Relationship between personality and self-stigma in mixed neurotic spectrum and depressive disorders – cross sectional study

Marie Ociskova 1,2, Jan Prasko 2, Dana Kamaradova 2

1 Faculty of Arts, Department of Psychology, Palacky University Olomouc, Czech Republic; 2 Faculty of Medicine and Dentistry, Palacky University Olomouc, Department of Psychiatry, University Hospital Olomouc, Czech Republic.

Correspondence to: Marie Ociskova, Faculty of Arts, Department of Psychology, Palacky University Olomouc, Czech Republic; e-mail: marie.ociskova@fnol.cz

Submitted: 2015-02-01 Accepted: 2015-03-11 Published online: 2015-04-01

Key words: personality traits; self-stigma; hope; dissociation; neurotic spectrum disorders; depression

Abstract

INTRODUCTION: Self-stigma is a maladaptive psychosocial phenomenon affecting a considerable part of psychiatric patients. Nevertheless, not everyone with mental health issues internalizes societal stigma. The goal of the study was to identify psychological features significantly connected to the presence of self-stigma.

METHOD: 76 neurotic inpatients undergoing a six-week hospitalization in the psychotherapeutic department attended the study. The probands completed following questionnaires at the beginning of the treatment – ISMI (Internalized Stigma of Mental Illness Scale), TCI-R (Temperament and Character Inventory, revised version), ADHS (Adult Dispositional Hope Scale), DES (Dissociative Experiences Scale), BAI (Beck Anxiety Scale), BDI-II (Beck Depression Scale, second edition), and CGI (Clinical Global Impression, both the subjective and objective versions). Descriptive statistics processed the scales scores, t-tests, correlations, linear regression, and backward stepwise regression.

RESULTS: The overall level of self-stigma in the neurotic patients with possible comorbid depression significantly correlated with several psychological features. Self-stigma significantly positively correlated with the harm avoidance trait, the symptoms of dissociation, anxiety, and depression, and the overall level of psychopathology measured by objCGI and subjCGI. It also significantly negatively correlated with the persistence and self-directedness traits and hope and its subscales – pathway thinking and agency. After applying backward stepwise regression, only three of the mentioned factors predicted the level of self-stigma – self-directedness, hope, and the subjective evaluation of own mental state. Other factors were suppressed during the analysis.

CONCLUSION: Patients with more severe psychopathology show larger tendencies to stigmatize themselves. Also low self-directedness and lack of hope are typical for individuals with higher levels of self-stigma. These personality characteristics are affected by self-stigma and play a significant role in the efficacy of both the pharmacological and psychotherapeutic treatment of neuroses. Thus, the issue of self-stigma requires our attention and needs to be addressed in the treatment.
**Introduction**

Stigma of mental disorders presents one of the current issues dealt by psychiatrists and clinical psychologists. Psychiatric patients might be targets of stigmatizing prejudices at several levels. They might be despised and discriminated by society and its institutions (such as schools and health care facilities). Many individuals with mental health problems also suffer from self-stigma (Livingston & Boyd 2010). These persons uncritically believe the societal prejudices and thus are persuaded of their inferiority and untreatability of their mental issues (Corrigan et al 2011). According to some researchers, self-stigma is a part of the stigma that brings the most harmful consequences. Self-stigma often leads to dysphoric emotions and a decrease in self-esteem and quality of life (Corrigan et al 2006). Social isolation or other forms of potentially maladaptive behavior are also common. In the extreme, self-stigma might lead to suicide (Schulze & Angermeyer 2003). The negative impact on the treatment efficacy of mental disorders is also the rule rather than the exception (Tsang et al 2010; Ritscher & Phelan 2004). The results of our study (Ociskova et al 2014) identified the inverse relationship between self-stigma and the treatment efficacy in neurotic spectrum disorders.

Nevertheless, not everyone, who is stigmatized by society, internalizes the perceived prejudices. Some individuals are ready to persuade others that their stereotypes do not correspond to reality (Camp et al 2002). Others do not notice stigma, and for this reason they do not develop self-stigma. Thus, it is important to identify personality traits, which serve as a buffer against the negative impacts of stigma, and which increase the risk of the internalization of stigma. The current research explores the relationship between self-stigma and personality through the lenses of the Cloninger's biosocial theory of personality (Farmer & Goldberg 2008). These studies have found that self-stigma in psychiatric patients is connected with higher scores in the harm avoidance scale and lower scores on the persistence and self-directedness scales (Marjetić et al 2010). Self-directedness and persistence share similarities with the Snyder’s theory of hope. According to Snyder (2000), hope emerges when a person identifies a goal to achieve and has approximately fifty percent chance of success. The individual consequently thinks of adaptive and flexible ways to achieve it and is sufficiently motivated to pursue the chosen way or to change it if necessary (Snyder 2000). When these conditions are sufficiently fulfilled, feelings of hope emerge. It has been shown that individuals with internalized stigma experience despair and hopelessness rather than hope (Livingston & Boyd 2010; Hasson-Ohayon et al 2008).

