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Between self-stigma and the will of recovery. Difficulties in accepting a psychiatric diagnosis – case study

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Summary

The consequence of social exclusion of the mentally ill patients is often a worsening of the course of the disease and prognosis. The psychiatric diagnosis is very important for the so-called labeling, which is one of the stages of the stigma process, and it also has a lot of social implications.

The purpose of this work is to take look at the issue of psychiatric diagnosis, especially the diagnosis of paranoid schizophrenia and its consequences for the patient's social functioning. The authors of the article have reviewed the literature on the importance of psychiatric diagnosis in the context of self-stigmatization of mental illness and have presented, based on medical records, a clinical case of a patient who had significant difficulties in accepting the diagnosis of paranoid schizophrenia. The stigma of mental illness is the reason of subjectively experienced suffering for people with psychiatric diagnosis and their relatives, but it is also relevant to public health. Psychiatric diagnosis has significant social consequences, which is why it is so important that the process of diagnosis is not a routine activity for psychiatrists, free from ethical reflection.

Key words: psychiatric diagnosis, stigmatization, schizophrenia

Introduction

The undoubted effect of stigmatization and social exclusion of mentally ill people is the worsening of the course of the illness [1]. The term 'self-stigma' in the title means self-stigmatization, which is referred to in literature as the second illness [2] and is associated with internalizing and referring to oneself negative stereotypes present in the mentality of the society, which often worsens the prognosis, leading to a decrease in the sense of value, dignity and self-efficacy in the patient bringing the so-called stigma [3]. Not without significance is psychiatric diagnosis, which affects the so-called labeling–one of the main stages of stigma [3, 4].

The purpose of the work is to look at the issue of psychiatric diagnosis and its role and consequences, as well as presenting the case of a patient who exhibited significant difficulties with the acceptance of the diagnosis made by psychiatrists. On the one hand, she pinned her hope on the therapy used, on the other, she did not want to accept the diagnosis of paranoid schizophrenia. The authors of the work used here medical documentation and available Polish and foreign literature concerning the issues included in the title of the study.

Psychiatric diagnosis

Diagnosis of mental disorders is one of the basic tasks of a specialist psychiatrist and as such it presents a special social context [3]. The social effects of psychiatric diagnosis can sometimes be a greater burden for the patient than just overcoming psychopathological symptoms associated with the illness [5]. According to Corrigan [6], the negative impact of the diagnosis on the patient's social functioning is an example of the structural stigmatization of the mentally ill, while approaching the diagnosis as a description of the symptoms on a certain continuum, also including the construct of the norm, could reduce the stigmatizing consequences, as it would not emphasize the difference of a person with mental disorders. Already in the late 1970s, Promieńska [7] raised the issue of moral evaluation in the context of psychiatric diagnosis. In the case of the analysis of the issues of moral assessments and psychiatric diagnoses, we definitely deal with the situation of the co-existence of numerous causes of a semantic blurring of many basic concepts, as recognizing the links between the sphere of axiological choices of a man and his/her mental health is significant for certain trends of psychiatry and ethical reflection, which results in blurring the difference between the act of moral assessment and psychiatric diagnosis.

Oleksandr et al. [8], in relation to the ethics of psychiatric diagnosis, presents two main extreme directions regarding the problem of the relation of mental health to illness, i.e., nosocentrism and normocentrism. Nosocentrism is the doctor's thinking focused on the search for illness and pathology, where any deviation from the expected function of the human psyche is classified as a sign of illness, symptom or syndrome. This approach is often associated with overinterpretation of mental illness [9]. In contrast, normocentrism is the doctor's thinking focused on seeking only sanogenic factors, so that even abnormal behaviors are psychologized and explained by the situation and are not excluded from the framework of mental health. The absolutization of this principle lies at the root of antipsychiatry [8].

Rosenhan [10] used to write about normal people in an abnormal environment as follows: "If there is mental health and mental illness, how can they be distinguished? This question is not a freak invention or madness. Regardless of how deeply we are convinced that we can distinguish a healthy person from a mentally ill person, the evidence for this is not fully convincing (…)".

