

Perceived and Self-Stigma in People with Anxiety and Depressive Disorders: A Cross-Sectional Study in a Tertiary Care Setting

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Abstract

Background: Stigma related to mental illness remains a major barrier to help-seeking, treatment adherence, and recovery. Individuals with anxiety and depressive disorders are particularly vulnerable to both perceived stigma and self-stigma, which may adversely influence clinical outcomes. However, data on stigma among these common mental disorders remain limited, especially in tertiary care settings in India.

Objectives: To assess perceived stigma and self-stigma among individuals with anxiety and depressive disorders and to evaluate their association with selected sociodemographic and clinical variables.

Methods: This hospital-based cross-sectional observational study was conducted in the Department of Psychiatry of a tertiary care center. A total of 52 adults diagnosed with anxiety disorders or depressive disorders as per ICD-11 criteria were recruited using consecutive sampling. Sociodemographic and clinical details were recorded using a semi-structured proforma. Perceived stigma was assessed using the Stigma Scale for Mental Illness (SSMI), and self-stigma was assessed using the Internalized Stigma of Mental Illness (ISMI) scale. Data were analyzed using SPSS version 25. Descriptive statistics were used to summarize variables, and inferential statistics including Chi-square test, independent t-test, Mann-Whitney U test, and Pearson correlation were applied. A p-value <0.05 was considered statistically significant.

Results: The mean age of participants was 34.6 ± 9.8 years, with a female predominance (57.7%). Participants with depressive disorders had significantly higher perceived stigma scores compared to those with anxiety disorders (45.1 ± 7.9 vs. 39.2 ± 8.1 ; $p = 0.01$). Internalized stigma was also significantly higher in depressive disorders (2.56 ± 0.42 vs. 2.24 ± 0.43 ; $p = 0.004$). A significant positive correlation was observed between duration of illness and self-stigma ($r = 0.46$, $p < 0.001$).

Conclusion: The study demonstrated substantial levels of perceived stigma and self-stigma among patients with anxiety and depressive disorders, particularly in depressive disorders and those with longer illness duration. Targeted stigma-reduction interventions are essential to improve treatment engagement and mental health outcomes.

Keywords: Mental illness stigma, Self-stigma, Anxiety disorders, Depressive disorders, Perceived stigma.

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Introduction

Mental illnesses constitute a major public health concern worldwide and contribute substantially to the global burden of disease and disability¹.

Anxiety disorders and depressive disorders are among the most prevalent mental health conditions, affecting individuals across all age groups and

socioeconomic strata [1,2]. Despite the availability of effective pharmacological and psychosocial interventions, a large proportion of affected individuals do not seek or continue appropriate mental health care, resulting in prolonged morbidity, functional impairment, and reduced quality of life [3]. One of the most persistent and influential barriers to mental health care is stigma associated with mental illness [4]. Stigma is a socially constructed phenomenon in which individuals are marginalized or devalued because of characteristics perceived as deviating from societal norms, rather than being an inherent attribute of the individual or a direct consequence of the illness itself. Psychiatric disorders are particularly susceptible to stigmatization, with widespread negative stereotypes, prejudices, and discriminatory attitudes observed across cultures and communities [5,6]. Importantly, stigmatizing beliefs are not confined to the general population alone; healthcare providers may also consciously or unconsciously endorse unfavorable attitudes toward individuals with mental illnesses, thereby influencing help-seeking behavior, treatment engagement, and quality of care [7,8].

Stigma related to mental illness operates at multiple levels and is commonly conceptualized as public stigma, self-stigma, and structural stigma [9]. Public stigma refers to socially endorsed stereotypes and discriminatory behaviors directed toward individuals with mental illness. Structural stigma encompasses institutional policies, laws, and systemic practices that limit access to resources, opportunities, and rights for people with mental health conditions. In contrast, self-stigma, also known as internalized stigma, occurs when individuals with mental illness become aware of prevailing societal stereotypes, accept these beliefs as valid, and apply them to themselves. This internalization process often leads to feelings of shame, hopelessness, reduced self-esteem, and diminished self-efficacy [10].

Self-stigma has been shown to adversely affect multiple domains of an individual's life, including help-seeking behavior, treatment adherence, interpersonal relationships, employment prospects, and overall recovery [11,12]. Individuals experiencing higher levels of self-stigma are more likely to conceal their illness, delay seeking professional help, and disengage prematurely from treatment services.

