

SELF-STIGMA AND ITS INFLUENCE ON EMPLOYMENT PROSPECTS FOR INDIVIDUALS LIVING WITH SCHIZOPHRENIA

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Abstract

Mental illnesses encompass a spectrum of symptoms affecting cognition, emotion, communication, and behavior, with schizophrenia being a severe example leading to self-stigmatization and reduced self-esteem. Scientific advancements have revolutionized psychiatric treatment by introducing various psychopharmaceuticals, facilitating the deinstitutionalization of mentally ill individuals. Chlorpromazine's discovery in 1950 was a significant milestone in schizophrenia treatment, contributing to community living. However, successful reintegration into daily life depends on numerous factors beyond medication. This article examines the multifaceted aspects of living with schizophrenia in the post-asylum era and highlights the complex nature of recovery.

Keywords: mental illness, schizophrenia, self-stigmatization, psychopharmaceuticals, community living, recovery

1. Introduction: mental illness and self

The term mental illness is used to express a wide range of symptoms that cause problems in thinking, feeling, communicating with others and, behavior as well as assessing the range of possibilities of the sufferer. Especially, schizophrenia, as one of the most serious mental illnesses, often leads to reduced self-esteem translated into a limited assessment of individual capabilities, therefore to self-stigmatization.

The scientific developments that led to the discovery of a large number of psychopharmaceuticals helped to live the mentally ill outside the mental hospital. Although the critique and therapeutic delegitimization of confinement in asylums precede it, pharmaceutical viruses helped in the total reshaping of a post-asylic model of psychiatric treatment. Especially for schizophrenia, a milestone in its treatment was the discovery of chlorpromazine in 1950 (Lopez-Munozetal, 2005), which along with other antipsychotics medicines, contributed to the improvement of treatment prospects and assisted in the deinstitutionalization and living of sufferers outside the special hospitals and asylums, in the community. Although these developments have opened up new horizons in increasing the chances of integrating patients into ordinary activities, in reality, the daily quality of life and the perception of their potential to follow the fast and demanding daily rhythms of life depend on a multitude of factors.

The role of self-esteem is crucial because high self-esteem is linked to mental health and quality of life, which is an important strengthening factor for the good prognosis and course of schizophrenia, the recovery of the functionality of mentally ill people after seizures and hospitalizations, their reintegration into the daily activities of the community (Fungetal, 2008). Mental illness, on the other hand, is aggravated by the subjective experience of the disease when it is exclusively negative and causes changes in the patient's quality of life since it itself acts as a stressor.

The negative influence of the opinions of the immediate social environment reduces the self-confidence of the mentally ill, which in turn affects both the manifestation and the course of the disease, the acceptance of treatment, the recovery of the possible lost daily skills of patients, and the ability to follow the daily rhythm of life in the community. Moreover, taking into account the above parameters, the fundamental ability of the individual to derive life satisfaction decreases as low self-esteem and self-stigmatization prevail (Mechanicet al., 1994), creating a condition that threatens healing and rehabilitation prospects (Page, 1977; Link, 1987). Reduced self-esteem increases the patient's anxiety and puts him at greater risk, contributing to the maintenance of chronic symptomatology (Lysakeret al., 2010) and making the individual vulnerable to dealing with the stigmatizing perceptions that society has of the mentally ill.

2. Stigma, self-esteem, and work

The phenomenon of stigmatization is a complex concept, involving stereotyping, prejudice, marginalization, and social deviance, and threatening to colonize the greater range of the individual's identity (Good et al., 2007). In this way, social identity becomes part of the self-image and affects self-esteem, and the stigmatizing mole, that is, the attribution of a derogatory characterization, leads to the formation of a worn social identity that to the extent that the mentally ill embraces it is proportional to self-stigmatization (Dovidio, Major & Crocker, 2000; Warner, 2005). That is, the acceptance and internalization of stereotypes by people with a mental disorder are done if the individuals themselves consider them true (Corrigan & Watson, 2002; Corrigan & Rao, 2012). In this way, the stigma is reflected in the identity of the mentally ill, and mental illness leads the individual to limit his rights and his human value (Goffman, 1963), since and to the extent that the "label" of mental illness ends up being a key axis of his definition.

