

## "Self-Care? Narratives of Patients Diagnosed with Schizophrenia and the Issue of the Identity-Management"

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### Abstract:

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This article is based on the collection and analysis of narratives of people diagnosed with schizophrenia in Greece. The research question that arises concerns how the stigma of mental illness determines the way that those diagnosed with schizophrenia are understood by them. Management of "ailing biography" could be utilized by psychiatric health services as well as by care services. Especially when these supportive structures develop and intervene in the liquid individualized societies of late modernity and in the liquid institutional environment of community-oriented psychiatric care in order to hear these "voices from below", of the people themselves who are at risk of stigmatization, the utilization of their differentiation, will enhance a patient-centered orientation of mental health services and corresponding social care.

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**Keywords:** Auto-stigmatization, self-esteem, illness narrative's, self-management, schizophrenia

### 1. Introduction: Stigma, Auto-Stigma, and Schizophrenia

Mental illnesses and especially serious mental illnesses, such as schizophrenia are related to both social stigma and auto-stigmatization and have a decisive effect on the formation of social identity. Social stigma and auto-stigmatization are also associated with the patient's self-esteem which is particularly important for the course of his illness and for the restoration of wounds and biographical ruptures (Bay, 1991), and for the quality of his life in general in an environment of deep individuation, where the deterioration of identity and the self threatens the integrity of the biography (Monaghan & Gates, 2015). The connection between stigma and chronic diseases in general, and the corresponding embodiment, has been extensively studied, highlighting the central importance it has in an individualized social environment (Charmaz, 1983; Inman, 2019; Maffoni et al., 2017; Loco et al., 2009; Valasaki, 2021).

The management of stigma is thus not limited to a secondary dimension of mental illness but is a major component of it, and an object of care and self-care itself. Especially in the *liquid* context of community psychiatry that tends to take shape in Greece, where long-term confinement is no longer the main treatment option (Madianos, 2020; Moudatsou et al, 2021; Missouridou et al, 2022).

The stigmatizing perceptions of people with mental disorders permeate the entire social fabric, influencing the vicious circle of ever-changing social boundaries within which patients, especially with diagnosed schizophrenia, are trapped, such as the phenomenon of the revolving door and the corresponding limitation in the repertoire of roles (Wright, Grofein & Owens, 2000), a similar orientation to address them by mental health services and social services called upon to "manage" such situations is of strategic importance. Care is specifically aimed at managing worn-out identity (Goffman, 1961) as of particular importance. These perceptions are perceived by the mentally ill and play an important role in rehabilitation and social inclusion, orienting their action.

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Stereotypes and prejudices resulting from discrimination against the mentally ill and the stigmatizing characteristics that have been attributed to them entail negative attitudes and mobilize specific behaviors of non-acceptance and rejection. When the stigmatized identity is accepted and internalized by the patient then he is led to auto-stigmatization. These procedures are especially pronounced in the cases of patients diagnosed with schizophrenia since it is still the most powerful metaphor for "madness". The stigma of schizophrenia is still associated in the liquid therapeutic horizon of community psychiatry with procedures for limiting rights and the human value described by Goffman in reference to institutional psychiatry (Goffman, 1963), but also to the classical critical views of labeling (Hoffman, 1963; Scheff, 1966).

In the representations of public opinion in Greece, schizophrenia is still associated with irrational and violent reactions. This is due to many factors, such as the spectacular descriptions of the behavior of schizophrenics by the media, cinema, and news reports, which distort the reality of mental illness, causing fear and, by extension, stereotypical perceptions of it (Economou et al., 2009; Wahl, 1992). The large number of unintended admissions, which in Greece still exceed voluntary ones (Stylianidis, 2017), contribute to the consolidation of stigma (Madianos et al., 1987; Madianos et al., 1997).

For this reason, in this text we emphasize the way in which the stigma is reflected in the discourse of people diagnosed with schizophrenia, in a central hospital of Attica, in Athens, highlighting their narrative references to practices in relation to others. To the extent that mental illness, in general, is not a physical disease but a complex biopsychosocial phenomenon, the investigation of how the deterioration of identity is perceived by the sufferers themselves is of key importance both for themselves and for the services that are called upon to manage a dynamic complex of social demands and individual life plans.

