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The Relationship between Stigmatizing Beliefs about Mental Disorders and Psychiatric Symptom Levels

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Abstract

Objective: Stigmatizing beliefs about mental illnesses negatively affect the course of illnesses in many ways. Modified Labeling Theory attempts to explain the factors that mediate the relationship between stigma and psychiatric symptoms. This study aimed to investigate the relationship between stigmatizing beliefs and psychiatric symptom levels.

Methods: This cross-sectional correlational study included 203 individuals aged 18–65 years with no history of psychiatric illness or treatment who presented to the outpatient psychiatry clinic of a university-affiliated hospital between April 2023 and April 2024. Participants completed a Sociodemographic Information Form, the Beliefs Toward Mental Illness Scale, and the Symptom Checklist-90 (SCL-90).

Results: 203(F: 140, M: 63) participants were evaluated. A positive correlation was observed between psychiatric symptom levels and stigmatizing beliefs about mental disorders ($p<0.05$ and $p<0.01$). It was determined that the "SCL-90 psychoticism subscale" value could predict stigmatizing beliefs.

Conclusion: The data we obtained are consistent with the literature reporting a positive correlation between stigma and disease severity. In our study, it was found that this relationship was also valid in newly diagnosed individuals and at the symptom level. It is important to address stigmatizing beliefs, which are one of the biggest obstacles in the treatment process of mental illnesses, from the first examination.

Keywords: Social Stigma, Modified Labeling Theory, Mental Disorders

Ruhsal Hastalıklara Yönelik Damgalayıcı İnançların Psikiyatrik Semptom Düzeyleri ile İlişkisi

Özet

Amaç: Ruhsal hastalıklara yönelik damgalayıcı inançlar, hastalıkların seyrini birçok yönden olumsuz etkilemektedir. Modifiye Damgalama Teorisi, damgalama ile psikiyatrik semptomlar arasındaki ilişkiye aracılık eden faktörleri açıklamaya çalışmaktadır. Bu çalışma, damgalayıcı inançlar ile psikiyatrik semptom düzeyleri arasındaki ilişkiyi araştırmayı amaçlamaktadır.

Gereç ve Yöntem: Bu kesitsel ilişki arayıcı (korelasyonel) çalışmaya, Nisan 2023–Nisan 2024 tarihleri arasında bir üniversite hastanesinin ayaktan psikiyatri polikliniğine başvuran, geçmiş psikiyatrik hastalık ve tedavi öyküsü olmayan 18–65 yaş aralığındaki 203 birey dâhil edilmiştir. Katılımcılara Sosyodemografik Bilgi Formu, Ruhsal Hastalıklara Yönelik İnançlar Ölçeği ve SCL-90 Belirti Tarama Listesi uygulanmıştır.

Bulgular: 203 (K:140, E:63) katılımcı değerlendirildi. Psikiyatrik semptom düzeyleri ile ruhsal hastalıklara yönelik damgalayıcı inançlar arasında pozitif bir korelasyon saptandı ($p<0,05$ ve $p<0,01$). "SCL-90 psikotizm alt ölçek" değerinin damgalayıcı inanç düzeylerini öngördürebileceği belirlendi ($p<0,001$).

Sonuç: Elde ettiğimiz veriler, damgalama ve hastalık şiddeti arasında pozitif korelasyon olduğunu bildiren literatür ile uyumludur. Çalışmamızda bu ilişkinin, yeni tanı almış bireylerde ve semptom düzeyinde de geçerli olduğu saptanmıştır. Ruhsal hastalıkların tedavi sürecindeki en büyük engellerden biri olan damgalayıcı inançların, ilk muayeneden itibaren ele alınması büyük önem taşımaktadır.