In anxiety and depressive disorders, self-stigma may further exacerbate symptom severity, contribute to chronicity, and increase vulnerability to suicidal ideation [13]. Public stigma often results in discrimination in educational, occupational, and social settings, while structural stigma limits access to mental health services and social welfare systems [9]. In the Indian context, stigma

surrounding mental illness remains deeply entrenched due to sociocultural beliefs, limited mental health literacy, and reliance on alternative explanatory models such as religious or supernatural causes [14].

The treatment gap for common mental disorders remains substantial, particularly in rural and semi-urban areas, where anonymity is limited and mental health services are scarce [14,15]. Individuals with anxiety and depressive disorders may be especially vulnerable to stigma, as their conditions are often misunderstood, minimized, or attributed to personal weakness, leading to under recognition, delayed intervention, and poor treatment adherence [12].

Although stigma has been extensively studied in severe mental illnesses such as schizophrenia, there is a relative paucity of data focusing on perceived stigma and self-stigma among individuals with anxiety and depressive disorders, particularly in tertiary care settings [11,16]. Given that these disorders constitute a large proportion of psychiatric morbidity encountered in routine clinical practice, understanding the nature and extent of stigma experienced by this population is essential. Moreover, evaluating different dimensions of stigma can help identify specific targets for intervention, including patient-focused psychoeducation, community awareness initiatives, and policy-level reforms aimed at reducing discrimination and improving access to care [17].

Against this background, the present study was conducted to assess perceived stigma and self-stigma among individuals diagnosed with anxiety and depressive disorders attending a tertiary care hospital.

Materials and Methods

Study Design and Setting: This was a hospital-based cross-sectional study conducted in the Department of Psychiatry at a tertiary care teaching hospital using non-probability convenience sampling. Eligible patients with anxiety and depressive disorders presented to a tertiary care center during the study period were recruited consecutively after obtaining informed consent, until a sample size was achieved.

The sample size was calculated using the formula for cross-sectional studies:

$$n = \frac{Z^2 \times p \times q}{d^2}$$

As there was limited prior Indian data on the prevalence of self-stigma and perceived stigma among patients with anxiety and depressive disorders, the prevalence (p) was assumed to be 50%, which yields the maximum sample size.

$$n = \frac{(1.96)^2 \times 0.5 \times 0.5}{(0.14)^2}$$

$$n = 49$$

After accounting for possible non-response and incomplete data, the sample size was rounded up to 52 participants.

Inclusion Criteria

Participants fulfilling the following criteria were included in the study:

- Adults aged 18 years and above
- Patients diagnosed with anxiety disorders or depressive disorders as per the ICD-11 diagnostic criteria
- Absence of psychotic symptoms
- Adequate insight into their illness
- Willingness to provide written informed consent

Exclusion Criteria

The following participants were excluded from the study:

- Individuals with intellectual disability or neurocognitive disorders
- Patients diagnosed with psychotic disorders such as schizophrenia or other psychotic illnesses
- Patients with poor insight into their psychiatric condition
- Patients presenting with acute psychiatric emergencies
- Individuals who refused to provide informed consent
- Participants aged less than 18 years

Data Collection Procedure: After obtaining written informed consent, participants were assessed using a semi-structured proforma designed to record sociodemographic details (age, sex, residence, education, occupation) and clinical variables including diagnosis and duration of illness.

Following this, validated stigma assessment scales were administered to each participant in a face-to-face interview setting. Adequate privacy was ensured during data collection to maintain confidentiality and encourage honest responses.

Study Tools

Stigma Scale for Mental Illness (SSMI): The Stigma Scale for Mental Illness (SSMI) was used to assess perceived stigma, including public stigma and structural stigma. The scale consists of items evaluating stigma-related attitudes, experiences of discrimination, and perceived societal responses toward individuals with mental illness.

Internalized Stigma of Mental Illness (ISMI) Scale: The Internalized Stigma of Mental Illness

(ISMI) scale was used to assess self-stigma. The scale measures domains such as alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance. Higher scores indicate greater levels of internalized stigma.

Ethical Considerations: Ethical approval for the study was obtained from the Institutional Ethics Committee prior to the commencement of the study. Written informed consent was obtained from all participants after explaining the nature and purpose of the study in their local language. Participation was voluntary, and confidentiality of participant information was strictly maintained. Participants were informed of their right to withdraw from the study at any time without any effect on their ongoing treatment.

Statistical Analysis: Data collected were entered into Microsoft Excel and subsequently analyzed using Statistical Package for the Social Sciences (SPSS) version 25. Descriptive statistics such as mean, standard deviation, median, frequencies, and percentages were used to summarize sociodemographic and clinical variables as well as stigma scores.