## 2. Care and stigma

The stigma of mental illness leads to a damaged identity associated with negative results in terms of self-esteem but also a high risk of being placed in a limited repertoire of roles (Wright, Grofein & Owens, 2000), stereotypes are activated and guide the adoption of a career of a chronic patient (Warner, 1994). Stigma also affects the relationship with care services in general, as negative connotations discourage the timely reading of treatment, as the "label" of the mentally ill is attributed to the diagnosis, especially when accompanied by medication (Foster, 2001), which it is often ingested negatively by both the general population and the affected person because it often has particularly obvious side effects and in turn create additional discomfort (Bhugra, 1989).

The representations of public opinion on the danger of the mentally ill are deeply rooted and evident even in the legislative authorities that contribute to the implementation of coercive measures of a restrictive nature (Cutcliffe & Hannigan 2001). According to Greek law, a mentally diagnosed patient can be forced into involuntary hospitalization, even if he has never broken the law, due to its suspected danger, which feeds back the stigma (Christensen, 1997).

Thus, the vicious circle of stigma is perpetuated, as the poor outcome of the disease with the parallel consequences of antisocial behavior and violence consolidates public perceptions of mental illness (Sartorius, 1999), erodes communication with the close environment by hitting the self-image and creating guilt and auto-stigmatization (Corrigan & Rao, 2012). According to the modified labeling theory (Link, 1987), the social stigma is likely to be internalized by the person who bears the label of the mentally ill, experiencing shame and a "second disease", a sense of divergence that constantly feeds the detachment, isolation, and tendency to hide his experiences (Ritsher, Otilingam & Grajales, 2013). Thus, since the stigma is not limited to the patient but is diffused to the familiar others (Hoffman, 1963) his chances of emotional support and similar care by the members of his family (Austin & Moner, 2004), therefore the outcome of the disease, since psychological pressure and difficult daily needs are aggravating.

Strategies for dealing with stigma, both by sufferers and professionals, are varied. Many sufferers react and are outraged by stereotypes, others show indifference (Yanos et al., 2008; Corrigan, Rafacz & Rusch, 2011; Girma et al., 2013; Wright et al., 2000). The greater the exposure to stigmatization, the more intense the auto-stigmatization. Repeated experiences of social rejection over time will reduce individuals' self-esteem, and the fewer such experiences people have, the more likely it will be to maintain high levels of self-esteem (Link, 1982).

However, once auto-stigmatization is established it becomes a social force that reduces the motivation and abilities of the mentally ill (Rosenberg, 1979; Link, 1982), which directly affects the possibilities of intervention on the part of medical and social services care, in general, particularly in liquid environments, such as those of community psychiatry in late modernity. In some cases, Corrigan & Watson (2002) note individuals manifest righteous anger against social stereotypes, and this helps them keep their self-esteem high and they try to change their passive role in the mental health system, seeking to participate in their treatment planning (Champerling, 1978; Deegan, 1990). Finally, the extent to which individuals assimilate these negative beliefs varies depending on how the reactions of others are evaluated and interpreted by the sufferers themselves. These beliefs should be understood in order to make possible and effective care policies more cooperative.

### 3. Research Questions and Method

Follow in the targeted literature review, the focus of this research is the investigation of the experience, regarding the issues of auto-stigmatization and self-esteem in 11 patients diagnosed with schizophrenia in a Psychiatric Hospital of Attica in Greece.

- How do mentally ill people perceive their illness?
- How do mental patients manage the diagnosis of mental illness in relation to their social environment?
- How does mental illness affect the self-esteem of the mentally ill?
- How does mental illness affect the perception of the social image that the mentally ill have of themselves?
- How do the mentally ill perceive the social acceptance of others in relation to their illness?
- How does mental illness affect the relationships of the mentally ill with others?