Anahtar Kelimeler: Toplumsal Damgalama, Modifiye Damgalama Teorisi, Ruhsal Bozukluklar

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INTRODUCTION

Stigma is defined as the devaluation, humiliation, and exclusion of a particular group or individual compared to the rest of society due to specific characteristics they possess (Ordu, 2023). While the negative attributes of the stigmatized group are often emphasized, their positive qualities are frequently overlooked (Gärtner et al., 2022). In addition to the individual being stigmatized by society, there is also "internalized stigma," in which a person stigmatizes themselves, and "perceived stigma," where individuals feel stigmatized even in the absence of overtly exclusionary behaviors (Taskin, 2007). Both internalized and perceived stigma are associated with the stigmatizing attitudes present in society (Ritsher et al., 2003). It is well known that individuals with mental disorders constitute the group most exposed to stigma (Taskin, 2007). Deeply ingrained societal prejudices regarding mental disorders place patients and their families in highly challenging and distressing circumstances. The stigma experienced by patients undermines their self-esteem, disrupts family and social relationships, and hinders their ability to obtain employment and secure a place within society. Consequently, individuals with mental illness are compelled to cope not only with the debilitating symptoms of their condition but also with the burdens of social stigma (Drake & Wallach, 2020).

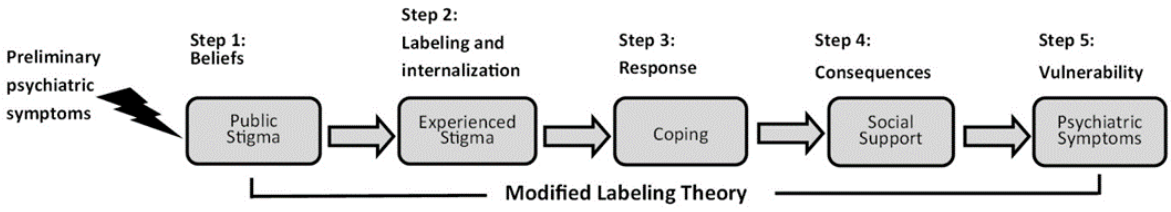
Numerous studies suggest that stigma toward mental illness primarily arises from specific societal prejudices (Ahad et al., 2023). Reports indicating that individuals who have recovered from a mental illness or who have relatives with mental illness tend to exhibit fewer stigmatizing attitudes further support this view (Corrigan et al., 2012; Rodrigues et al., 2025; McLaren et al., 2023). Stigma has also been reported to vary by sociodemographic characteristics; more stigmatizing attitudes are observed in segments of the population with lower socioeconomic and educational levels (Taşkın, 2007). Age, sex, and marital status have likewise been reported to be associated with stigma (Lo et al., 2021).

Stigma related to mental illness adversely affects various aspects of the disease process, particularly treatment-seeking and treatment adherence (Thornicroft et al., 2022; Jingman et al., 2024; Schomerus et al., 2019). A one-year follow-up study reported that baseline stigma levels were associated with the persistence of symptom severity at follow-up, and this association was mediated by social support and perceived stigma (Hunter et al., 2017). Another study conducted among postpartum women found that negative beliefs about mental illness were related to the severity of psychiatric symptoms (Fleischman et al., 2022).

The "Modified Labeling Theory (MLT)" proposed by Link and colleagues aims to explain how stigmatizing beliefs affect the course of mental illness in individuals with psychiatric disorders through its impact on psychiatric symptoms. According to this theory, individuals with mental illness are aware of the prejudices that exist in their society concerning mental disorders. Moreover, once a mental health professional diagnoses an individual, they become "labeled." Thus, the individual becomes a member of the "stigmatized group" and begins to experience stigma by internalizing existing societal prejudices. The individual's response to this adverse situation and the level of social support they receive influence the development of psychiatric symptoms (Link et al., 1989). Link and colleagues proposed a five-stage model to explain the relationship between negative beliefs about mental illness and psychiatric symptoms: societal beliefs, labeling through

diagnosis, the individual's response to this situation, outcomes, and vulnerability. In this framework, stigmatizing beliefs at the initial stage adversely affect psychiatric symptoms at the final stage, mediated by certain factors (Figure 1).

Figure 1. Preliminary psychiatric symptoms and Modified Labeling Theory (MLT)



The literature suggests that the majority of studies investigating the relationship between mental illness and stigma have primarily focused on severe psychiatric disorders, such as schizophrenia and bipolar disorder, in which disability is more frequently observed (Dubreucq et al., 2021). In addition, there has been a notable increase in recent years in research investigating the association between substance use disorders and stigma (El Hayek et al., 2024). By contrast, studies on conditions that are more prevalent in the general population, such as depression and anxiety disorders, remain relatively limited. Nevertheless, stigma constitutes a significant challenge across the treatment processes of all psychiatric disorders (Nabors et al., 2024).