Dissociation is seen as a coping strategy to deal with intense anxiety states, and painful trauma experiences (Watson et al 2006; Ross 2007; Ptacek et al 2007). We reported high level of dissociation in panic disorder (Pastucha et al 2009b), obsessive compulsive disorder (Prasko et al 2009; Raszka et al 2009), dissociative disorders (Pastucha et al 2009c) and borderline personality disorder (Pastucha et al 2009a). There is no information about relation between dissociation and self-stigma in literature.

The goal of this study was to identify personality factors, including hope and dissociation, influencing the level of self-stigma in patients with neurotic spectrum disorders with or without comorbid depression. The factors examined were personality traits according to the Cloninger’s biosocial theory, hope, dissociation, and the symptoms severity.

**Method**

**Patients**

Patients are suffering from neurotic spectrum disorders with or without comorbid depression and personality disorder, referred to an intensive psychotherapeutic inpatients program, were enrolled in the study. The inclusion criteria were:

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

Excluded were patients diagnosed with bipolar disorder, schizophrenia and other psychotic disorders, organic disorder, and those who were severely physically handicapped. Patients with mild or moderate depression and patients with comorbid personality disorders were included.

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

**Methods of evaluation**

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

TCI-R (Farmer & Goldberg 2008) – Temperament and Character Inventory, revised version, consists of 240 items out of which 5 are check items. The inventory measures four temperaments and three character traits and number of their subscales. The temperament scales are novelty seeking, harm avoidance, reward dependence, and persistence. The character scales are self-directedness, cooperation, and self-transcendence (Gillespie et al 2003). Czech norms were made by Preiss and Klose (2001).
ADHS (Snyder 2000) – Adult Dispositional Hope Scale includes 12 items – four of them are focused on pathway thinking, another four are related to a sense of agency, and the last four are distractors. Patients choose one of the eight points on a scale according to a level of the agreement with the statements.

DES (Bernstein & Putman 1986) – Dissociative Experience Scale describes 28 experiences. Patients mark a spot on a 10 cm line according to how often they experience the symptoms. The Czech version of the scale is psychometric equal to the original one (Ptacek et al 2007). Pathological dissociation might be evaluated by using Dissociative Experience Scale Taxon (DES-T). DES-T consists of 8 out of 28 items of DES (items 3, 5, 7, 8, 12, 13, 22, and 27) and focuses on depersonalization, derealization, identity alteration, and amnestic quality of pathological dissociations (Waller & Ross 1997).

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

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

BAI (Beck et al 1988) – The scale represents 21 symptoms of anxiety, each with a four-point Likert scale. The patient chooses perceived symptoms and their severity experienced during the last week.

CGI (Guy 1976) – Clinical Global Impression is a global evaluation of the severity of psychopathology. The sources of the assessment are two. The first presents an assessment by a physician (objCGI) about the seriousness of the psychopathology; the second one is a self-evaluation done by a patient on a scale 1–7 where every point of the scale has described its unique characteristics (subjCGI).

Statistics were calculated by using the Prism (GraphPad PRISM version 5.0; http://www.graphpad.com/prism/prism.htm) and SPSS 17.0 (2008). Descriptive statistics processed demographic data and average scale scores; means, medians, standard deviations, and character of data distribution were also identified. The differences in the scores during the treatment were calculated by pair t-tests. The relations between the categories were evaluated by correlations and linear regression. A further analysis was performed with backward stepwise regression. It agreed that a 5% level of statistical significance would be accepted in all tests. The research was conducted in accordance with the latest version of the Helsinki Declaration and the Guideline for Good Clinical Practice (EMEA 2002). The study was approved by the local ethical committee. All patients signed informal consents.

Results

Subjects

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

Tab. 1. A primary diagnosis and comorbidities.