We consider understanding the answers to these questions to be a valuable source of information for organizing more patient-centered care. Qualitative research was selected for this topic because it mainly explores the concepts and perceptions of the respondents and seeks to give descriptions of their lives and interpretations of the concept of the phenomenon under consideration (Kvale, 1983), i.e. the qualitative research approach is consistent with the nature and purposes of this research, considering that the discourse of people diagnosed with schizophrenia is reliable and escapes clinical categorization, potentially hiding interpretive surprises (Britten, 1995). Thus, self-esteem and possible self-stigmatism are sought in meaning, that is, how the mentally ill themselves perceive their illness, how they manage their diagnosis in relation to their social environment, and how schizophrenia affects their self-esteem and aspects of their lives, such as perception of functionality and management of daily difficulties.

Table with survey participants' data

a/a		Gender	Age	Marital status	Education	Occupational status
1	A.K.	Female	35	Unmarried	Higher education	Unemployed
2	B.S.	Male	31	Unmarried	Higher education	Unemployed
3	G.K.	Male	29	Unmarried	Higher education-not completed	Working occasionally
4	G.P.	Male	27	Unmarried	Higher education-not completed	Unemployed
5	G.X.	Male	32	Unmarried	Higher education-not completed	Unemployed
6	I.S.	Male	44	Unmarried	Higher education	Working occasionally
7	L.K.	Female	41	Unmarried	Higher education	Working occasionally
8	L.N.	Male	50	Divorced	Higher education	Unemployed
9	M.G.	Female	26	Unmarried	Higher education-not completed	Unemployed
10	P.G.	Female	47	Unmarried	Higher education	Working occasionally
11	P.M.	Female	43	Unmarried	Higher education-not completed	Working occasionally

The choice of interviews was thus considered the most appropriate and effective way of exploring the above research questions, characterized by flexibility (Burgess, 1980; Silverman, 2006), having, in addition, the possibility of exploring verbal communication.

In particular, the semi-structured interview was chosen because, on the one hand, it is characterized by a set of predetermined questions and because they are flexible in terms of the content and order of the questions (Grawitz, 2004), and because this research technique is used to investigate the phenomenon examined from the point of view of the respondents (DiCicco -Bloom & Crabtree, 2006).

The following topics emerged from the thematic analysis of the interviews, which are then discussed from the perspective of the relationship with the self:

- The experience with mental illness (with the following hypotheses: a negative experience, hospitalization, I do not have a normal life),
- Diagnosis management (with the following subthemes: I would only talk to people who would understand me, only specialists can understand me, fear of disappointment of my own people, fear of rejection, mental illness to self-confidence)
- Influence of mental illness in social relationships (with the following hypotheses: I have persecuted them all, others are wary of me, that I understand the degree of acceptance of others towards me, my relationships have not been affected).

#### 4. The experience with mental illness

##### 4.1. Mental illness as a negative experience

For the majority of participants, mental illness was a purely negative experience. Some participants reported that their lives changed radically, suddenly, and in a bad way, linking this change, indirectly, both with experiences resulting from the disease itself and from side effects of treatment.

"[...] I had nerves enough, I didn't accept that this was happening to me, I was saying because to me... Eu... Nerves... (thinks) this" (PH, p. 8)

"Then there was the shock that I got it because I was indifferent, and I was going back and forth, and I had physical pain. I felt like crap" (MG, p.9)

In order to capture this negative experience from the above narrators, expressions of loans of medical speech (akathisia) are used, or on the contrary, expressions that reverse the medical discourse by utilizing unscientific words that do not stigmatize (I have nerves). These alternatives are especially important parameters in the management of the stigma of mental illness, and often the competent services include in their therapeutic repertoires similar strategies of strengthening one or the other such as depression, an emotional state more acceptable in the public space.

