MENTAL HEALTH LITERACY, STIGMA, SHAME AND SELF CRITICISM: A STUDY AMONG YOUNG ADULTS

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ABSTRACT

Mental health literacy (MHL) and mental illness stigma (MIS) represent new horizons of study and intervention, particularly important, for both communities and clinical settings (European Commission & Portuguese Ministry of Health, 2010). In this paper we aimed to: a) describe a clinical sample (CS) and non clinical group (NCG) in aspects related to family history of psychopathology, contact with mental illness and "learning about mental illness"; b) differentiate groups in terms of MHL, shame and self criticism; c) test associations between MHL with shame and self criticism; and, in the clinical sample, d) test the relationship between self stigma, shame and self criticism; e) explore the predictor role of other's support in self stigma. To do so we collected data from a sample of 187 young adults, including CS and NCG, using: a Sociobiographic Questionnaire; Opinions about Mental Illness (Cohen & Struening, 1962); Other as Shamer Scale (Goss, Gilbert & Allan, 1994); Internalized Shame Scale (Cook, 1994); and Forms of Self Criticizing and Self Reassuring Scale (Gilbert, Clarke, Hempel, Miles, & Irons, 2004). Our results show that: most of the subjects learned what is mental illness at school; CS know more people that has or had mental illness than NCG; there are no differences on MHL within samples; shame and self criticism are higher in the CS and correlate with self stigma; others support predict self-stigma. Several research and clinical implications are presented.

Keywords: mental health literacy, shame, self criticism, clinical sample, community sample, young-adults.

BACKGROUND

Mental health literacy

As education has been a key component to promote health and prevent disease through the 21st century (Nutbeam, 2000), it is argued that mental health literacy is essential to communities mental empowerment

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(Loureiro et al., 2012). But, in the domain of mental health, health literacy is a relatively new area of research and intervention.

Mental health literacy (MHL) is a concept presented by the Australian researcher Jorm in 1997 and corresponds to knowledge and beliefs about mental health disorders which aid their recognition, management and prevention. It includes the ability to: a) recognize specific disorders and different types of psychological distress; b) have knowledge and beliefs about the risk factors and causes; c) request self-help interventions or professional help available; d) adopt attitudes prone to appropriate recognition and help seeking; d) seek adequate health information (ibidem). Also, from the recent salutogenic view that guides the OMS definition of health literacy, "cognitive and social skills which determine the motivation and ability to gain access to, understand and use information in ways which promote and maintain good health" (1998, p.10), one may also consider that MHL contemplates e) the knowledge about healthy life styles and f) active well-being strategies and behaviors.

Mental Illness Stigma

MHL can be one of the central aspects to promote mental health and prevent mental disorder but, on the other side, Mental Illness Stigma (MIS) can be an obstacle. Stigma associated with mental illness contains three essential domains: stereotypes (negative beliefs) about mental illness, prejudice (cognitive and affective responses) towards people with mental illness and discrimination (negative/hostile behavior) (Corrigan & Watson, 2002).

Public stigma and self stigma refer two types of stigmatization processes (ibidem). The first underlines the stigmatization from the community towards people with mental illness/problems. This behavior is based on the idea that people with mental illness and without it belong to different two groups, and facilitates maintaining social distance. Self-stigma then traduces the stigma the person suffering from a mental problem has internalized from others. The person identifies with the stigmatized group and labels (ibidem). Both of the described types prejudice prevention, treatment and recovery as seriously affect the use of mental health services from the process of help seeking, to the treatment chosen, its management so as investing on recovery (Hogan, 2003). In fact, stigma may inhibit people from using mental health services to avoid shame, criticism and discrimination (Eisenberg, Downs, Golberstein & Zivin, 2009).

MHL and MIS and the experience of being affected by a mental problem across the development

The prevalence of mental health problems is increasing and the OMS (2001) estimates that one in each four people has mental disorder and that most of the population contacts with someone that is now or was before ill.