The power of stigma is so great that it remains indelible and is consolidated for life even if the symptoms subside and the person fulfills the social role there is still distrust, fear, and avoidance (Sartorius & Schulze, 2005). The mentally ill are treated with fear and distrust in their social relationships and especially in areas related to their social status in finding work, and housing, significantly degrading their quality of life (Madianos et al., 1987; Page, 1977). When patient incorporates these postures, their self-esteem collapses, and he or she is ashamed and avoids asking for help from specialists because this certifies the severity of their condition (Feldhaus et al., 2018; Jesse et al., 2013). For this reason, the most important effects of reduced self-esteem and self-stigmatization are

the reductions of the interests, self-efficacy, and functionality of the individual, that is, self-confidence and self-sufficiency are affected since feelings of embarrassment, shame, and guilt about mental illness prevail and there is a mood to avoid the mentally ill from society (Corrigan et al., 2006). As a result, the lack of social acceptance, which brings alienation and social withdrawal and reduced self-esteem and motivation, hinders treatment and also undermines the hope of achieving goals in areas such as work (Blajeski et al., 2021).

Also based on research it has been found that the higher levels of consciousness and auto-stigmatism a person has, the greater discouragement he experiences (Cavelti, Kyrgic, Beck, Rusch & Vanth, 2012) and this implies feelings of negative self-esteem, despair that accumulate and lead to lower levels of quality of life (Link et al., 2001), since their social network is limited by the outcome of isolation, low incomes or even unemployment (Wrigley et al., 2005).

A key sector for survival that is influenced by both social stigma and self-stigmatization is the integration of the mentally ill into the labor market (Hipes et al., 2016). The labor market is an environment where discrimination can have serious consequences (Baldwin and Marcus, 2007; Cook, 2006; Stuart, 2004). Also, people with mental illness reported that they were relegated or dismissed from work, despite having the necessary qualifications, due to their mental illness (Cook, 2006; Corrigan, 2003; Stuart, 2004). In addition, employers explicitly express negative attitudes towards employees with mental illnesses and may be reluctant to hire them (Cook, 2006; Stuart, 2004). This lack of trust can arise from the anxiety caused by the belief that the stigmatized person is dangerous, the uncertainty of interaction with the person, or a possible violation of rules (Hebl et al., 2000). The culmination of the stigma process is discrimination and reduced life opportunities for people who are characterized as mentally ill. Vigor leads to frustration, decreased social support, decreased self-esteem, decreased desire to seek help, and finally unemployment (Link, 1987; Link et al., 1989; Ritsher and Phelan, 2004; Sirey et al., 2001).

The research conducted to date internationally on the subject of self-stigmatization is mainly quantitative, which does not allow deeper access to the subjective experience of the participants in relation to their illness, and this results in the loss of a large part of the information on this subject. For this reason, this research attempts to record the entire course of thought of the participants regarding their subjective experiences.

That is, it attempts systematic access to 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 the management of daily difficulties, focusing on the field of work.

3. Research Questions and Method

Following the targeted literature review, the main objective of this research is to investigate the experience on the issues of self-assessment and self-punctuality in 11 patients diagnosed with schizophrenia at the Psychiatric Hospital of Attica.

- How do the mentally ill perceive their illness in relation to their life prospects?
- How do patients experience mental illness?
- How does mental illness affect the self-esteem of the mentally ill and how does this in turn affect its relationship with others?
- How do patients themselves consider that mental illness affects their "functionality" in relation to their social environment and their work?

Understanding the answers to these questions is a valuable source of information for the organization of patient-centered care. Qualitative methodology was chosen on this topic because it mainly explores the concepts and perceptions of the participants 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, taking into account that the ratio of people diagnosed with schizophrenia is reliable and goes beyond clinical categorization, potentially hiding interpretive surprises (Britten, 1995). Thus, self assessment and possible self-stigmatization are sought in terms of 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 the perception of functionality and the treatment 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- non-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 considered the most appropriate and effective way to the above research questions because it is characterized by flexibility (Burgess, 1980; Silverman, 2006), additionally having the possibility of verbal communication. In addition, interviews allow researchers to examine non-verbal communication that it often reveals more and much more substantial information than verbal (Creswell, 2016). In particular, the semi-structured interview was chosen because, on the one hand, it is characterized by a set of predetermined questions and, on the other hand, it is flexible in terms of the content and order of the questions (Grawitz, 2004) as it is examined from the perspective of the participants, an element that in the case of people diagnosed with schizophrenia is particularly important when we want to record social phenomena such as the internalization of stigma.