Another narrator also refers to the consequences of the disease without using the specific psychiatric terminology, sharing a request for care based on ordinary expressions, familiar to everyone, "cage", a "labyrinth" from which it cannot get out:

"As if I am a bird locked inside a cage and cannot open the cage and fly the bird. So much so. I feel imprisoned. (hits the hands on the table)" (LK, p.12)

"The first thoughts are that I find myself in a maze, a maze that I am trying to survive. That is it. Because it is a disease that is insidious and swallows you up. Yes!" (LN, p.12)

In the gap between medical discourse and everyday expressions, the rhetoric of deviation is found, where the concept of "madness" reigns. "Madness" is interpreted as the threshold of deviation. One of the participants said that she refuses to accept the new reality mainly because she now carries the label of "crazy":

"I wish I were fine. I do not accept my situation now. It saddens me very much! I cannot accept that I am 'crazy', in quotes. You are stigmatized by the world. I'm stigmatized, yes." (P.G., p. 7)

##### 4.2. Hospitalization: between stigma and care

All participants said they have been hospitalized in a psychiatric clinic and except for one, the rest were hospitalized involuntarily and by prosecutor's order.

The way this experience was experienced varies from participant to participant. Nevertheless, a common denominator is experiences associated with practices at the limit of legality, which produce enhanced stigmatization:

"Uh... and just the fact that I was with a prosecutor's office that bothered me very much because I stayed longer in the hospital, it wasn't intentional... voluntary hospitalization, it was involuntary." (LK, p.10)

"With the prosecutor's office, I felt very, very bad! They took me in handcuffs, I did not understand, I was in another reality, and I did not understand, I was scared, I did not know where they were going to take me, they handcuffed me... They came and picked me up while I was sleeping." (PG, p. 11)

Violent indictment at bedtime, handcuffs, and uninformed consent, are practices associated with a sense of loss of control of the self and deconstruction of the relationship with others. What the narrators indirectly denounce and to which the narrators attribute a strongly negative dimension are the practices of hospitalization, without denying the status of the patient. Forced hospitalization, medication, or related therapeutic practices are often judged not only as inevitable but also as positive, as they feed the feeling that a perspective of managing the suffering self is possible:

"I felt... on the one hand, I was not in control of myself, and my mother did well and made a prosecutor's order and secondly I felt somewhat relieved because again in the unit I would be with the medication let's say I slept and was hospitalized just fine" (BS, p.10)

"A very important part is hospitalization because it helps you rethink some things in your past. I was hospitalized yes, and I had time to think." (GP, p.10)

#### **4.3. I no longer have a "normal" life**

Most of the participants reported that their illness prevents them from having a normal life. This is because they believe that in some way they differ significantly from "normal" people and their lives are differentiated from that of people who do not suffer from some mental disorder. The foundation of this sense of divergence seems to be on the one hand negative deviation, on the other hand, a sense of the inability to completely control oneself and life prospects:

"Yes, it prevents me from having a normal life as I would like it to be... It makes me negatively different from others. I am like a man who has been sucked into a black hole. This idea of mine is like a black hole, which absorbs me and then I can't participate in the normal flow of things, like most people." (GP, p. 37)

"Yes. Because for a lifetime I will need medicines, I will not be free. I have to inject myself every month so as not to get the same again. I find it difficult to enter into a relationship with the other sex, ok and I don't feel comfortable but when I can't manage myself, if you have a relationship it's even more difficult and that is, I have these problems, it's not that I don't have difficulty, but I can't, because I don't have control of my own thoughts and... that's why I'm having a harder time." (PG, p. 38)

### **5. Diagnosis management**

An additional objective of the present study was to investigate the management of the diagnosis of mental illness in relation to the immediate social environment. The first question is whether the participants themselves choose to disclose to third parties the fact that they have been diagnosed with schizophrenia and "negative attention" on the part of others. The general stigmatization of people with mental illness, the ignorance that the majority of the population has about the "nature" of mental illnesses, and the demonization of people facing a mental illness, force these people to hide the fact of the diagnosis of mental illness. Indeed, most respondents reported that their diagnosis has not been communicated to many people but only to remarkably close people, usually family members:

"My relatives know it. Not all relatives. My father, my mother, my siblings and some of my friends" (GP, p. 12)

"Yes, it is mainly known by persons of the 1st degree of kinship, the others do not" (LK, p. 13)

"I try not to find out and ... only my own people, my very familiar ones. I try not to spread it because there is a stigma." (LN, p. 13)

In fact, some participants did not intend to disclose this information to those close to them either, but were forced to seek medical help or their subsequent hospitalization:

"They found out, or they learned that I was in the mental hospital, that I've been to the mental hospital before because they were asking what H.' is doing, where H. is, and my folks told them that he's in the mental hospital." (HS, p. 13)

"Because I had done some prosecutorial, as I told you hospitalizations and my lawyer had to find out to do it to me ... I know that in collaboration with the mom who was also a lawyer, they made me the prosecutor's office.