Accordingly, mental health literacy becomes an essential tool for personal and community development (Loureiro et al., 2012). But, numerous studies report low levels of MHL and high levels of Mental Illness Stigma (MIS) in the population (cf. BMC, 2007; European Commission & Portuguese Ministry of Health, 2010; Jorm, 2012; Phelan, Link, Stueve, & Pascosolido, 2000), consistently suggesting that the communities have low levels of knowledge about mental health problems (its causes, consequences, risk factors, treatment options). This has been seen across different countries, cultures and age groups (cf. ibidem) and in Portugal two teams have been developing enormous work on this issue: "FelizMente" a project developed by Loureiro and his team (Loureiro et al., 2012), and "Opening space to mental health" with "Encontrar+se" and "Upa faz a diferença" (Campos, 2014; Palha, 2014).

As Palha (2014) alerts "there´s still no country or culture without the belief that a person suffering from mental health problems is less worthy; each of us has, in some way, some kind of stigma". In a lot of countries stigma can also look structural, as social and health politics don´t support the fundamental rights of people with mental disorder or problems (ibidem; Jorm, 2014). Recently, Jorm (ibidem) has shown that in some countries public inquiries demonstrate that the community prefers that the public money goes just to cancer and heart disorder treatments (because these problems are life threatening) than also to mental disorders treatments and prevention (even though this can be extremely disabling) although both conditions are not fully successfully treated in significant percentage of the cases.

Stigma is a communitarian problem. It is learnt from several sources: at home, in school, at work, from the media; and people with mental health problems are more stigmatized than those with other health conditions (Byrne, 2000; Corrigan et al., 2005) so they feel even more negative emotional experience than that felt as the psychological problem. For example, discrimination in the workplace or school has been common across children

and adults – some employers or teachers express the belief that people with mental illness/problems lack of intellectual competence, social aptitude or creativity. Also in the context of social relationships, segregation emerges reflecting the fear of danger or dependency. Close social support networks, as family, also become affected by stigma specially in case of chronic mental illness (Byrne, 2000). Media brings to the public stories inspired on stereotypes reinforcing stigmatized ideas and attitudes, shame and criticism. In the movies, marketing campaigns, literature, music and newspaper, people with mental health problems play dangerous or pathetic characters (ibidem).

Considering that recent approaches to psychopathology have recognised the importance of shame and self criticism across several types of psychopathologies, these variables and its pathogenic nature (e.g., Matos, Pinto-Gouveia, & Duarte, 2012a), deserve a specific attention in terms of relations with stigma and mental illness. In fact, it has been argued that both factors are transdiagnostic, increase vulnerability, effect expression of symptoms and elevate risk of relapse (Gilbert, & Irons, 2005; Tangney, & Dearing, 2002; Zuroff, Santor, & Mongrain, 2005). Regarding to shame it is considered as a secondary conscious emotion. It is experienced as painful and uncomfortable, associated with the perception that one has personal attributes, personality characteristics, engaged in attitudes or behaviors that others will find unattractive and reject or put-down (Matos, Pinto-Gouveia & Duarte, 2011). In what concerns self criticizing it traduces the conscious cognitive and emotional process of the self being simultaneously evaluator and object of evaluating as adequate/successful or inadequate/unsuccessful (Gilbert, 2007). In this internal process it plays roles of dominance or, submission in order to correct mistakes or prevent failure. Accordingly, the self analyses triggers the emotional response of thinking as being attacked, persecuted or feeling with anger, disgust or hate. On the other side, when the self triggers self compassion and kind attitude to regulate cognitions and evaluations he reassures internally.

Although the situation has been clearly improving, in the recent times, and one might guess MIS will decrease, deep work is necessary across all life-span stages and social contexts. Surprisingly, data from a recent document of European Commission & Portuguese Ministry of Health (2010) suggests that five year old children manifest stigma.