<table>
<thead>
<tr>
<th>Primary diagnosis</th>
<th>Number</th>
<th>Comorbidities (number of patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Without</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Neurotic spectrum</td>
<td>59</td>
<td>21</td>
</tr>
<tr>
<td>Panic disorder/ agoraphobia</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>OCD</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>GAD</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Mixed anxiety-depressive disorder</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Adjustment disorders</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Social phobia</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Dissociative/somatoform disorder/neurastenia</td>
<td>10</td>
<td>3</td>
</tr>
</tbody>
</table>

Dis = disorder; PD = a personality disorder
In 59 patients (77.6%) the primary diagnosis was a neurotic disorder and in 17 patients (22.4%) it was a depressive disorder. 52 patients (68.4%) were diagnosed with comorbid disorders (Table 1). 23 patients (30.3%) had a comorbid personality disorder.

**Medication**

Patients were treated by using standard dosages of antidepressants (Table 2). There were no significant differences between average doses of antidepressants in patients with and without a comorbid depressive disorder (60.00±38.24 mg versus 46.73±34.54 mg of paroxetine equivalent, Mann-Whitney test: M-W U=326; n.s.). There were no significant differences in mean doses of anxiolytic or antipsychotic medication between patients with and without comorbid depression.

**Relationship between self-stigma and personality traits**

The level of self-stigma significantly positively correlated with harm avoidance (Table 3). The reward dependence and persistence trait was significantly negatively connected to self-stigma, as well. The more patients stigmatize themselves; the more isolated and less persistent they were in their efforts to deal with stressors and hassles. The similar connection was identified between self-stigma and self-directedness.

**Relationship between internalized stigma and hope**

There was an extremely significant correlation between self-stigma and hope (Table 3). Similarly both subscores of Hope Scale – pathway thinking and agency – significantly correlated with the level of self-stigma.

**Relationship between internalized stigma and level of dissociation**

The level of self-stigma was significantly positively connected to the overall level of dissociation measured by DES (Table 3). The more patients stigmatize themselves, the more they dissociate. The pathological dissociation evaluated by DES-taxon was positively connected to self-stigma as well (Table 3). Self-stigma is then related to both to the pathological and non-pathological symptoms of dissociation.

**Internalized stigma and its relation to the severity of the psychopathology**

Self-stigma significantly positively correlated with the level of depressive symptoms (BDI-II), the anxiety symptoms (BAI), and the clinical global evaluation of the severity of psychopathology made by the psychiatrist (objCGI) as well as the assessment made by the patients themselves (subjCGI) (Table 3).

**Relationship between internalized stigma, depressivity, and a personality disorder**

The average score of ISMI was also statistically higher among patients with depression than in the non-depressive group (Table 4). The patients without a depressive disorder had significantly lower scores in most ISMI subscales (alienation, stereotype agreement, social withdrawal) except for the stigma resistance subscale that was significantly higher. There was no significant difference in the perceived discrimination subscale. It seems that the depressive individuals with neurotic disorders stigmatize themselves more than the...
non-depressive neurotic ones and are also less resistant against self-stigma.

The average overall rating of ISMI was statistically higher in the patients with a comorbid personality disorder compared to the patients without a personality disorder (Table 4). The subscales that influenced this difference most significantly were the alienation and perceived discrimination. Both of them were noticeably higher in the patients with a personality disorder. For this reason, the patients with a personality disorder stigmatize themselves more than the individuals without a personality disorder. It comes from the feelings of being alienated and discriminated against them.

Factors most contributing to self-stigma

As there were many psychological features significantly connected to the overall level of self-stigma, we decided to perform backward stepwise regression to reduce the number of the factors to the most explaining factors. The factors chosen for regression were those that correlated the most with the overall level of self-stigma. Due to the considerable overlap between hope (measured by Hope Scale) and depression (measured by BDI-II), we decided to include the most correlating factor into regression analysis – hope. The same process of decision making was applied in the case of objective and subjective CGI. The factors included in regression were harm avoidance, persistence, self-directedness (all of them measured by TCI-R), the overall level of hope (Hope Scale), dissociation measured by DES, and the subjective evaluation of the mental state (subjCGI).

The dependent variable was the overall level of self-stigma (measured by ISMI). The outcome of backward stepwise regression identified three the most significant factors explaining 64.6% of the variance of the overall score of ISMI ($p<0.0001$). The only significant independent variables were self-directedness, hope and the subjective evaluation of the mental state (subjCGI).

Tab. 3. Mean scores of TCI-R subscales, Hope scale, DES, and rating scales and their correlations with the ISMI.