Presentation of a clinical case

A 32-year-old patient, married, childless, living with her family. There is no information in the family history about the occurrence of mental illness. The patient graduated from law department in legal matters and then began her legal advisor training.

Mental disorders began at the age of 27. According to her husband, she began to repeatedly claim that she did not want to live, she was afraid that her superiors at work would accuse her of allegedly making mistakes. She exhibited self-destructive behavior and suicidal tendencies. She reported to a psychiatrist who recognized depression and recommended venlafaxine and trazodone. The patient was on medicines for half a year.

The illness came back in the fall, three years later. After returning from work, the patient stated that she felt persecuted, that strangers on the street were talking about her. At home, she began looking for installed wiretaps. She repeated that she did not want to live, she asked her husband to help her in taking her own life and re-arrange his life anew.

The outpatient psychiatrist prescribed olanzapine, chlorproticsen, trazodone, and escitalopram. Despite being on a drug regime, the symptoms continued. Due to the lack of improvement in outpatient treatment, the patient was referred to the psychiatric ward of a nearby hospital. She was prescribed venlafaxine and olanzapine there. She began to reveal specific suicidal plans – she planned to jump from a tall building. Therefore, she was discharged with the diagnosis of recurrent depressive disorder – severe depression with psychotic symptoms and transferred to the psychiatric ward, where she was hospitalized for over a month at the age of 31. During hospitalization in the local ward, the patient exhibited bizarre, maladjusted behavior, poor affect, did not engage into any delusional content, although the patient's behavior indicated that she could be subject to persecutory delusions at that time. Venlafaxine (up to 300 mg/d), mianserin (up to 90 mg/d), olanzapine (up to 20 mg/d), aripiprazole (up to 30 mg/d), and perazine (up to 300 mg/d) were used in the treatment. During hospitalization, the patient repeatedly asked if she would have to take medicine for life, was afraid of the diagnosis of schizophrenia, claimed that she would not want to live with such a diagnosis.

After improving of her mental state, the patient was discharged home with the diagnosis: other acute and transient psychotic disorders. Two weeks after discharge, the patient was re-admitted to the general psychiatric ward, as a result of increased suicidal thoughts and auto-aggressive behavior. At the time of admission, she presented as emotionally stiff person, answered questions in a weakly modulated, monotonous voice, did not develop threads. She was visibly confirming the presence of suicidal thoughts, denied the occurrence of hallucinations, but the attending physician considered the possibility of dissimulation. She would often ask for discharging home and whether she would have to take medicine for the rest of her life. Her behavior and specific thinking logic contrasted with the level of education, which could indicate the development of depleting symptoms of the schizophrenic process. During this hospitalization, she was treated with venlafaxine (up to 150 mg/d), olanzapine (up to 20 mg/d), risperidone (up to 5 mg/d), and aripiprazole (up to 30 mg/d). After less than a month,

she was discharged with a diagnosis of recurrent depressive disorder, an episode of severe depression without psychotic symptoms, and then admitted to a psychiatric clinic to continue treatment, which was sought for by the patient's family. During this hospitalization, the patient showed low activity, had a pale affect, was unwilling to take action. She repeatedly asked doctors about the diagnosis, expressed great concern as for the diagnosis of schizophrenia. She told her husband that she was too young to be ill, she was afraid that she would not be able to work or have children. Olanzapine (up to 20 mg/d) and aripiprazole (up to 30 mg/d) were maintained in treatment, and paroxetine (up to 20 mg/d) was included. After improving her mental state, the patient was discharged in a balanced mood and drive, without any productive symptoms or suicidal thoughts and tendencies.

During outpatient treatment, the patient was repeatedly motivated by the attending physician to the concept of psychotherapy, but she never decided on it. She would have had to admit and accept that she needs the help of a psychotherapist, while she still denied such a need.