In this work, we will focus on the young adult population, clinical and non-clinical. Young-adults are the most vulnerable generation to the first onset of mental health problems, are the group that most benefit from early recognition and autonomous help seeking (as they are developmentally increasing the adolescent autonomy from parental supervision), are particularly vulnerable to stigmatization consequences (as they are building new social support networks, romantic relationships, entering university or searching for a job, renting new accommodation) and potential responsible for breaking the stigma process (educating their friends, family and children).

OBJECTIVES

Our aim is to describe levels of Mental Health Literacy so as their relationships with shame, self criticism, and also with sociobiographic variables in clinical and non clinical samples of young adults. In specific the study: a) describes a clinical group and two community groups in aspects related to family history of psychopathology, contact with mental illness and "learning about mental illness" context; b) differentiates the three groups in terms of mental health literacy, shame and self criticism; c) tests the associations between mental health literacy with shame and self criticism; and, in the clinical sample, d) tests the relationship between self stigma, shame and self criticism; and e) explore the predictor role of other's support in self stigma.

PARTICIPANTS

In this study we collected data from a total sample of 187 young adults, including clinical and community samples. The clinical sample (CS) comprised 55 subjects, mostly women (81.8%) and single (87.3%). The mean age was 26.49 and the mean of years of education was 14.67. The non clinical sample (N=132) was divided in two groups using an age criteria: Group 1 (NCG1=Non Clinical Group 1) comprised subjects with 30 or less years old (N=30) and Group 2 (NCG2= Non Clinical Group 2) above 30 years old (N=102). Both groups were composed predominantly by female participants (81.4% and 76.7% respectively), mostly single in Group 1 (92.2%) and

married in Group 2 (43.3%). The means were 23.88 (years old) and 15.11 (years of education) for Group 1, and 39.87% (years old) and 16.37 (years of education) for Group 2.

METHOD

This is an exploratory descriptive correlational study with quantitative measures. As mentioned, data was collected using a non clinical sample and a clinical sample.

The collection of both samples strictly complied with all ethical and methodological procedures inherent in this type of research: contact with mental health and educational institutions (for the clinical sample) and formal proposals to the respective ethic committees. The non clinical sample was recruited through an online questionnaire. The participants received a brief explanation of the study objectives, information on the understanding of the role of both participants and researchers and on the responsibilities and rights inherent to each role. They were also assured confidentiality and anonymity.

Instruments for data collection included measures of: *Sociobiographic variables, Opinions about Mental Illness, Internal and External Shame, Self-Criticizing and Self-Reassuring.* A simple description of these measures will be presented.

A *sociobiographic questionnaire* was developed by authors to measure: age, education/job, family history of mental illness, contact with mental illness, source of learning about mental illness, having or not mental problem, professional support, social support.

The *Opinions about Mental Illness* scale was developed by Cohen and Struening in 1960-1962 and was validated to the Portuguese population by Loureiro, Dias and Aragão (2008). It was initially used in hospital workers and then expanded to the research of clinic and non clinic population opinion. It has 51 items and 5 factors: 1) Authority – people with mental illness are an inferior class and as authority must be respected they require authority; 2) Benevolence – a kindly and paternalistic view of people with mental illness inspired mostly by humanism and religion than by science; 3) Mental illness hygiene ideology – the idea that mental illness is like any other physical illness and requires rational based approach for adequate treatment by professionals; 4) Social restrictiveness – activities such as marriage, childbearing, parenting, working or voting should be restricted; 5) Interpersonal etiology – mental illness is influenced by interpersonal experiences as lack of love and support in childhood. In our study the scale presented a good internal consistency (Cronbach alpha = .82).

Internal shame as it is measured by the *Internalized Shame Scale* (ISS; Cook, 1996; Matos, Pinto-Gouveia & Duarte, 2012b), comprising 29 items, refers to negative self-directed evaluations and affects related to aspects of the self seen as unattractive. The values of the internal consistency of the scale in the validation study was alpha = .95 and in our study alpha =.97.