From the thematic analysis of the interviews, the following topics emerged, which are then discussed from the point of view of the relationship with the self in relation to the perception of "functionality":

- How do I perceive my mental illness? What does mental illness mean to me, which I consider to be the and what is the appropriate treatment?
- My experience with mental illness: (a) illness as a negative experience, (b) illness and hospitalization, (c) perception of "abnormal" life.
- Have my abilities and social skills been affected, especially in relation to work?
- Influence of mental illness or illness on self-confidence and plans for the future

4. Perceptual patterns for illness and life prospects

4.1. How do I perceive my mental illness?

4.1.1. What mental illness means to me.

All participants seem to be quite well informed about their illness not exclusively bibliographically but through their own experiences with it. Thus, everyone spoke and described schizophrenia based mainly on experiences, which, however, they describe by referring to scientific terminology (delirium, atony, etc.), revealing familiarity with a form of knowledge derived from their long personal experience with therapies. For them, schizophrenia is a disease that causes them first (a) intense and abrupt emotional transitions, (b) a significant distortion of reality through paranoid ideas and visions:

"I have some symptoms. Hmm... One I am happy, the other I am sad. One I want this, the other I want the other, I'm undecided, I get stuck in thoughts, I think they follow me on the street, and I look back." (LK, p.4)

"I'm confused, delirious, shouting and things like that. atony..." (LN, p.4)

"I was out of control; I was out of place and out of time. I didn't have communication with the environment at the time."

(MG, p.4)

It follows from the statements of the participants that each patient experiences and perceives the diagnosis and the disease in a different way and to a different degree including work:

"It has prevented me from having better interactions, a more developed social and friendly circle and has generally hindered me in my life." (AK, p. 1)

"It means that the person who has manifested the symptoms of schizophrenia has a mental illness, manifested in various forms, which, however, make him incapable of offering some tasks, let's say to work." (PH, p. 2).

"[...] it makes it exceedingly difficult for me in my life. I'm not very functional." (PG, p. 3)

For some participants, the development of the symptoms of mental illness changed their quality of life drastically and especially the unreasonable thoughts in which they developed due to the disease that created a distorted reality that in one way or another prevents them from following the usual rhythm of everyday life:

"It goes more in my mind what I experienced, which essentially changed my whole life from that moment onwards." (GK, p.

1).

"[...] you think of some things in an absurd way. So, you have some obsessions... on absurd things. And you don't face reality as it is" (G.G., p. 2)

"Simply put, it was as if I went to another world of my own away from the real one, I created a fantasy and lived it minute by minute all day every day every day for quite a while." (GK, p. 2)

But there were also the participants who treated the disease and the diagnosis more detachedly and realistically, based on a virulent approach to the disease. For them, the disease creates a condition that arises from some organic (cerebral) dysfunction and requires significant pharmacotherapy in order to overcome:

"That I have something I have to take medication." (S, p. 2)

"I think it was a simple disease that may be related to some lack of hormone in the brain that generally affects my system, my body." (BS, p. 2)

4.1.2. Causes of disease

As for the origin of the disease, the opinions of the participants differ, which is consistent with the multifactorial nature of the mental illness. Some participants attributed the disease to emotional causes, that is, some unpleasant event that triggered strong negative emotions such as anger and anxiety. For others, the disease is the result of organic dysfunction and/or previous negative and traumatic experiences while there were also those who attributed their disease to hereditary causes because they had a patient in their family environment.

"It is probably due to some brain dysfunction which was caused by a ... the occasion was an erotic disappointment that I had." (BS, p. 4)

"In some wrong stimuli I had in the past that stigmatized me. That is, some bad experiences. That is, all this worked cumulatively, resulting in this disease." (GP, p. 4)

"My mother's brother died in a mental hospital, it must probably be hereditary because my mother didn't study, she was one, she was in elementary school, and she had some outbursts in character." (PG, pp. 4-5)

"Partly in heredity, partly in acquired ... in the conditions that everyone grew up in, in their experiences, in the first years of their lives." (AM, p. 5)

The perception of the etiology of the disease can influence both treatment expectations and biographical perspectives for the future, regarding issues such as work.

4.1.3. Therapy

Regarding the possibility of healing, the majority of participants believe that they will not reach the level of quality of life they had before they fell ill, that disease left an indelible trace in their biographical path:

"No, one cannot have a full cure." (BS, p. 6)

"It is not eliminated but some cure rate there is a 60%. 60% to 70%." (PH, p. 7).