At the age of 31 she was admitted again to a psychiatric clinic due to a significant deterioration of her mental condition, which had been going on for several days. She was restless, tearful, did not spontaneously produce delusional content, but her behavior indicated that she could be under their influence. She signed the consent for hospitalization reluctantly, shortly after admission she tried to strangle herself with her hands using a coat strap. It was necessary to apply direct constraint to the patient in the form of four-limb immobilization with safety belts.

During hospitalization, the disintegrative patient denied the presence of suicidal thoughts, was inactive, did not participate in occupational therapy, and spent most of her time in bed. Her short-term memory deterioration and formal thought disorder in the form of distraction were observed. During medical visits and also in individual conversations with doctors, she repeatedly asked persistently about the diagnosis, the need to take medicines for life and about the possibility of having children. Having been informed about the diagnosis of schizophrenia, she said that she had never had symptoms of schizophrenia, claimed that she had always been depressed and asked, even demanded that such a diagnosis should be written on the discharge card. She was treated with paroxetine (up to 40 mg/d), flupentixol (up to 6 mg/d) and olanzapine (up to 10 mg/d). Due to the poor response to treatment, electroconvulsive therapy was applied, which resulted in a slight improvement in the patient's mental state. After completing the electrical procedures, the treatment was changed to clozapine (up to 150 mg/d), aripiprazole (up to 7.5 mg/d) and vortioxetine (up to 20 mg/d). Piracetam (up to 800 mg/d) was also used to improve memory function.

As a result of the applied pharmacological treatment, incomplete improvement in cognitive functions and psychomotor drive was obtained. Suicidal thoughts and tendencies subsided, the patient stopped self-destructive behavior. She was discharged with the diagnosis of paranoid schizophrenia, under her husband's care, in quite satisfactory general condition.

Both during hospitalization at the clinic and outpatient visits, elements of psychotherapy, especially psychoeducation, were carried out to help the patient reconcile with

the illness. It has been repeatedly explained to her that by taking regular medications she could achieve a long-term remission of the illness, that it is possible to return to work and have children. The patient never undertook specialist psychotherapy outside the hospital, neither individual nor group one, because she did not show such will and motivation.

Consequences of psychiatric diagnosis

To prevent a significant decrease in self-worth, people who have been ill for many years try to fight the psychiatric diagnosis and the need for treatment. Once they reach a relatively good level of insight, they experience doubts, fears whether to tell about their problem and to whom, and whether it is worth disclosing the fact of the illness, which undoubtedly constitutes a risk of reducing life chances and losing social status. Social isolation developing at that time is associated with fear of negative evaluation and rejection [1, 11–13].

The literature says about the so-called psychological costs resulting from psychiatric diagnosis and stigmatization, which is understood as a consequence of the dissonance between the imagined ideal state and reality. These are negative emotions felt by an individual due to a lack of acceptance of the discrepancy between expectations he/she perceives and reality [14, 15]. It is a matter of psychological discomfort which is a subjective reaction to a difficult situation related to the lack of its acceptance [14]. The psychological costs pertaining to the very experience of mental illness are not the same as the costs of social stigmatization, as they result from everyday struggles with the manifestations of disorders, with their own weaknesses and limitations. Thus, a person may experience the costs of two types, those related to the discomfort of finding themselves in a difficult situation of health disorders as well as those resulting from stigmatization, negative, unfair treatment by other people [14]. It is also self-stigmatization when a person realizes and relates to himself/herself negative aspects of the situation and negative ways of being stereotyped in a specific way, often deeply embedded in social mentality [2, 13, 14]. Therefore, in addition to cognitive costs, the patient may experience various types of emotional costs resulting from psychiatric diagnosis and the attitude of other people towards it, such as a sense of harm, resentment and anger, a sense of violation of their own dignity, unfair, unequal treatment, guilt or embarrassment, a sense of weakness, powerlessness and helplessness, fear of losing strength and resources, fear of the future, or a sense of rejection from others, for example, due to otherness, specific trait, assigned 'defect', as well as a sense of disappointment, unfulfilled hope when the actions of a given person do not result in the expected effects, when the people in whom someone had hoped failed [14, 16].