External shame reflects the experience of the self representing himself as being negative in the mind of others and focusing on the aspects that others would stigmatize, attack, humiliate or reject in public. The *Other as Shamer Scale* (OAS; Goss, Gilbert & Allan, 1994; Matos, Pinto-Gouveia & Duarte, 2011) measures external shame across 18 items and 3 factors: Inferiority; Emptiness and Mistake. The values of the internal consistency of the scale in the validation study was alpha = .91 and in our study alpha =.95.

The *Forms of Self-Criticizing/Attacking and Reassuring Scale* (FSCRS) was developed by Gilbert, Clarke, Hempel, Miles and Irons in 2004 and validated to the Portuguese population by Castilho and Pinto-Gouveia in 2011. It has 22 items and 3 factors: Inadequate Self, Hated Self and Reassuring Self. The values of the internal consistency of the scale in the validation study were: Inadequate Self alpha = .90 (and in our study alpha =.93); Hated Self alpha = .86 (and in our study alpha =.84). We didn´t use the Reassuring Self scale.

RESULTS

Family History of Psychopathology, contact with mental illness and learning context about mental illness

Our results show that in the clinical sample the higher percentage of participants (58.2%) had positive family history of psychopathology. In both groups of the normal sample, the majority of the participants had not relatives with mental illness (26.5% for Group 1 and 46.7% for Group 2). In terms of knowing someone with psycho-

pathology, 86.7% of the participants in non clinical Group 2 responded "yes", 63.6% in the clinical sample and 56.9% in the non clinical Group 1. The learning context mostly selected was "school" (20% in the clinical sample; 36.3% in Group 1 and 20% in Group 2).

Differences between groups: Opinions about mental illness

The three groups under study (CS=Clinical Sample; NCG1=Non Clinical Group 1; and NCG2= Non Clinical Group 2) were compared in their opinions about mental illness. No significant differences were found between groups (Table 1).

Table 1. Differences between groups in the Opinions about mental illness

	CS (N=55)		NCG1 (N=30)		NCG2 (N=102)			
	M	DP	M	DP	M	DP	F	p
Authority	44.24	6.5	45.35	8.4	44.31	8.7	.399	.672
Benevolence	50.27	4.7	50.91	5.1	50.41	6.7	.276	.759
Mental Hygiene Ideology	25.78	5.1	27.63	4.5	27.48	3.1	2.938	.056
Social Restrictiveness	40.96	6	41.31	6.5	41.92	6	.207	.813
Interpersonal Etiology	30.80	5.8	30.83	7.28	31.43	7.1	.092	.912

Note: CS-clinical sample; NCG1 and NCG2-non clinical groups.

Differences between groups: Shame and Self Criticism

In relation to shame and self criticism, significant differences were found between CS and the NC groups, with CS showing higher values than the other two (Table 2).

Table 2. Differences between groups in Shame and Self Criticism

	CS (N=55)		NCG1 (N=30)		NCG2 (N=102)		
	M	DP	M	DP	M	DP	F
OAS	27.62_a	13.4	14.47_b	9.7	17.03_b	13.2	22.186***
ISS	52.42_a	19.9	26.18_b	17.1	25.67_b	13.1	41.445***
FSCRS hated self	5.56_a	4.9	1.66_b	2.4	1.97_b	2.6	23.985***
FSCRS inadequate self	20.98_a	8.3	10.01_b	7.1	10.47_b	6.9	38.248***

*** $p<.001$; Note 1: Means with differing subscripts within rows are significantly different at the $p<.05$ based on Bonferroni Test. Note 2: OAS-Other as Shamer Scale; ISS-Internalized Shame Scale; FSCRS-The Forms of Self-criticizing/attacking and Self-reassuring Scale; CS-clinical sample; NCG1 and NCG2-non clinical groups.

Correlational Analysis

We performed correlational analysis in the three groups with the aim of testing the associations between the factors of the Opinions about mental illness with Shame and Self criticism. The only significant correlation was in the clinical sample, between "mental health hygiene ideology" and the "hated self" of the FSCRS (r =-. 31, *p*=.034).