"Yes, I believe it is cured or can be significantly improved. At an 80%. I believe that I will become again as before. Yes."

(HS, p.7)

However, there were also participants who are particularly optimistic about their therapeutic course, stating that they believe that they can reach the level of abilities and quality of life they had before they became ill:

"With the help of doctor's yes. So, I believe that I will become again as I was before." (AK, p. 6)

"Yes, it's something that's done therapeutically. It may take some time, but it will be fought. Yes, you can become as you were before. Yes, you can come back yes." (GP, p. 6)

"Yes, I think it is cured. There may be a complete cure I don't know. Yes, I believe I can be like before I got sick." (MG, p. 7)

4.2. My experience with mental illness

A specific objective of this study is to investigate the experience of participants with mental illness from its inception until today and its overall assessment by them.

4.2.1. A negative experience

For the majority of participants, he experienced mental illness as a negative experience. Some participants reported that their life changed radically and in a bad way. Emotions had now changed, and individuals began to experience unprecedented emotions and in great intensity:

"[...] I had nerves enough, I didn't accept that this was happening to me, I was saying because to me... Eu... Nerves...

(scthat's enough." (PH, p. 8)

"Then there was the shock that I got because I couldn't sit down, and I was going back and forth, and I had physical pain. I felt like crap." (MG, p.9)

Very characteristic and intense were the descriptions mentioned by two participants who experience particularly intensely the advent of the disease in their lives. One participant who during the interview was experiencing extraordinarily strong emotions said that the disease has trapped her in a life that she did not choose and likens her life now to that of a prisoner who she can no longer have a say in her life. On the other hand, another participant likened his life to the disease to himself in a maze from which he cannot get out:

"Excruciating, tyrannical, non-liberating, for the individual in their thoughts. 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 am in a maze, in a maze that I am trying to survive. That's it. Because it is a disease that is insidious and swallows you up. Yes!" (LN, p.12)

For some participants, this change in the quality of life brought them a strong emotional charge. In fact, one of the participants mentioned that she refuses to accept the new reality mainly because she now bears the label of "crazy":

"I wish I was fine. I do not accept my situation now. It saddens me very much! I can't accept that I'mcrazy in quotes. you're stigmatized by the world. I'm stigmatized, yes."

4.2.2. Hospitalization

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

"I was admitted by prosecutor's order, basically caused it inside the police station and with what I did they were forced to lock me in a room ..." (GK, p. 9)

"My introduction to the Ps.N.A. was done of my own free will, it lasted about a month." (PH, p. 10)

"Uh... and just the fact that I was introduced toit bothered me very much because I stayed longer in the hospital was not 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 didn't understand, I was in another reality and I didn'tunderstand, I was scared, I didn't know where they were going to take me, they handcuffed me... They came and picked me up while I was sleeping." (PG, p. 11)

Although the involuntary admission was accompanied by negative emotions, several of the participants admitted that daily was an inevitable event as the symptoms of the disease were on the rise and their behavior was not functional. they felt safe, but they also had time to reflect on what this experience might offer them:

"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 relieved because again in the unit I would be with the medication let's say I was sleeping, and I 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)

4.2.3. I do not live 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 are significantly different from "normal" people and their lives are differentiated from that of people who do not suffer from a mental disorder.

"Yes, it prevents me from having a normal life as I would like it to be... It makes me differ naively 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 cannot 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 establish 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 harder and that is, I have these problems, it's not that I don't have difficulty, but I can't, because I'm not in control of my own thoughts and... that's why I'm having a harder time." (PG, p. 38)

4.3. It has changed "my functionality"

During the interview, participants were asked about whether the disease affected what professionals define as functionality, namely their abilities to follow the rhythm of daily life, in their various dimensions.