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Mean scores + SD</th>
<th>Correlation with ISMI whole score $r$</th>
<th>$p$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCI-R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Novelty seeking</td>
<td>97.97±15.32</td>
<td>$r=0.199$</td>
<td>n.s.</td>
</tr>
<tr>
<td>Harm avoidance</td>
<td>119.90±19.06</td>
<td>$r=0.64$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>Reward dependence</td>
<td>95.26±13.44</td>
<td>$r=0.28$</td>
<td>$p=0.05$</td>
</tr>
<tr>
<td>Persistence</td>
<td>100.30±22.29</td>
<td>$r=0.47$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>Self directedness</td>
<td>122.10±19.81</td>
<td>$r=0.72$</td>
<td>$p&lt;0.0001$</td>
</tr>
<tr>
<td>Cooperation</td>
<td>123.30±13.92</td>
<td>$r=0.21$</td>
<td>n.s.</td>
</tr>
<tr>
<td>Self-transcendence</td>
<td>66.16±15.52</td>
<td>$r=0.098$</td>
<td>n.s.</td>
</tr>
<tr>
<td>Hope Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole score</td>
<td>34.74±11.94</td>
<td>$r=0.68$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>Pathway thinking</td>
<td>18.68±6.24</td>
<td>$r=0.66$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>Agency</td>
<td>16.05±6.82</td>
<td>$r=0.61$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>DES</td>
<td>14.11±13.84</td>
<td>$r=0.46$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>DES-T</td>
<td>8.30±12.49</td>
<td>$r=0.36$</td>
<td>$p=0.005$</td>
</tr>
<tr>
<td>BAI</td>
<td>23.64±11.96</td>
<td>$r=0.30$</td>
<td>$p≤0.05$</td>
</tr>
<tr>
<td>BDI-II</td>
<td>25.18±11.47</td>
<td>$r=0.54$</td>
<td>$p≤0.0001$</td>
</tr>
<tr>
<td>Obj CGI</td>
<td>4.73±1.031</td>
<td>$r=0.31$</td>
<td>$p=0.01$</td>
</tr>
<tr>
<td>Subj CGI</td>
<td>4.58±1.223</td>
<td>$r=0.38$</td>
<td>$p=0.005$</td>
</tr>
</tbody>
</table>

Fig. 1. A linear regression between ISMI and Hope scale. $F=58.33$, $DF=1.000, 67.00; p<0.0001$

Discussion

The prejudices about individuals with mental disorders and related stigma are one of the present issues dealt by mental health experts. Stigma brings the most harmful consequences when being internalized. While some psychiatric patients stigmatize themselves readily, others do not and remain psychologically resilient (Camp et al 2002). This is why we tried to identify psychological factors that might be connected to self-stigma. In our study, there were numerous factors significantly correlating with self-stigma. Regression analysis resulted in the identification of three principal factors related to the overall level of self-stigma – self-directedness (the trait of the Cloninger’s biosocial theory), hope (the concept of Snyder), and the subjective evaluation of one’s own mental state (subjCGI).

Margetić with colleagues (2010) also described the significant relationship between self-stigma and self-directedness. Up to their theory, the individuals with
higher levels of self-stigma are more prone to blame others or fate for their unhappiness, they lack purpose in their lives and seem to lack inner resources to pursue desired goals. They also suffer from lower self-acceptance and wearing a mask as they feel shame for their mental health problems, they rather act in a socially expected ways than authentically. While significant in the correlation matrix, the correlation between harm avoidance and self-stigma was diminished after entering regression analysis. This finding is not consistent with the results of the study of Margetić with colleagues (2010) who mentioned harm avoidance and self-directedness as two factors significantly contributing to self-stigma after applying multiple regression. The explanation may be that this relationship would not be suppressed if it were just the Cloninger’s personality traits what entered regression in our study. It is probable that hope was the factor that suppressed the influence of harm avoidance.

The firm relationship between self-stigma and hope has been shown in other studies (Corrigan et al 2011; Lysaker et al 2007). Despair and hopelessness are emotions related to self-stigma. The significant connection to the Snyder’s concept of hope also suggests that these feelings and self-diminishing thoughts are linked to the decrease in self-esteem. Lower self-esteem is also one of the factors accompanying internalized stigma (Lysaker et al 2007; van Zelst et al 2014). However, we did not measure it in this study, and it is possible that it would lead to slightly different results.

The third significant factor connected to self-stigma, the severity of psychopathology, has also been supported by findings of other authors (van Zelst et al 2014). The causes of this connection might present an inspiration for future research using qualitative methodology.