The importance of hope in the struggle with the illness itself was mentioned, among others, by Libman and Nasierowski. Hope is one of the dimensions of human mental functioning and constitutes an element that integrates human mental life, gives strength in existential struggles in both health and illness. It plays a significant role in activities aimed at improving the broadly understood social functioning of the patient [17].

Negative consequences resulting from the experience of mental health disorders and the phenomena of stigma and self-stigma associated with it are confirmed by the results of numerous studies [16, 18–20].

Mental illness undoubtedly entails adverse changes in survival and behaviors that disable contact and entering into social relationships, therefore reducing the ability of acting out social roles [21]. Considering the functions of psychiatric diagnosis in the context of the phenomenon of stigmatization, one cannot ignore the idea of postpsychiatry and Open Dialogue Approach. Criticism of 'psychiatric imperialism' (in so-called critical psychiatry or postpsychiatry) is justified, above all in the situation when modern medicine is heading towards a certain technicalization and depresonalization of the patient [22]. In turn, Open Dialogue Approach relies on a coherent approach to care within the family or social network. It was born on the wave of searching for the optimal way to treat mental illness, and especially psychosis. It is language that shapes our reality, which is why it is so important to create a common understanding of the problem. The patient's family, friends and social network are seen as competent or potentially competent partners in the recovery process. In Open Dialogue Approach, all participants have equal status in the dialogue, so participating in it allows individuals to overcome the stigma of mental illness and the discriminatory impact of psychiatric diagnosis [23, 24].

Self-stigmatization in the course of schizophrenia

Stigmatization of mental illness in general, and schizophrenia in particular, is a constant problem and a phenomenon with negative implications in social life, throughout the recovery process and translating into a worse quality of life of patients [25]. The authors of the study *Measuring the self-stigma associated with seeking psychological help* distinguish the concepts of public stigma and self-stigma. Public stigma – refers to a situation in which the individual is socially unacceptable, which encourages negative attitudes and reactions towards him/her. On the other hand, self-stigma leads to a decrease in self-esteem caused by self-labeling as a socially unacceptable person [26]. For example, patients diagnosed with bipolar disorder have a more positive picture of themselves and experience less self-stigmatization compared to patients with schizophrenia. Patients with schizophrenia appear to struggle with more self-stigmatizing attitudes than patients with bipolar disorder [27].

When considering the issues of stigmatization and self-stigmatization of mental illness, one cannot ignore the issue of insight. In the work entitled *Insight and recovery in schizophrenic patients* the correlation of insight and recovery in patients with schizophrenia according to the criteria of both symptomatic and functional remission is examined. Insight recovery was positively correlated with female gender, older age, treatment, pre-illness social adaptation, and low levels of negative symptoms of schizophrenia at the beginning of the study [28]. Along with the increase in the level of insight into the illness, the sense of influence on its course increases, and thus the level of social functioning improves in all aspects of the patient's life. The patient is then aware of the need to take and adhere to the rules of treatment and self-observation.

He/she demonstrates the ability to establish and maintain lasting interpersonal relationships and independence in satisfying basic life needs, as a result of which remission periods are extended, and patients function better in the community and have a sense of freedom from illness [29, 30].

Self-stigmatization of mental illness is associated with the aforementioned concept of stigma. The stigma of mental illness applies primarily to people suffering from psychotic disorders. Depressive disorder, for example, does not evoke so many negative associations, and even inclines to compassion, help and care for the ill. Schizophrenia has negative connotations, raises anxiety, distance, anger, thus causing people not to admit their illness [31]. Torrey [32] described schizophrenic patients as "modern lepers" – someone who is treated by or was treated by a psychiatrist is being considered to be different, worse than others; in social terms such a person is unpredictable and unable to respond properly. This label is difficult to get rid of even after the patient returns to the so-called 'normality'.

