-stigma, significant correlations between perceived stigma and self-esteem/self-efficacy were found which parallel earlier findings (Kahng & Mowbray, 2005; Link et al., 2001). Significant associations were shown between self-esteem/self-efficacy and self-stigma/perceived stigma. As shown by the Z-scores, we can see that there is an increase of correlation coefficients from stereotype agreement to self-concurrence. This implies that the effect of stigma on self-esteem and general self-efficacy is intensified along the process of self-stigmatization. Similar to Corrigan et al.’s findings, our study shows that diminished self-esteem and self-efficacy are most
prominent for the stages of self-concurrence and self-esteem decrement. This evidence suggests that the internalization of stigma further impeded their feeling of self-worth, and their expectation that they would accomplish tasks.

Self-stigmatized individuals may not adhere to prescribed psychiatric treatment to minimize the chance of being labeled. Some of them may feel hopeless and think that treatment yields no beneficial effects for them (Corrigan, 2004; Watson & Corrigan, 2001). Others may think that their illness will be discovered by others when they are utilizing mental health facilities or services. Our findings support this phenomenon that higher self-stigma correlated significantly with poor psychosocial treatment compliance. Our findings have also demonstrated a significant correlation between the ‘stereotype awareness’ subscale of the CSSMIS and the ‘attendance’ subscale of the PTCS. This implies that higher perceived stigma is associated with poor attendance of psychosocial treatment. This goes harmoniously with the findings of Sirey et al. (2001) that those depressed elderly people with strong perceived stigma are more likely to discontinue outpatient treatment. However, no significant correlation is found between participation and perceived stigma. It may imply that if someone can overcome the barrier of perceived stigma in utilizing psychiatric services, their level of participation should increase. The above correlations suggest that self-stigmatization is closely related to self-esteem and self-efficacy decrement and treatment non-compliance, and imply that self-stigmatization is a serious obstacle for the recovery process of mental health consumers.

The psychometric properties of the Chinese Version of the Self-stigma of Mental Illness Scales have been well established. Other than a correlational study, further research should focus on studying the possible psychological mechanism as to how self-stigma impedes the recovery of mental health consumers. More sophisticated statistical analyses such as multiple regression or path analysis should be implemented to explore the explanatory effects of self-stigma on psychosocial treatment noncompliance, and to verify the inter-relationships between perceived stigma, self-stigma, self-esteem and self-efficacy in altering treatment compliance. Future research should therefore be targeted towards alleviating the detrimental effects of stigma by means of appropriate intervention programs.

This study adopted the quantitative approach to obtaining information on self-stigma of mental health consumers. Although numerical figures are useful for objective data analyses, a limitation of this study is that we did not include qualitative data expressing participants’ feelings of self-stigmatization. However, we did make interesting observations and heard impressive remarks from our respondents during the administration of the questionnaires on issues that we did not ask. Some self-stigmatized participants expressed that the public undermined their ability and did not give them equal opportunities for participation in the community. They further contended that this discriminatory public attitude made them give up treatment. This is because they think it is impossible to remove the label of ‘being crazy’ from the public no matter how hard they try. One participant said that he felt ashamed to be mentally ill. This feeling was most intense when he arrived at the day hospital to receive treatment. These comments clearly conveyed the message that self-stigma interferes with treatment compliance, which parallels our quantitative analysis described earlier. Meanwhile, it points to the fact that a qualitative approach to studying the experience of self-stigma will help us to understand this phenomenon better. Studies with a combination of quantitative and qualitative approaches should therefore be implemented in the future so that we may gain more thorough understanding of how the negative effects of self-stigma obstruct the recovery of mental health consumers.
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