So, they had to find out, and because I'm on a supervisory board, not me, but my sister, my accountant, my lawyer, and my mom, they had to find out at least." (LK, p.13)

From the narratives of the participants, it follows that the hospitalization itself brings about a blow of identity, institutionally validating the deviation, the "madness":

"My illness suddenly appeared, I had begun to become aggressive, but then I started going out to shout I am God and my mother locked me at home, she did not ask for the help of a specialist. It did not help me. A cousin of mine from Thessaloniki found out about it, he came and saw me, he saw that I was taking psychiatric drugs, he made a prosecutor's order, and I went to Dafni. In Thebes I am the madwoman of Thebes..."(PG, p. 13)

Stigmatization seems to concern loved ones equally. Many times, relatives in order not to be characterized as relatives of a "crazy" person pressure patients not to reveal that they are facing a mental disorder:

"My parents were telling me you're going to say you're overworked, I know, that's something like that." (AM, p. 14)

Thus, the stigma seems not to be, even in terms of the dimension of its management, an individual issue, but in the first instance a question of the close environment in its entirety. However, there were participants who referred to alternative forms of management, stating that public notification of the disease could be an option:

"I could yes, yes speak freely" (IS, p.15)

"I have no issue not to say it" (AM, p.15)

What is more, public disclosure of the disease appears to a minority of narrators as a strategy of deconstructing stigma: mental illness is something that can happen to anyone if the appropriate circumstances arise:

"No, no, I don't keep it hidden. And in fact, if they look at me with half an eye, I will tell them that it happens to many people, especially now with the pseudo-economic crisis we have, it is logical that the other person despairs and also that there are dysfunctions in the brain functions especially if you have a genetic factor behind it." (BS, p. 14)

Therefore, the management of stigma seems to be a complex process, which is also influenced by the conjuncture (the conditions of economic crisis affect everyone adversely) but also by the policies of dealing with differences, from which alternative forms of behavior arise.

### **5.1. I would only talk to people who would understand me**

When participants were asked if and to whom they would deliberately talk about their illness, most reported that they would only talk to someone if they were sure they would understand them and not judge them. The fear of outcry and stigmatization seems to be quite strong:

"... to my friends better. To my friends yes. Yes, because there are some things that I may not be able to talk to my parents or relatives and I feel more comfortable with my friends." (PH, p.15)

"For the disease? No... No. Because others are not familiar with this disease and look at you strangely. Yes! I believe that people will react badly if they find out about it. (He thinks) I do not know... I'm just afraid yes." (MG, p.15)

"Nope! I could not talk to someone freely about the disease. Because I do not want to feel marginalized. I do not want to feel... I do not want to talk about my disease. I say I have schizophrenia ok? I do not want to say this thing. I want to be normal outside" (PG, p.15)

Other participants kept the discussion about the disease exclusively among them and their doctors or specialists involved in the diagnosis and therapeutic approach. They believe that others, except specialists, do not have the training and knowledge to manage such information.

"To health professionals. Not to tell you the truth. Only to specialists." (LK, p.15)

From this formal choice, it is implicitly clear that the orientation of medical and social services can affect the form of the therapeutic relationship.