4.3.1. Before and after

Most of the participants reported that the biggest drawback after the onset of the disease was the impairment in their ability to do things they did before. In fact, when their current degree of 'functionality' is estimated to be significantly lower than in the past:

"My life has changed because I'm no longer able to do things I did, in the first place. (AK, p.8)

"I just wanted to sit in my bed because I couldn't stand up, etc., I couldn't function, I couldn't work, I wasn't able to work,

I had suicidal tendencies as well." (BS, p. 8)

"Of course, my life has changed, I can't work, I can't do the social events I did and things like that." (LN, p.9)

The majority of participants argued that they believe that they will not reach the level of functionality they had before they became ill. An additional element that emerged is that they feel that they themselves are dominant in this therapeutic journey and that they are responsible for improving or worsening their condition. themselves as well as the consequences of their non-compliance with it:

"[...] if you cut the drugs you may fall into a relapse." (BS, p. 6)

"If I stop my treatment, the drugs, I believe yes I will go back to the state I was in. No, I don't think I'll be like before." (PH, p. 7).

One of the most important changes that occurred after the diagnosis is taking medication. While most people admitted that without the drugs they could not return to basic functionality and be autonomous, there are side effects that create additional obstacles for them. As before:

"As the doctors have told me if I ever have to stop the drugs, I will go back not to my good self, to myself who had the

problem. Yes, and I have been told that I will take the medication forever or else I will relapse." (PH, p. 7)

"Uh... I had talked to a doctor, and he had told me when I left the mental hospital of Thessaloniki that the pills you take will be taken all your life" (IS, p. 7)

However, medication for them is a factor that enables them to have the maximum possible functionality.

"The point is that you are now taking the appropriate medication to deal with it, and if you try to follow your doctor's instructions, I think it offers you a high standard of sustainability" (BS, p. 18)

"I thought I didn't need them. Not now I need to take them." (HS, pp.18-19)

"Uh I felt that I was bound to the drugs but in fact, later on, I saw that they are very good for me. Without drugs, I cannot live. It can't be done, it can't be done, I'm not functional, and there's a chance I'll be relapsing without the drugs" (LK, p.19)

On the other hand, some of the participants seemed to be particularly vision in terms of their therapeutic course, stating that they believe that they can reach the level of functionality and quality of life they had before they became ill:

"With the help of doctors yes. So, I think I will become again as I was before. With the help of the doctor and with the effort of his own." (AK, p. 6)

"Yes, it's something that's done therapeutically. It may take some time, but it will be fought. Yes, you can become as you were before. Yes, you can come back yes." (GP, p. 6)

"Yes, I think it is cured. There may be a complete cure I don't know. Yes, I believe I can become like before I got sick" (MG, p. 7)

4.3.2. My work has been negatively affected

One area in which the operating discount seems to be greater is the labor one. All participants reported being graduates or graduates of higher education, and some had already begun to work when the first symptoms of the disease appeared.

"Because at work if you are not in a good psychological state you cannot meet the demands that exist." (AK, p. 20)

"Yes! I can't work because of my mind; I don't have a very good concentration." (MG, p.21)

"[...] for example if I want to work somewhere because I take medication now I would not work as I worked when I was without the drugs. I would work less, I work less." (HS, p.21)

For some this was mainly the case in the early stages of the disease where most of the participants had not fully realized what was happening and had not yet started their medication:

"Yes, it has. In the early stages of the disease, that is, until I was restored at first with the drugs, I could not tune myself in. In the initial, in the initial months of treatment yes."

The effect of mental illness on the ability of patients to work was also evident from the answers they gave about whether they would claim a job worthy of their abilities.

"Nope. I don't think so. I'm thinking of getting involved with rural. We have some field in the province and that's what I'm going to deal with." (HS, p.41)

"To tell you the truth not yet, I'm not ready for a job yet. In the future maybe yes. But now no, I want to stabilize myself to feel ready for myself that I can stand on my own two feet." (LK, p.41)

"I've ruled it out of work. Because of the disease and the age, I also resigned from the practice of law, etc." (LN, p.42)

"Now I don't have much potential. Because my mind is not working very well." (MG, p.42)

In addition to their low functionality due to the illness, some participants also focused on the stigma that surrounds people with mental illness, which acts as a deterrent to looking for a job.