In the clinical group, we also tested the association between self stigma (through the question "I do evaluate myself negatively because of mental illness") and shame and self criticism. There were significant associations of self stigma with internalized shame (*r*=.46, *p*=.001), hated self of FSCRS (*r*=.53, *p*<.001) and inadequate self of FSCRS (*r*=.35, *p*=.016). There was no significant association with externalized shame.

Regression Analysis

Social support from others seems to predict self stigma in the clinical group, however none of the predictors (family, friends and colleagues) isolated predicted this variable (Table 3).

Table 3. Multiple Regression Analysis for the Clinical Sample: predictors of self stigma

	B	**SE B**	_
Step 1			
Constant	1.646	.488	
Colleague's support	.131	.141	.179
Friend's support	.068	.154	.085
Family's support	.208	.117	.277

Note: R^2= .202, *p*=.020

DISCUSSION AND CONCLUSIONS

Mental health literacy, a new area of research and intervention appears to be essential to mental health promotion and disorder prevention but the stigma related to mental illness needs some attention in order to prevent prejudicing experience of shame and criticism. In line with previous research our study aimed to a) describe a clinical group and two community groups in aspects related to family history of psychopathology, contact with mental illness and "learning about mental illness" context; b) differentiate the three groups in terms of mental health literacy, shame and self criticism; c) test the associations between mental health literacy with shame and self criticism; and, in the clinical sample, d) test the relationship between self stigma, shame and self criticism; and e) explore the predictor role of other's support in self stigma.

Our results show that the clinical group revealed higher percentage of psychopathology in the family. This result is in line with previous genetic and environmental studies (e.g., Nestad, Samuels, Romanoski, Folstein, & McHugh, 1994) and reinforces the need to maintain investment in early detection, prevention and intervention studies. The NCG2 (age>30) demonstrated higher percentage of subjects who know people with psychopathology. This difference is probably due to age; however this result emphasizes the importance of mental health literacy interventions throughout lifespan as suggested by all studies in this field, namely BMC (2007). Regarding the context of learning, all of the three groups seem to have learned about mental illness mostly in school. In this line of thought, the school environment seems to play a major role in MHL learning and internalizing MHL knowledge, even in informal ways. Future studies should further explore this relationship and, if proven, formal MHL interventions could be conducted in schools to maximize their results.

The groups did not differ in terms of MHL as previous reviews suggested (cf. Byrne, 2000). This result has important research and clinical implications, such as: a) MHL interventions should target both clinical and non

clinical populations; b) although different levels of different components of MHL were found among the groups, and therefore may indicate different needs, these differences were not significant indicating a general MHL learning and training for all the groups; c) MHL does not seem to improve with age alone, therefore all age groups should be considered in MHL interventions planning.

In terms of shame and self criticism, the CS showed higher levels of both comparing with the non clinical groups (who did not differ from one another). This can be due to psychopathology characteristics (and therefore unrelated to mental illness) and/or due to self stigma. Further studies on self stigma are necessary to better understand the impact of mental illness on "self to self" and "self to others" relationships. Self stigma can have an important role in the effectiveness of psychotherapeutic interventions.

In the clinical group, our results indicate that self stigma seems associated with self criticism (hated self form). Further investigation is needed to prove this association. This can have implications in clinical practice: planning interventions focused on self criticism (and therefore self compassion) to reduce self stigma could be useful in both CS and NCG by maximizing help-seeking and therapeutic gain of recovery. Social support (or the lack of it) seems to play a major role in self stigma prediction. Social and community interventions are essential to reduce not only social and community stigma but also self stigma. MHL interventions should target not only the individuals but also their communities and social networks: awareness and improvement of first aid support skills can be helpful.

Although the importance of several results, some limitations must be taken into consideration. One limitation of our study is the difference of the number of subjects in each group under study, as well as the predominance of women in all groups. Further studies may overcome this limitation and corroborate our results in more equitable groups. In relation to the measures used, we consider that using specific mental illness-related shame and self criticism instruments could improve the quality of our results, however there are, to our knowledge, no specific mental illness-related instruments with psychometric properties studied in Portuguese population.

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