The literature suggests a bidirectional association between stigma and the course of psychiatric illness. According to the model proposed by the MLT framework, mediating factors such as the experience of stigma following diagnosis, the individual's psychological response to this diagnosis, and the level of social support play an important role in shaping illness trajectories. To limit the potential influence of prior mental health service contact and treatment-related experiences on stigmatizing beliefs, we focused on first-time psychiatric help-seekers. The present study aims to investigate the relationship between stigmatizing beliefs and psychiatric symptom levels in conditions that are more prevalent in the general population, such as depression and anxiety disorders, which generally follow a more favorable course compared to severe mental illnesses. Accordingly, this study addressed the following research questions among first-time psychiatric help-seekers:

1) Are stigmatizing beliefs about mental disorders associated with psychiatric symptom severity among first-time psychiatric help-seekers?

2) In terms of whether an association exists between stigmatizing beliefs and symptom severity, do SCL-90 symptom dimensions differ?

3) Which sociodemographic and clinical characteristics are associated with stigmatizing belief levels in this population?

MATERIALS AND METHOD

Type of study

This was a cross-sectional correlational study.

Sample

This study was conducted at the outpatient psychiatry clinic of a university-affiliated hospital between April 2023 and April 2024. The inclusion criteria were being between the ages of 18 and 65, having no previous history of psychiatric illness or psychiatric treatment, and presenting to a psychiatric clinic for the first time. To control for the confounding influence of the "history of illness and treatment" factor—demonstrated in numerous studies to affect individuals' attitudes toward mental illness—the study sample was restricted to individuals seeking psychiatric help for the first time. This methodological choice was intended to eliminate the impact of prior hospitalization, medication use and side effects, and social challenges, all of which may shape perceptions of mental illness during the course of treatment. Individuals with a co-occurring diagnosis of mental retardation, bipolar disorder, psychotic disorder, or alcohol/substance use disorder, as well as those for whom inpatient treatment, electroconvulsive therapy, or referral to a higher-level center was recommended by the attending psychiatrist, were excluded from the study. In addition, individuals who were unable to comprehend and complete the study questionnaires were also excluded. The final sample consisted of 203 participants. The minimum required sample size was estimated using G.Power (version 3.1) for a two-tailed correlation analysis. Assuming a small-to-moderate effect size ($r = 0.20$), an alpha level of 0.05, and 80% power (Hazra & Gogtay, 2016), the required sample size was 194. All eligible consecutive first-time psychiatric help-seekers who presented during the data-collection period were invited to participate. Accordingly, the final analyzable sample comprised 203 participants with complete data, exceeding the minimum requirement.

Data Collection Tools

In addition to the Sociodemographic Information Form, two standardized instruments were employed in this study. The Symptom Checklist-90-Revised (SCL-90-R) was used to screen psychiatric symptoms and assess their severity, while the Beliefs Toward Mental Illness Scale was administered to evaluate participants' negative beliefs about mental disorders.

Sociodemographic Information Form: The researchers prepared this form to record sociodemographic variables previously reported to be potentially associated with stigma in prior studies, including each participant's age, sex, marital status, employment status, economic status, living area, past psychiatric history, and whether they had any relatives with mental illness (Taşkın, 2007, Lo et al., 2021).

Beliefs Toward Mental Illness Scale (BTMI): Originally developed in 1998 and adapted into Turkish with established validity and reliability, this scale consists of 21 items rated on a 6-point Likert scale: 0 (strongly disagree), 1 (mostly disagree), 2 (partially disagree), 3 (partially agree), 4 (mostly agree), and 5 (strongly agree)

(Bilge & Çam, 2008). It comprises three subscales: "Hopelessness and Deterioration in Interpersonal Relationships," "Danger," and "Shame." Hopelessness and Deterioration in Interpersonal Relationships Subscale [11 items] addresses the belief that mental illness disrupts interpersonal relationships and the sense of helplessness experienced when interacting with individuals who have a mental disorder. Danger Subscale (8 items) reflects thoughts and fears regarding the perceived dangerousness of individuals with mental disorders. Shame Subscale (2 items) pertains to the notion that having a mental disorder is a source of shame. Both total and subscale scores can be calculated. Higher scores indicate more negative beliefs about mental illness. In the Turkish adaptation study, the scale's internal consistency was reported as Cronbach's $\alpha = 0.82$ (Bilge & Çam, 2008). In the present study, Cronbach's α was 0.88.