"In Greece, it has to do with the social stigma let's say the social mentality. That is, the other person who suffers from mental illnesses is still stigmatized. That is, while you are not crazy, they consider you crazy let's say without being. There is no active symptomatology anymore, but because it has been diagnosed." (BS, p. 41)

"Yes definitely, it would definitely stop me. Unless they didn't know I was mentally ill." (PG, p.41)

However, there were also participants who believed that they could claim a job as they would have claimed it before and that their illness is not an obstacle to this:

"In my case, I think I would find a job worthy of my potential." (AK, p.40)

"I don't think it would stop me, I could do this job again that I did as the assistant waiter, it was a very good opportunity in my life, and I would like to do it again." (GP, p.40)

4.4. Effect of mental illness on self-confidence

One area in which the diagnosis of the disease has had a significant effect 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 that has been negatively affected by the disease but also about the value they now have as humans. Many wondered why this should happen to them. Typical words and expressions such as "defective" "shame on myself", "I feel disadvantaged" dominated their descriptions:

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

"I feel like a flawed man. I feel bad when I realize I'm at this level and I want to get away with it." (GP, p. 37)

"A little misery, misery, not happiness, disappointment, pessimism, emotional charge, sadness, sometimes excruciating or tyrannical. Not the best. (her voice breaks- emotions.)" (LK, p.37)

On the other hand, one participant mentioned that while on the one hand, he felt punctual about his situation on the other hand he accepted that it is something beyond his control and he cannot do something "magical" to disappear.

"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)

For a participant, the whole process of illness and confinement functioned as a new and positive experience for him:

"I haven't... I'm not sad, I'm I can say happy to some extent that I was given this opportunity and was hospitalized and went through this experience. Positive, yes." (HS, p.38)

5. Discussion and conclusions

It emerges from the patients' narratives that the internalization of stigma in the vast majority of cases is a negative experience with many implications, mainly in the perception of social functioning and the ability to work, which is of key importance for their survival. stigmatization (Link, Frank, &Wozniak, 1987; Link, 1982), and this is of particular importance at a time when treatment is not limited to biological interventions but must be combined with both mental and social interventions, including work (Bustilloetal, 2001).

However, as the narratives show, not all patients are self-stigmatized. Some act on stigma by taking energy and strength, while others put it in second place in relation to more practical issues, such as daily living and financial survival. They also develop a positive identity, for example through interactions with groups of mentally ill people, resulting in positive self-perceptions. This finding suggests that the problem of self-stigmatization could be addressed through cognitive-behavioral approaches (Watson et al., 2007). Also, through interaction with other more experienced patients, self-stigma can be reduced and for this reason, self-help groups are particularly important (Mustafa, 2021). This fact makes it particularly important whether or not to have self-stigmatization as a factor that can prevent or promote the rehabilitation of the mentally ill and for this reason the transformation of the image that patients have of themselves and consequently the reduction of this; stigmatization and an increase in self-esteem are a key part of the process of regaining their functionality. This means that stigma should be treated therapeutically in the context of an integrated approach to psychosocial rehabilitation with a particular focus on addressing internalized shame and low self-esteem, and this is the conclusion of most research (Wood et al., 2017). Ignoring self-stigma and self-esteem due to illness in therapeutic planning can lead to serious obstacles to the rehabilitation of cv traumas (Fung & Tsang, 2008, Yanos et al., 2010).

Also, according to Yanos et al. (2012), self-stigma and functionality are related and altered over time, and this means that it is a manageable parameter through appropriate psychoeducational interventions (Corrigan, 2003). That is, stigma affects social functionality by suggesting that interventions targeting internalized stigma can affect functionality, social reintegration, and professional rehabilitation. It is especially important, especially in times of economic crisis, to create employment opportunities for mentally ill people under appropriate conditions, such as supported employment models (Krupa & Carter, 2015).

Another important parameter in the management of low self-esteem and self-stigmatization is the apt treatment and management of the problems of the disease either by pharmaceutical or other therapeutic methods. Stigma is the negative symptoms of the disease, especially when these are evident. An important aspect of schizophrenia is cognitive deficits, as well as dysfunctions in most areas of cognitive, motor, and sensory function (Wexler & Bell, 2005). For this reason, understanding and coping with these difficulties is of key importance in psychosocial rehabilitation, because verbal learning, memory, and verbal disorganization are important prognostic factors of work behavior (Gibson, 2004).

This means that all the individual aspects of the disease must be addressed at the same time, including both its symptoms as such and the consequences they have on the social identity, self-stigmatization, and self-esteem of patients within the framework of a multifaceted and interdisciplinary approach (Tzanakis, 2022). Educational interventions and skills development will have the maximum possible effectiveness and will contribute decisively to the professional rehabilitation and reintegration of patients into society as productive individuals.