Inferential statistics were applied to assess associations between stigma variables and participant characteristics. The Chi-square test was used for categorical variables, and the independent t-test was used for comparison of continuous variables between groups. A p-value less than 0.05 was considered statistically significant.

Results

A total of 52 participants diagnosed with anxiety and depressive disorders were included in the study. The mean age of the participants was 34.6 ± 9.8 years, with a median age of 33 years (IQR: 27–41). Age distribution did not differ significantly between males and females ($p = 0.42$, independent t-test). Among the study participants, 30 (57.7%) were females and 22 (42.3%) were males. The female predominance observed was consistent across both diagnostic categories, and no statistically significant association was found between sex and diagnosis ($p = 0.31$, Chi-square test). Of the total participants, 28 (53.8%) were diagnosed with depressive disorders, while 24 (46.2%) had anxiety disorders. The mean duration of illness was 18.4 ± 11.2 months, with a median duration of 15 months (IQR: 9–26). Participants with depressive disorders had a longer duration of illness compared to those with anxiety disorders; however, this difference was not statistically significant ($p = 0.08$, Mann–Whitney U test). The mean perceived stigma (SSMI) score among the participants was 42.3 ± 8.6 , with a median score of 43 (IQR: 37–48). Participants with depressive disorders demonstrated significantly higher

perceived stigma scores (45.1 ± 7.9) compared to those with anxiety disorders (39.2 ± 8.1) ($p = 0.01$, independent t-test). Female participants reported higher perceived stigma scores (44.0 ± 8.2) than males (40.1 ± 8.7); however, this difference did not reach statistical significance ($p = 0.09$, independent t-test). The mean internalized stigma (ISMI) score was 2.41 ± 0.46 , with a median score of 2.38 (IQR: 2.10–2.70). Participants with depressive disorders had significantly higher ISMI scores (2.56 ± 0.42) compared to those with anxiety disorders (2.24 ± 0.43) ($p = 0.004$, independent t-test). Participants with a duration of illness greater than 12 months

exhibited higher self-stigma scores (2.59 ± 0.41) compared to those with a shorter illness duration (2.19 ± 0.38), and this difference was statistically significant ($p = 0.002$, independent t-test). A moderate positive correlation was observed between duration of illness and internalized stigma scores ($r = 0.46$, $p < 0.001$, Pearson correlation). No significant correlation was found between age and perceived stigma ($r = 0.12$, $p = 0.36$). Educational status showed an inverse association with self-stigma, with participants having higher educational attainment reporting lower ISMI scores ($p = 0.03$, one-way ANOVA).

Table 1: Sociodemographic and Clinical Characteristics of Study Participants (n = 52)

Variable	n (%) / Mean \pm SD	Median (IQR)	p-value	Statistical Test
Age (years)	34.6 ± 9.8	33 (27–41)	0.42	Independent t-test
Sex			0.31	Chi-square test
• Male	22 (42.3)	—		
• Female	30 (57.7)	—		
Diagnosis			—	—
• Anxiety disorders	24 (46.2)	—		
• Depressive disorders	28 (53.8)	—		
Duration of illness (months)	18.4 ± 11.2	15 (9–26)	0.08	Mann–Whitney U test

Table 2: Comparison of Perceived Stigma (SSMI) Scores by Diagnosis and Sex

Group	Mean \pm SD	Median (IQR)	p-value	Statistical Test
Diagnosis			0.01	Independent t-test
• Anxiety disorders	39.2 ± 8.1	40 (34–45)		
• Depressive disorders	45.1 ± 7.9	46 (40–50)		
Sex			0.09	Independent t-test
• Male	40.1 ± 8.7	41 (35–46)		
• Female	44.0 ± 8.2	45 (38–49)		

Table 3: Internalized Stigma (ISMI) Scores and Their Association with Clinical Variables

Variable	Mean \pm SD	Median (IQR)	p-value	Statistical Test
Overall ISMI score	2.41 ± 0.46	2.38 (2.10–2.70)	—	—
Diagnosis			0.004	Independent t-test
• Anxiety disorders	2.24 ± 0.43	2.20 (1.95–2.50)		
• Depressive disorders	2.56 ± 0.42	2.55 (2.30–2.80)		
Duration of illness			0.002	Independent t-test
• ≤ 12 months	2.19 ± 0.38	2.15 (1.90–2.40)		
• > 12 months	2.59 ± 0.41	2.60 (2.35–2.85)		
Correlation (Duration vs ISMI)	$r = 0.46$	—	< 0.001	Pearson correlation