Both the patients with comorbid depression and those with a comorbid personality disorder showed significantly higher levels of self-stigma. These results are in accordance with findings from the previously published studies that found a strong connection between self-stigma and depression (Ritsher et al 2003; Ritsher & Phelan 2004; Vauth et al 2007). Others proved that individuals with borderline personality disorder suffer from a higher level of self-stigma than persons with social phobia (Rüscher et al 2006). These comorbidities increase the probability that the patient would highly stigmatize himself. It is possible that this readiness to develop self-stigma is one of the factors contributing to a frequently stated poorer treatment efficacy in the patients with axis I disorders with comorbid personality disorders (Shea et al 1992; Reich & Vasile 1993). An equivalent relationship seems to exist between comorbid depression in neuroses and treatment efficacy (Maddock & Blacker 1991; Noyes 2001). Although the current

| Tab. 4. ISMI – the mean scores of the whole group and comparisons of the depressive and non-depressive subgroups and the subgroups with and without a personality disorder. |
|---------------------------------|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Mean of the whole group | Patients with depression (n=17) | Patients without depression (n=59) | Unpaired t-test | Patients with personality disorder (n=21) | Patients with personality disorder (n=55) | Unpaired t-test |
| Overall score | 66.78±13.71 | 75.18±8.77 | 64.18±13.97 | t=3.056 df=70; p≤0.005 | 72.70±12.12 | 64.50±13.70 | t=2.345 df=70; p≤0.05 |
| Alienation | 15.58±4.33 | 17.65±3.353 | 14.95±4.424 | t=2.316 df=70; p≤0.05 | 18.00±3.95 | 14.65±4.14 | t=3.111 df=70; p≤0.005 |
| Stereotype agreement | 13.88±3.47 | 15.65±2.805 | 13.36±3.493 | t=2.470 df=73; p≤0.05 | 14.48±3.47 | 13.65±3.47 | t=0.9276 df=73; ns |
| Perceived discrimination | 10.53±2.95 | 11.82±2.531 | 10.14±2.975 | t=2.107 df=71; p≤0.05 | 12.05±2.72 | 9.96±2.85 | t=2.825 df=71; p≤0.01 |
| Social withdrawal | 13.79±3.97 | 16.24±3.364 | 13.05±3.858 | t=3.062 df=71; p≤0.005 | 15.00±2.96 | 13.34±4.22 | t=1.613 df=71; ns |
| Stigma resistance | 11.00±2.80 | 9.412±2.093 | 11.48±2.828 | t=2.789 df=71; p≤0.05 | 10.45±2.86 | 11.21±2.78 | t=0.030 df=71; ns |

Fig. 2. A linear regression between ISMI and DES. F= DFn 11.73, DFD=1.000, 69.00; p<0.001
state of knowledge highlights the necessity to address the issue of self-stigma in these patients. The question, which yet remains unanswered, is the causality of this phenomenon. It is probable that the relationships between depression and self-stigma and personality disorders and self-stigma are bidirectional. The identification of the developmental processes of self-stigma in the high-risk patients also poses an important issue for further study and the establishment of more efficient therapeutic programs.

The study has several limitations. The number of participants was relatively small, and some patients did not fulfill all the required items in the test battery. A particular risk poses the use of the psychological methods based on self-evaluation. The use of these scales and questionnaires is conditioned by the ability of introspection of the probands and their willingness to be honest in the statements. Another limitation presents a diffuse character of diagnoses that patients suffered from. The participants were diagnosed with various neurotic disorders, and approximately one-third of them suffered from a comorbid depressive disorder. That why the main objection considers diversity of the sample and sample size. The sample is very heterogeneous and modest in size, considering analyzes made in the study. It includes patients with the whole range of neurotic disorders, with and without depression, also those with multiple comorbidities, and with and without personality disorders. Personality structure in such sample may vary significantly.

Specific diagnostic groups might respond to the intensive treatment differently. Unfortunately, the numbers of the participants in the particular diagnostic units were too small for statistical analyzes. Patients were also treated with various medication. The influence of medication was not explored. In spite of the diagnostic and treatment diversity, self-stigma proves to be a factor significantly connected to the well-being of the patients and needs to be addressed in the clinical treatment, especially while working with the patients with more severe psychopathology.

**CONCLUSION**

Patients, who suffer from neurotic disorders and dispose of a higher level of internalized stigma tend to feel hopeless, have the external locus of control a more likely suffer from more severe psychopathology than patients with lower levels of self-stigma. Self-stigma is connected to poorer well-being and might affect treatment efficacy. It is a maladaptive psychosocial factor that needs to be addressed in the therapeutic programs aimed at the treatment of neuroses.

The results of this study might be used to distinguish a correct choice of an optimal therapeutic strategy for the patients suffering from neurotic spectrum disorders. Because the current methods of the treatment cannot help all patients, and a number of them remain resistant to the treatment, it is necessary to search for alternative therapeutic approaches. These should be aimed especially at patients who suffer from hopelessness, low levels of self-determination, and dispose of higher levels of self-stigma.

**REFERENCES**