Symptom Checklist-90-R [SCL-90-R]: The SCL-90-R is a screening instrument developed in 1977 at the Psychometric Research Unit of Johns Hopkins University to assess the level and distribution of psychological symptoms. Psychometric properties of the Turkish version (validity and reliability) have been established (Kılıç, 1991). The scale consists of 90 items evaluating nine distinct symptom dimensions: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Each item is scored on a 5-point Likert scale ranging from 0 (none) to 4 (extremely). Global Severity Index (GSI) derived by dividing the total score of all completed items by the number of items answered and reflects the overall severity of psychological distress. Subscale scores are calculated by summing the item values within each subscale and dividing by the total number of items in that subscale. Specifically, the Somatization subscale includes 12 items, Obsessive-Compulsive 10 items, Interpersonal Sensitivity 9 items, Depression 13 items, Anxiety 10 items, Hostility 6 items, Phobic Anxiety 7 items, Paranoid Ideation 6 items, and Psychoticism 10 items. The GSI score ranges are interpreted as follows: 0–1.5 indicates "normal," 1.5–2.5 indicates a "high level of pathology," and 2.5–4.0 indicates a "very high level of pathology." In the Turkish adaptation study, Cronbach's α coefficients for the subscales were reported as follows: somatization (0.82), obsessive–compulsive (0.84), interpersonal sensitivity (0.79), depression (0.78), anxiety (0.73), hostility (0.79), phobic anxiety (0.78), paranoid ideation (0.63), psychoticism (0.73), and the additional scale (0.77). In the present study, Cronbach's α coefficients for the subscales were reported as follows: somatization (0.86), obsessive–compulsive (0.71), interpersonal sensitivity (0.85), depression (0.88), anxiety (0.84), hostility (0.85), phobic anxiety (0.79), paranoid ideation (0.76), psychoticism (0.79), and the additional scale (0.67).

Implementation

Patients presenting to the outpatient clinic were informed about the study, and those who consented to participate were asked to complete the SCL-90-R and the Beliefs Toward Mental Illness Scale (BTMI) before their medical examination. Participants then submitted their completed forms to the evaluating psychiatrist. After verifying that the scales were completed in full and that the participant met the inclusion criteria, the psychiatrist recorded the participant's sociodemographic information.

Statistical Analysis

Descriptive statistics are presented as mean, standard deviation, median, minimum and maximum values, frequencies, and percentages. Pearson's correlation analysis was used to examine correlations, while the t-test and one-way ANOVA were employed to compare group means. Initially, in order to identify factors affecting the severity of stigma, each independent variable's relationship with the dependent variable was evaluated using univariate analyses. Correlation analysis was performed for continuous independent variables; for categorical variables, the independent samples t-test was used. Independent variables with a p-value of <0.25 in the univariate analyses were included as candidate variables in multiple linear regression models. In addition to these variables, age, sex, and education level were also entered into multivariable regression models. The models were constructed by including all independent variables simultaneously and using stepwise selection. In the multiple linear regression analysis, independent variables with a p-value of <0.05 were considered statistically significant. All data analyses were performed using SPSS version 29 for macOS.

RESULTS

Sociodemographic Characteristics of the Participants

The study included 203 participants: 140 women and 63 men. The mean age of the participants was 33.13 ± 13.34 years. Participants were predominantly female (69.0%) and resided mainly in urban areas (77.3%). More than half were married (58.1%), and the most common employment status was unemployment (44.4%). Most participants reported a lower-middle socioeconomic status (76.8%). Approximately one in five participants (22.7%) reported having a relative with mental illness (Table 1).