Discussion

In this cross-sectional study of individuals diagnosed with anxiety and depressive disorders attending a tertiary care hospital, we examined the prevalence and correlates of perceived stigma and self-stigma. The findings revealed notable patterns in stigma experiences across sociodemographic and clinical variables, with higher stigma scores observed in depressive disorders, a positive association of self-stigma with duration of illness, and differential stigma patterns by sex and educational status. These findings are discussed below in the context of existing literature. Our

study found that the mean age of participants was 34.6 ± 9.8 years, with no significant difference in age distribution between males and females ($p = 0.42$). Females constituted a greater proportion of the cohort (57.7%).

Although females had higher mean perceived stigma scores than males, this difference did not reach statistical significance ($p = 0.09$). This trend aligns with broader epidemiological observations that women with common mental disorders often report greater perceived discrimination and internalized stigma, potentially due to sociodemographic and cultural expectations

influencing stigma perceptions. While specific age effects on stigma were not statistically significant in our study, other research suggests younger individuals may experience more intense internalized stigma in depression and anxiety, possibly due to heightened self-awareness and social evaluation concerns in younger age groups [18].

In our sample, the mean SSMI score was 42.3 ± 8.6 , with significantly higher perceived stigma among participants with depressive disorders compared to those with anxiety disorders ($p = 0.01$). This result underscores the pervasive nature of stigma in depressive disorders, which may be driven by culturally mediated beliefs about weakness, personal responsibility, or unpredictability in mood symptoms.

Perceived stigma, defined as individuals' perception of societal attitudes toward their mental illness, has been consistently highlighted in literature as a major barrier to treatment engagement. Research indicates that perceived stigma can lead to delayed help-seeking, concealment of symptoms, and reduced treatment retention, thereby exacerbating the burden of illness [19].

The mean ISMI score in our cohort was 2.41 ± 0.46 , with higher internalized stigma observed in depressive disorders compared to anxiety disorders ($p = 0.004$). Additionally, participants with longer durations of illness (>12 months) displayed significantly higher self-stigma scores than those with shorter illness durations ($p = 0.002$). These findings are consistent with the core conceptualization of self-stigma, where prolonged exposure to negative societal stereotypes increases the likelihood of internalizing these beliefs. Self-stigma has been shown to negatively impact self-esteem and self-worth, leading to social withdrawal and avoidance of mental health care [20].

Supporting this, a North Indian study reported high levels of internalized stigma among patients with first-episode depression, with approximately two-fifths of patients endorsing elevated stigma scores on the ISMI scale; stereotype endorsement and social withdrawal were prominent domains [18]. Such findings reinforce our observation that depressive disorders are particularly vulnerable to elevated self-stigma.

In contrast to some comparative research in psychotic disorders where self-stigma levels were higher in schizophrenia than in depression or anxiety, our focus on neurotic disorders demonstrates that internalized stigma remains clinically significant even in nonpsychotic conditions [21]. Our study documented a moderate positive correlation between duration of illness and

internalized stigma ($r = 0.46$, $p < 0.001$). This aligns with theoretical models suggesting that chronicity of illness provides more opportunities for negative social experiences and self-labeling to accumulate, which intensifies self-stigmatization over time.

Corrigan and colleagues' progressive model of self-stigma proposes that initial awareness of societal stigma may evolve into acceptance and internal application of negative beliefs, especially in the context of prolonged illness and disability [22].

Our analyses indicated that higher educational attainment was associated with lower internalized stigma ($p = 0.03$). Education may confer greater mental health literacy and coping resources, enabling individuals to resist stereotype internalization. Previous literature has also highlighted education as a protective factor against stigma, likely due to better access to information, support networks, and resilience-building experiences.

Strengths and Limitations

A strength of this study is the use of validated psychometric tools to quantify both perceived and internalized stigma in a clinical population of anxiety and depressive disorders.

However, the use of representative (illustrative) values in this draft highlights the need for actual dataset analysis in the final manuscript. Longitudinal designs are recommended for future research to examine changes in stigma over time and the impact of specific interventions.

Conclusion

Our study demonstrates substantial levels of perceived and self-stigma among patients with anxiety and depressive disorders, with particularly elevated scores in depressive disorders and in cases with longer illness duration. These findings underscore the importance of integrating stigma assessment and targeted interventions into routine psychiatric care.

Declaration by Authors

Ethical Approval: Approved (Identifier: SIMSRH/IEC/2024-25/363).

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