## 5.2. Fear of disappointment in my own people

An additional reason why participants seemed negative about talking freely about their illness to non-specialists is the auto stigmatization that they themselves develop as a result of the general bias and stereotypes towards mental illness. Some participants report that they themselves feel "inferior", "relegated" as well as that they somehow disappoint the people who love them and who usually had different expectations of them:

"But let us tell relatives like my uncles let us say my godmother... I would not want to talk because it degrades me by an opinion in their eyes. So I feel flawed." (GP, p.15)

Auto stigmatization seems to feed on the possibility of rejection by other acquaintances and strangers, another reason that most cite as a reason why they would not speak openly about their illness:

"I mind what they think of you... Oops, this one now is one that has the slight schizophrenia, it's in her world, she's crazy, she doesn't have a sound brake, that's kind of how I see it and I don't want to give rights much." (LK, p. 17)

## 5.3. Effect of mental illness on self-confidence

One area in which the advent of the disease has had a significant influence is the opinion and feelings that it causes for themselves. The vast majority of participants reported experiencing particularly negative feelings not only about their quality of life affected by the disease but also about what value they now have as people. Many wondered why this should happen to them. Words and expressions like "defective", "shame on myself" and "I feel disadvantaged" dominated their descriptions:

"Depression, sadness, you feel a failure, you feel helpless and generally if you are not at the dance, you are not... away from dancing big words, you say let's say. I was ashamed of myself for having this disease let's say." (BS, p.37)

On the other hand, one participant mentioned that while on the one hand, he felt bad about his condition on the other hand he accepted that it is something beyond his control and he cannot do something "magical" to disappear. He is the only participant who puts the discussion about how his self-esteem was affected in a different context, focusing on the fact that accepting one's situation is perhaps the only way:

"Ok, I feel disadvantaged, but beyond that, since I can't since it's not up to me to get the magic wand to change situations." (AM, p.38)

## 6. Influence of mental illness on social relationships

The disease has a significant influence on social relations, as reported by the majority of participants. But for some even after the start of medication while perhaps many symptoms have been regulated and reduced the existence of the disease has made them not have their previous quality of life, especially in terms of their social interactions. Before the advent of the disease, most of them reported that they had satisfactory social relationships, something that changed when they were diagnosed with the disease. There were participants who reported that they themselves were isolated because of the sense of disadvantage they felt for themselves and their lives in general. As a result, their friends and acquaintances were also removed until they were completely lost:

"They've changed because... psychotic assistance hinders you... in relationships, social relations... I had friends and friendships. But then I did not have them anymore. They changed on both sides. Both from me and from them [he thinks] I have isolated myself and they left themselves. Ok, I can't say I have social relationships now." (AK, p.25)

"Before I was all day with friends, friends, shops, outings. Continuity with people. A lot of people and now I am in a room all day and I do not see anyone except my own. I cannot judge exactly why I have driven everyone away and I have not seen any reactions or anything" (G.G., p.25)

On the other hand, there were also participants who reported that the others were removing them. Mental illness but also obvious symptoms and behaviors that may seem strange cause misgivings in others who do not know how to manage them. As a result, the following are removed:

"And initially it was because I was still lost and could not even talk, communicate, or fill out a sentence. That is, I would scare the rest of us as I was. But I also didn't know who I was." (GK, p.28)

"Yes, they learned about my illness, and it is what we said was twisting by engagement and they immediately got drooping and they put a label on me, and it tells you this is like that, no I will not continue with this one, I am going to do my own life. I said it myself." (LK, p.29)

This sense of disadvantage and shame for their condition, which is a major dimension of the experience of the disease, seems to be a deterrent to the narrators speaking openly about it, especially to people who are new acquaintances:

"Yes, let us say if I am interested in a partner, I would be ashamed to talk about my problem, I would not want it to be learned. That is more. Perhaps there is still no knowledge and understanding of the problem and there is some misinterpretation. I feel both fear and shame." (PH, p.30)

"Yes, very, very precisely for what you said I am ashamed or afraid to tell them about my illness and that is where all my problems come in. In being able to express me and tell them you know I am here and she, no... Eu... and to want me for who I am not for what they would like me to be." (LK, p.30)

However, even a few of the participants reported that their social relationships were not affected by the presence of the disease.