Table 1. Sociodemographic Characteristics of the Sample

Variable	Category	Mean ± SD /n (%)
Age	-	33.13±13.34
Sex	Female	140 (69.0%)
	Male	63 (31.0%)
Living Area	Urban	157 (77.3%)
	Rural	46 (22.7%)
Marital Status	Married	118 (58.1%)
	Single	85 (41.9%)
Employment Status	Employed	60 (29.6%)
	Unemployed	90 (44.4%)
	Retired	14 (6.9%)
	Student	39 (19.2%)
Economic Status	Low	21 (10.3%)
	Lower-middle	156 (76.8%)
	Upper-middle	23 (11.3%)
	High	3 (1.5%)
Having a Relative with Mental Illness	Yes	46 (22.7%)
	No	152 (74.9%)

Variable	Category	Mean ± SD /n (%)
Previous psychiatric diagnosis/treatment history	Yes	0 (0%)
	No	203 (100%)

Mean: arithmetic mean, SD: standard deviation, n: number, %: percentage

Beliefs Toward Mental Illness and Psychiatric Symptom Levels

For the SCL-90-R, mean (±SD) subscale scores were 1.92 ± 0.94 for depression, 1.60 ± 0.94 for anxiety, 1.41 ± 0.88 for somatization, 1.77 ± 0.91 for obsessive–compulsive symptoms, 1.64 ± 0.96 for interpersonal sensitivity, 1.71 ± 1.14 for hostility, 0.79 ± 0.83 for phobic anxiety, 1.55 ± 0.99 for paranoid ideation, 0.99 ± 0.78 for psychoticism, and 1.70 ± 0.89 for the additional scale. The mean (±SD) SCL-90-R total score was 1.32 ± 0.66 (Table 2).

Scale/Subscale	Min–Max	Median	Mean ± SD
BTMI (Total)	0.0–92.0	40.0	39.75 ± 18.07
SCL-90-Depression	0.0–3.8	2.0	1.92 ± 0.94
SCL-90-Anxiety	0.0–3.8	1.6	1.60 ± 0.94
SCL-90-Somatization	0.0–3.6	1.4	1.41 ± 0.88
SCL-90-Obsessive-Compulsive	0.0–5.5	1.7	1.77 ± 0.91
SCL-90-Interpersonal Sensitivity	0.0–4.0	1.6	1.64 ± 0.96
SCL-90-Hostility	0.0–4.0	1.5	1.71 ± 1.14
SCL-90-Phobic Anxiety	0.0–3.4	0.4	0.79 ± 0.83
SCL-90-Paranoid Ideation	0.0–4.0	1.5	1.55 ± 0.99
SCL-90-Psychoticism	0.0–3.4	0.8	0.99 ± 0.78
SCL-90-Additional Scale	0.0–4.0	1.6	1.70 ± 0.89
SCL-90-Total	0.0–3.3	1.2	1.32 ± 0.66

BTMI: Beliefs Toward Mental Illness Scale, SCL-90-R: Symptom Checklist-90-R, Min-Max: minimum-maximum value, Median: median value, Mean: arithmetic mean, SD: standard deviation.

Differences Between Groups in Terms of Beliefs Toward Mental Illness

There was no significant correlation ($p>0.05$) between participants' age and their total BTMI scores. Similarly, grouping participants by sex, marital status, urban/rural residence, or having a relative with mental illness revealed no statistically significant differences in BTMI mean scores (Table 3). Moreover, one-way ANOVA revealed no significant difference in BTMI mean scores based on participants' employment status or socioeconomic status.

Table 3. Differences in Mean BTMI Scores Across Sociodemographic Groups (n = 203)

Variable	Category	n	M	SD	Test statistic	p
Age	—	203	—	—	r(201) = 0.051	.472
Sex	Female	140	39.42	17.80	t(113.92) = −0.38	.707
	Male	63	40.48	18.78		
Living Area	Urban	156	39.39	18.63	t(83.61) = −0.40	.688

Variable	Category	n	M	SD	Test statistic	p
	Rural	46	40.52	16.13		
Marital Status	Married	118	41.53	18.55	F(2, 200) = 2.64	.074
	Single	78	36.36	15.72		
	Divorced/Widowed	7	47.57	28.68		
Employment Status	Employed	60	40.18	14.83	F(4, 198) = 1.12	.346
	Unemployed	18	34.67	25.22		
	Retired	14	41.64	25.28		
	Student	39	36.18	15.11		
	Homemaker	72	42.22	18.27		
Economic Status	Low	21	44.71	19.33	F(2, 200) = 1.00	.371
	Middle	156	39.44	18.13		
	Upper-middle / High	26	37.62	16.53		
Having a Relative with Mental Illness	Yes	46	44.17	18.19	t(73.60) = 1.87	.065
	No	152	38.45	17.98		