References

- Baldwin, M., Marcus, S. (2007). *Labor market outcomes of persons with mental disorders. Ind Relat. A. J. Econ. Soc.* 46(3), 481-510.
- Blajeski, S., Klodnick, V., Caruso, N., Sale, T. (2021). *How early stigmatizing experiences, peer connections, and peer spaces influenced pathways to employment after the first episode of psychosis. Psychiatric Rehabilitation Journal*, 32(2), 95-104.
- Britten, N. (1995). *Qualitative research: qualitative interviews in medical research. British Medical Journal*, 311(6999), 251-253.
- Burgess, R. (1980). *Field research: A sourcebook and field manual. London: Allen and Unwin.*
- Bustillo, J., Lauriello, J., Horan, W., Keith, S. (2001). *The psychosocial treatment of schizophrenia: An update. The American Journal of Psychiatry*, 158(2), 163-175.
- Cavelti, M., Kvrjic, S., Beck, E., Rusch, N., Vauth, R. (2012). *Self-stigma and its relationship with insight, demoralization, and clinical outcome among people with schizophrenia spectrum disorders. Comprehensive Psychiatry*, 53 (5), 468- 479.
- Cook, J. & Razzano, L. (2000). *Vocal rehabilitation for persons with schizophrenia: Recent research and implications for practice. Schizophrenia Bulletin*, 26(1), 87-103.
- Cook, J. (2006). *Employment barriers for persons with psychiatric disabilities: Update of reports for the President's commission. Psychiatric Serv*, 57(10), 1391-1405.
- Corrigan, P.W. & Watson, A.C. (2002). *The paradox of self-stigma and mental illness. Clinical Psychology: science and practice*, 9, 35- 53.
- Corrigan, P. (2003). *Perceptions of discrimination among persons with serious mental illness. Psychiatr. Serv.* 54(8), 1105-1110.
- Corrigan, P., Watson, A., Barr, L. (2006). *The self-stigma of mental illness: Implications for self-esteem and selfefficacy. Journal of Social and Clinical Psychology*, 25(9), 875-884.

- Corrigan, P.W. & Rao, D. (2012). *On the self-stigma of Mental Illness: Stages, Disclosure, and strategies for change*. *Canadian Journal of Psychiatry*, 57 (8), 464- 469.
- Creswell, J. (2011). *Educational research: planning, conducting, and evaluating quantitative and qualitative research*. Pearson Education.
- Dovidio, J.F., Major, B. & Crocker, J. (2000). *Stigma: Introduction and overview*. In T.F. Heatherton, R.E. Cleck, M.R. Hebl, J.G. Hull (Eds.), *The social psychology of stigma*. New York: Guilford Press.
- Feldhaus, T., Falke, S., Gruchalla, L., Maisch, B., Uhlmann, C., Bock, E., Lancer, R. (2018). *The impact of selfstigmatization on medication attitude in schizophrenia patients*. *Psychiatry Research*, 261, 391-399.
- Fung, K., & Tsang, H, Corrigan, P. (2008). *Self-stigma of people with schizophrenia as a predictor of their adherence to psychosocial treatment*. *Psychiatric Rehabilitation Journal*, 32(2), 95-104.
- Gibson, D. (2004). *Role models in career development: New direction in theory and research*. *Journal of Vocational Behavior*, 65(1), 134-156.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. England: Cliffs, NJ: Prentice Hall.
- Good, C., Dweck, C., Aronson, J. (2007). *Social identity, stereotype threats, and self-theories in Contesting stereotypes and creating identities* (Ed. Fuligni A.). Russell Sage Foundation: New York.
- Hebl, M., Tickle, J., Heatherton, T. (2000). *Awkward moments in interactions between non-stigmatized and stigmatized individuals*. In: Heatherton, T., Kleck, R., Hebl, M., Hull, J. (Eds.), *The Social Psychology of stigma*. New York: Guilford.
- Hipes, C., Lucas, J., Phelan, J., White, R. (2016). *The stigma of mental illness in the labor market*. *Social Science Research*, 56, 16-25.
- Jesse, O., LeKeldrick, T., Rodolfa, E. (2013). *Stigma for seeking therapy: Self-stigma, social stigma and therapeutic process*. *The Counseling Psychologist*, 41(6), 857-880.
- Karydi, M.V., Stefanis, C., Theleritis, C., Tzedaki, M., Rabavilas, A., Stefanis, N. (2010). *Perceived social stigma, self-concept, and self-stigmatization of the patient with schizophrenia*. *Comprehensive Psychiatry*, 51, 19-30.