"And of course, I maintain the friendships of the past. No, no, my social relationships have not changed. No, I am happy on this subject" (BS, p.25)

"For their part, they are all friendlier, they understand me better, and they also consider me as their competitor. In other words, I have come to a common alliance with others, and we are all fighting together for the same goods and the same wages." (GP, p.25)

### 6.1. The stakes of acceptance

From the responses of the participants, it is concluded that the "others" are divided into two main categories: (a) those who do not have a problem accepting people with mental illness, and (b) those who cannot accept such a person and remove it. For example, participants who stated that apart from close relatives no one else knows about their diagnosis said that they believe that there would probably not be the acceptance by others that would exist if the disease had not been diagnosed. In fact, there were participants who had previously experienced non-acceptance due to their diagnosis of the disease. On the other hand, there were participants who reported that the degree of acceptance of others towards them has not changed.

As can be seen from the above, the experience of mental illness for most participants is particularly painful and has significantly affected all areas of their lives, such as work and starting a family. Regarding the management of the diagnosis of their illness, most stated that they have chosen not to share with their environment the information that they have been diagnosed with schizophrenia due to the social stigma that accompanies this disease. In many cases, the diagnosis of their illness becomes known due to involuntary hospitalization, even though they themselves did not intend to communicate it to their environment. The main reason they would not want to talk about their illness seems to be the negative effect that this would have on their self-confidence, that is, it would make them feel inferior and lead them to auto-stigmatization. As follows from the above, most patients with schizophrenia choose to keep their diagnosis secret in order to maintain an intact social identity and to avoid the unpleasant effects of this diagnosis on their self-esteem and quality of life.

## 7. Discussion and Conclusion

From the narratives of patients, it follows that the internalization of stigma is a constant, in the overwhelming majority of cases negative, component. This confirms the classic approaches to the label (Link, Frank, & Wozniak, 1987; Link, 1982), and this is of particular importance at a time when at an ideological level the biopsychosocial model tends to dominate in Greece, according to which treatment and care are not limited to biological interventions but these must be combined with both psychic and social interventions, especially in the field of management of biography and individual identity.

The theory of auto stigmatization suggests that individuals either seek or accept ratings from others who support their current views (Swann, 1996). However, if we listen to the voice of the narrators carefully, we will find that the way in which stigma is managed seems to be differentiated, albeit slightly, on a case-by-case basis. As reflected in the narratives, the automaticity in mental illness is a dynamic process that the mentally ill internally adopt the stereotypical perceptions of the socio-cultural context of mental illness and develops negative emotions but adopt differentiated attitudes toward social interlocutors (Livingston & Boyd, 2010). This differentiation can be based on an intervention that reinforces the critical attitude and active forms of self-management, through also differentiated "pedagogical" interventions, including the use of medication and the symptoms perceived in the public space.

Some research shows that acceptance and internalization of stereotypes by people with a mental disorder are made if the individuals themselves consider them true (Corrigan & Watson, 2002; Corrigan & Rao, 2012). Interventions that deconstruct them, giving additional practical tools for their management in the public space have a lot to offer, as we detect from the narratives of the participants in our research. These narratives confirm that the higher levels of consciousness and self-stigmatization a person has, the greater discouragement he experiences (Cavelti et al., 2012), then associated with feelings of low self-esteem and despair that accumulate and lead to lower levels of quality of life (Link et al., 2001), since their social network is limited resulting in isolation, low incomes, and unemployment (Wrigley et al., 2005). Oh, however, from this finding it follows that pedagogical care interventions, based on the training of spoiled self-management can reverse this dynamic towards more active-productive relationships with oneself and others. Thus, the usual attempt of patients to keep their condition secret can be suspended, leading to further social isolation and auto-stigmatization through a self-fulfilling prophecy (Link, Mirotznik & Cullen, 1991). Unlike the physical disease in which social contacts are easier, people with mental illness have a reduced chance of support due to social isolation (Corrigan et al., 2001; Sartorius & Schulze, 2005). On the contrary, a more active and critical intervention, based on strengthening care of the sufferer self, may offer alternating, in addition to narrowly pharmaceutical interventions. Recovering self-esteem is a difficult, but important part of the therapeutic effort for the mentally ill (Link et al., 2001). This research confirms the need to design rehabilitation, treatment, and reintegration programs in the community, which will be adapted to the specific needs of stigmatized patients based on the "voice" of the patients' particulars, complementing biologically and psychologically oriented interventions with actions of a pedagogical and socializing nature.

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