BTMI: Beliefs Toward Mental Illness Scale. Two-group comparisons were performed using Welch's t-test. Multi-group comparisons were performed using one-way ANOVA. Associations with age were examined using Pearson correlation. Marital status categories were merged (divorced and widowed) due to small cell sizes. Socioeconomic status categories were merged (upper-middle and high).

The Relationship Between Levels of Stigmatizing Beliefs Towards Mental Illnesses and Levels of Psychiatric Symptoms

A significant positive correlation ($p<0.05$ and $p<0.01$) was observed between participants' BTMI scores and both the total and subscale scores on the SCL-90-R. When Pearson correlations were examined, the associations between BTMI-Total and the SCL-90-R subscales were weak for somatization ($r = 0.15$), depression ($r = 0.17$), anxiety ($r = 0.18$), obsessive–compulsive ($r = 0.26$), interpersonal sensitivity ($r = 0.26$), hostility ($r = 0.19$), phobic anxiety ($r = 0.26$), paranoid ideation ($r = 0.28$), psychoticism ($r = 0.29$), and additional items ($r = 0.22$), whereas the correlation between the SCL-90-R total score and BTMI-Total was moderate ($r = 0.30$). The SCL-Somatization score exhibited only a weak correlation with the BTMI-Hopelessness subscale ($r = 0.16$) and did not show significant associations with the remaining subscales. In the investigation of the relationships between BTMI subscale scores and symptom severity, the BTMI-Hopelessness score was positively associated with the severity of all psychiatric symptoms assessed by the SCL, with correlation magnitudes ranging from weak to moderate. The BTMI-Danger score demonstrated positive associations with all symptom severities except for somatization, whereas the BTMI-Shame score was significantly correlated only with the SCL-Obsessive-Compulsive and SCL-Phobic Anxiety subscales. The correlation coefficients are shown in Table 4. According to the regression analysis conducted to identify factors predictive of stigmatizing attitudes toward mental illness, the SCL-90-Psychoticism subscale ($p<0.001$) significantly predicted higher levels of stigmatizing beliefs and attitudes.

Table 4. Correlation Coefficients Between BTMI and SCL-90-R Scores

	1. BTMI-Total	2. SCL-90-Total	3. SCL-Somatization	4. SCL-Obsessive-Compulsive	5. SCL-Interpersonal Sensitivity	6. SCL-Depression	7. SCL-Anxiety	8. SCL-Hostility	9. SCL-Phobic Anxiety	10. SCL-Paranoid Ideation	11. SCL-Psychoticism	12. SCL-Additional Scale	13. BTMI-Danger	14. BTMI-Hopelessness	15. BTMI-Shame
1	1														
2	0.298**	1													
3	0.155*	0.765**	1												
4	0.264**	0.773**	0.459**	1											
5	0.261**	0.871**	0.524**	0.694**	1										
6	0.173*	0.901**	0.607**	0.686**	0.766**	1									
7	0.183*	0.857**	0.720**	0.582**	0.616**	0.751**	1								
8	0.192**	0.701**	0.359**	0.500**	0.620**	0.598**	0.518**	1							
9	0.262**	0.723**	0.527**	0.543**	0.598**	0.539**	0.640**	0.405**	1						
10	0.280**	0.840**	0.512**	0.618**	0.819**	0.731**	0.617**	0.661**	0.542**	1					
11	0.287**	0.861**	0.568**	0.638**	0.746**	0.715**	0.673**	0.596**	0.586**	0.760**	1				
12	0.220**	0.847**	0.651**	0.620**	0.630**	0.767**	0.745**	0.491**	0.562**	0.619**	0.650**	1			
13	0.882**	0.267**	0.122	0.225**	0.221**	0.173*	0.153*	0.167*	0.220**	0.229**	0.209**	0.183*	1		
14	0.941**	0.292**	0.165*	0.258**	0.260**	0.171*	0.183*	0.183**	0.250**	0.291**	0.311**	0.231**	0.682**	1	
15	0.401**	0.135	0.073	0.166*	00.14	-0.045	00.1	0.102	0.192**	0.113	00.14	0.065	0.232**	0.341**	1