Recapitulation

According to Hobfoll [34], the constructive basis of health is the individual's potential, personal resources and environmental resources that he/she can take advantage of. All the intra-psychological conditions of psychophysical resilience and recovery include: a sense of coherence, mental resilience, certain personality traits, i.e., a sense of agency, locus of control, a sense of self-efficacy, and remedial processes. A holistic reference to health and the treatment process recognizes the psychosocial separateness of the patient, his/her subjectivity and looks for treatment methods optimally adapted to individual health and psychological needs. It is about the social context of the illness, focusing on various conditions of patient's dysfunction, considering the patient's sense of dignity in the treatment process [33, 35].

The stigma of mental illness is the cause of subjectively experienced suffering for people with psychiatric diagnosis and their relatives, but it is also important for public health [3, 36]. Psychiatric diagnosis is particularly related to two stages of the stigmatization process, which are: labeling and stereotyping, and the diagnosis of paranoid schizophrenia significantly stigmatizes and socially excludes affected individuals [3, 25, 27, 32].

Psychiatric diagnosis has significant social consequences and may strengthen the stigma of mental illness, which is why it is so important that the process of diagnosis is not a routine activity for psychiatrists and a process free from ethical reflection [3]. Some authors point out that the process of clinical diagnosis has certain features in common with the stereotyping mentioned above, which consists in linking the highlighted social categories with negative stereotypes [6, 37, 38]. Using psychiatric diagnoses in clinical practice requires caution and sensitivity as for their stigmatizing potential, somewhat of discrediting nature [3, 32, 39], because, as the title of one of the articles on the subject reads: *Change Starts with us: Stigmatizing Attitudes Towards Mental Illnesses and the Use of Stigmatizing Language Among Mental Health Professionals*.

Stigmatization is an important factor influencing social involvement and interpersonal and professional functioning as well as treatment and care processes for individuals with mental illnesses [40]. This stigmatization can also be observed among mental health workers [1, 40]. Given the importance of a specialized language, research and interventions in this field can contribute to reducing the phenomenon of stigmatization of mental illness [40–43] as well as a better and fuller life without internalizing discrimination or self-stigma [44].

In conclusion, it is worth mentioning that classic psychopathology places high importance on the interaction between clinicians and patients. The so-called practitioner's subjective experience plays a key role in the diagnostic process. Psychoanalysis already assigned a privileged position to the feelings of the clinician and empathetic participation in the assessment and deep understanding of the patient [45]. However, the diagnostic and therapeutic process may contain some ethical pitfalls, such as the fact of not revealing the full diagnosis to patients with exacerbated delusional symptoms who refuse to receive antipsychotic treatment or who have difficult decision making abilities [46]. However, it is recommended to provide reliable information about the diagnosis after correcting the patient's severe mental state, despite the fact that this action may exacerbate the stigma [47].

Certainly, the diagnosis of paranoid schizophrenia can be markedly stigmatizing [13, 32], its common consequence being discrimination leading to the fact that the possibilities of normal life, work, therapy, rehabilitation, and social integration are reduced [43, 48–50].

The patient's story presented in the article elaborates on the problem of psychiatric diagnosis from two different perspectives: what is the diagnosis of schizophrenia for the patient herself and what significance should it have in psychiatric practice. The presented patient, despite agreeing to the proposed forms of therapy, resisted the final diagnosis of paranoid schizophrenia, since this illness brought along a kind of social stigma in her understanding (and not only hers), had negative connotations, which the patient was aware of. Therefore, she underwent the phenomenon of self-stigma and did not try to look objectively at her resources, the goals she had already achieved in life and the overall psychophysical well-being and relatively good social functioning despite such a diagnosis.

Conscious and prudent reflection, supplemented with personal ethical thought, as for the diagnosis of mental illness should be Extremely important for practitioners due to its significant clinical but also social implications. Self-stigmatization in the course of paranoid schizophrenia is a not fully researched scientific area, worth in-depth studying and supplementing, in order to more effectively combat the stigma of mental illness.

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