- Krupa, T., Chen, S. Carter, G. (2015). *Serious mental illness, vocational rehabilitation, and employment in Handbook of Vocational Rehabilitation and Disability Evaluation* (Eds Gatchel, R. & Schultz, I.), Springer.
- Kvale, S. (1983). *The qualitative research interview: A phenomenological and a hermeneutical mode of understanding. Journal of phenomenological psychology*,14, 71-196.
- Link, B. (1982). *Mental patient status, work, and income: An examination of the effects of a psychiatric label. American Sociological Review*, 47 (2), 202-215.
- Link, G. (1987). *Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. American Sociological Review*, 52(1), 96-112.
- Link, B.G., Cullen, F.T., Frank, J. & Wozniak, J.F. (1987). *The social rejection of former mental patients: Understanding why labels matter. American Journal of Sociology*, 92, 1461- 1500.
- Link, B.G., Struening, E.L., Neese- Todd, S., Asmussen, S. & Phelan, J. (2001). *Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illness. Psychiatric services*, 52 (12), 1621- 1626.
- Link, B.G., Cullen, F. & Struening, E. (1989). *A modified labeling theory approach to mental disorders: An empirical assessment. American Sociological Review*, 54 (3), 400- 423.
- Lopez-Munoz, F., Alamo, C., Cuenca, E., Shen, W., Clevo, P., Rubio, G. (2005). *History of the discovery and clinical introduction of chlorpromazine. Annals of Clinical Psychiatry*, 17(3), 113-135.
- Lysaker, P., Yanos, P., Outcalt, J., Roe, D. (2010). *Association of stigma, self-esteem, and symptom with a concurrent and prospective assessment of social anxiety in schizophrenia. Clin SchizophrRelat Psychoses*, 4(1), 41-48.
- Madianos, M., Madianou, D., Vlachonikolis, J., Stefanis, C. (1987) *Attitudes towards mental illness in the Athens area: Implications for community mental health intervention, Acta Psychiatrica Scandinavica*, 75, 158-185.
- Mechanic, D., McAlpine, D., Rosenfield, S., Davis, D. (1994). *Effects of illness attribution and depression on the quality of life among persons with serious mental illness. Social Science and Medicine*, 39(2), 155-164.

- Mustafa, Y. (2021). *Psychosocial rehabilitation interventions in the treatment of schizophrenia and bipolar depression*. *Arch Neuropsychiatry*, 58 (1), S77-S82.
- Page, S. (1977). *Effects of mental illness label in attempts to obtain accommodation*. *Canadian Journal of Behavioral Science*, 9, 85-90.
- Ritsher, J. and Phelan, J. (2004). *Internalized stigma predicts erosion of morale among psychiatric outpatients*. *Psychiatry Res.*, 129, 257-265.
- Sartorius, N. & Schulze, H. (2005). *Reducing the stigma of mental illness*. New York: Cambridge University Press. Silverman, D. (2006). *Interpreting qualitative data (3rd ed.)*. Thousand Oaks, CA: Sage.
- Sirey, J., Bruce, A., Alexopoulos, G., Perlick, D., Friedman, S., Mayers, B. (2001). *Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence*. *Psychiatr. Serv.* 52, 1615-1620.
- Stuart, H. (2004). *Stigma and work*. *Healthcare Papers*, 5 (2), 100-111.
- Tzanakis, M. (2022). *The Concept of Ulysses as An Understanding Form of Mental Illness in Individualized Societies: Testimonies in the Greek Post-Asylum Era*. *Psychology and Behavioral Sciences International Journal*, 20(1), 556029.
- Turner, R. (1981). *Social support as a contingency in psychological well-being*. *Journal of Health and Social Behavior*, 22, 357-367.
- Wexler, B., & Bell, M. (2005). *Cognitive remediation and vocational rehabilitation for schizophrenia*. *Schizophrenia Bulletin*, 31(4), 931-941.
- Wrigley, S., Jackson, H., Judd, F. & Komiti, A. (2005). *Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town*. *Aust NZ J Psychiatry*, 39, 514- 521.
- Yanos, P., Roe, D., Lysaker, P. (2010). *The impact of mental identity on recovery of severe mental illness*. *American Journal of Psychiatric Rehabilitation*, 13(2), 73-93.