Pearson correlation coefficients were used, *p<0.05, **p<0.01. According to conventional criteria, correlation coefficients between BTMI and SCL-90-R scores were generally in the weak ($|r| < 0.30$) to moderate ($0.30 \leq |r| < 0.50$) range, while correlations among SCL-90-R subscales were predominantly strong ($|r| \geq 0.50$). BTMI: Beliefs Toward Mental Illness Scale, SCL-90-R: Symptom Checklist-90-R.

DISCUSSION

It is well known that among mental illnesses, the diagnostic groups most exposed to social stigma are severe psychiatric disorders such as psychotic disorders and substance use disorders (Link, 1989). However, stigma has been reported to constitute a significant challenge not only in severe mental disorders but also in the treatment and follow-up processes of other psychiatric conditions that are more prevalent in the general population (Çilek & Akkaya, 2022; Wood et al., 2014; Angermeyer & Matschinger, 2003; Wahl, 2012). Our results extend this literature by demonstrating that, even among individuals with no prior history of psychiatric illness, higher levels of stigmatizing beliefs were positively correlated with greater symptom severity during their first episode of mental illness. This suggests that stigmatizing beliefs may not only be a consequence of illness-related experiences but may also act as a psychological vulnerability factor, shaping how individuals perceive, interpret, and respond to emerging psychiatric symptoms.

In numerous studies examining the link between mental illness and stigma, the principal reason for stigmatizing attitudes and behaviors is reported to be a lack of knowledge and experience related to mental illness (Ahad et al., 2023). Individuals who have previously recovered from a mental illness or have close relatives with mental illnesses exhibit fewer stigmatizing attitudes (Corrigan et al., 2012). By including only individuals seeking psychiatric help for the first time, our study excluded the confounding influence of previous psychiatric illness. We did not find a significant difference in levels of stigmatizing beliefs between participants who did and did not have close relatives with a mental illness. This result contradicts existing literature suggesting that having a family member with a mental illness reduces stigmatizing beliefs (Corrigan

et al., 2012; Grant et al., 2016). One possible explanation for this discrepancy is that our participants were selected from a clinical population. Cognitive distortions—such as a sense of worthlessness accompanying current symptoms—could have influenced the results. When interpreting this relationship, the specific diagnosis held by the family member may be relevant: interaction with individuals who have severe mental illnesses, known to be more heavily stigmatized, may not exert the same effect as interaction with those who experience comparatively lower levels of stigma. Further evaluation of relatives' psychiatric diagnoses could clarify this ambiguity. Additionally, given that psychiatric conditions can manifest differently in each person, it would be helpful to explore not only the specific diagnosis but also the illness's severity and course. Social factors—such as how closely the individual interacts with the relative living with mental illness or whether they reside together—may also shape this interaction. The omission of such factors is one of our study's limitations.

Some studies suggest that various sociodemographic characteristics—such as age, sex, marital status, and educational level—are associated with stigmatizing attitudes. These studies identify being male, being married, younger age, belonging to a minority group, and living in rural areas as risk factors for stigma (Lo et al., 2021; Townley et al., 2017; Ünal et al, 2010). Conversely, some evidence suggests that sociodemographic features may exert little or no influence on attitudes toward mental illness (Taskin et al., 2003). In our study, we did not find a statistically significant relationship between stigmatizing belief levels and sociodemographic characteristics. This result may be due to the limited scope of our study sample, which consisted of patients voluntarily seeking treatment at an outpatient clinic, and its relatively small size. To clarify this relationship, larger-scale community-based studies are warranted.

Stigma has been linked to diminished quality of life, self-esteem, and self-efficacy, as well as to poorer psychiatric symptom profiles and treatment outcomes (Ritsher et al., 2003; Jingman et al. 2024). According to MLT, once an individual is evaluated by a professional and formally diagnosed with a mental illness, they become more aware of societal stigma and begin to internalize it. People try different ways of coping with this experience, but the strategies they choose can influence the illness trajectory either positively or negatively (Link et al., 1989; Dubreucq et al., 2021). For example, "concealing one's disorder" has been associated with poorer treatment outcomes (Luoma et al., 2007). Being subjected to stigma and discrimination has been reported to predict higher levels of depressive complaints one year later (Dubreucq et al., 2021). Another follow-up study showed an indirect relationship between stigma and symptom severity at one-year follow-up, mediated by factors such as "experiencing exclusion," "using maladaptive coping strategies like hiding the illness," and "having low social support" (Hunter et al., 2017). Most of these mediators are related to illness and treatment processes. Our study focused on the direct relationship between preexisting stigmatizing beliefs and distinct symptom groups. By involving first-time psychiatric patients, we endeavored to eliminate the confounding factors related to the illness and treatment process that might mediate this relationship. Our analyses revealed a positive correlation between levels of stigmatizing beliefs and psychiatric symptom severity. Notably, detecting this relationship among individuals who have not fully undergone illness and

treatment or who are only at the early stages suggests a direct effect of stigmatizing beliefs on psychiatric symptoms. This indicates that this relationship can manifest at the symptom level and from the early phases of the illness.

Interpreted within MLT, one might argue that the five-step process—triggered by formal diagnosis—has not yet taken effect; hence, the relationship between stigmatizing beliefs and symptom severity is a direct one. However, information gathered at the time of admission may not fully reflect an individual's pre-illness beliefs. It remains unclear how symptoms experienced prior to clinical presentation might have influenced these beliefs. One study in the literature proposes that self-recognition is the first step in help-seeking (Schomerus et al., 2019). Even without a formal medical diagnosis, individuals who realize that they are experiencing psychiatric symptoms and decide to seek treatment may already view themselves as having a mental illness. This observation implies that the five-step MLT process can begin before any professional evaluation. Individuals who label themselves may effectively initiate the second step of the MLT. Furthermore, definitions based on incomplete or incorrect information can be even more stigmatizing than those provided by professionals. A person who self-labels with a presumed psychiatric disorder might engage in specific coping behaviors and seek social support in ways that can influence the severity of their symptoms. Consequently, the presence or severity of these symptoms may reinforce any underlying negative beliefs about mental illness [Figure 1]. This process, which may unfold before a formal evaluation, underscores the substantial impact of personal thoughts, attitudes, and experiences related to mental illness.

STRENGTHS AND LIMITATIONS

A key strength of this study is its focus on first-time psychiatric help-seekers with no prior psychiatric diagnosis or treatment. By minimizing potential confounding from prior contact with psychiatric care, the findings provide a clearer perspective on how stigmatizing beliefs may relate to symptom profiles at initial clinical presentation. A significant limitation of our study is that it is based on cross-sectional data, which precludes conclusions about temporal ordering and causality. Another limitation is that it was conducted in a clinical setting, excluding any population outside the hospital; therefore, it remains unclear to what degree our sample—patients who willingly sought help and presented to the outpatient clinic—represents the broader population. To address these and related questions, there is a clear need for large-scale, community-based longitudinal studies. Such research would provide more robust evidence regarding the bidirectional relationship between stigma and mental illness, clarify the role of mediating factors, and ultimately inform the development of targeted interventions aimed at reducing stigma and improving clinical outcomes.

CONCLUSION

Stigmatizing beliefs have been associated with numerous negative outcomes regarding the treatment and follow-up of mental illnesses. Our findings suggest that this relationship may be present from the earliest point at which symptoms are experienced. The strength of these associations was generally weak to moderate across SCL-90 symptom dimensions, with variation by symptom domain. In addition, psychoticism symptom severity

was independently associated with higher levels of stigmatizing beliefs in this clinical sample. The five-step process outlined in MLT may begin even before individuals seek professional care. This underscores the importance of addressing stigma at the earliest possible stage of psychiatric evaluation. To mitigate the adverse consequences of mental disorders, anti-stigma efforts are needed at both individual and societal levels. Since these beliefs are modifiable, integrating anti-stigma interventions into routine psychiatric care remains a promising approach. Efforts to reduce stigmatizing beliefs should begin as early as the first clinical encounter.

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