RESOCJALIZACJA POLSKA
POLISH JOURNAL OF SOCIAL REHABILITATION
19/2020
ISSN 2081-3767 | e-ISSN 2392-2656
RESEARCH REPORTS
DOI 10.22432/pjsr.2020.19.14

Katarzyna Frączek *, Beata Hintze **

* The Institute of Psychiatry and Neurology in Warsaw [katarzfra@gmail.com],
** The Maria Grzegorzewska University in Warsaw [beata.hintze@interia.pl]]

Resources as a predictor of stigma in people with mental illness using community-based support system

Abstract: Purpose: The aim of the study was to compare the level of resources (self-esteem, self-efficacy, basic hope), stigma and discrimination among people using one of two community-based support system (Community Self-Help Center and Occupational Therapy Workshops). **Methods:** In total 97 subjects with mental illness in the Mazowieckie Province (52 from Community Self-Help Center and 45 from Occupational Therapy Workshops) were examined with the use of the Rosenberg Self-Esteem Scale (SES), Generalized Self-Efficacy Scale (GSES), Basic Hope Inventory-12 (BHI-12) and Consumer Experiences of Stigma Questionnaire (CESQ). **Results:** Results shows no differences in the level of resources (self-esteem, self-efficacy, basic hope) between the study groups. Whereas for the entire study group the predictor of the stigma was the level of self-esteem – the lower the self-esteem people using community-based support systems had, the more stigma they felt. **Conclusions:** Self-esteem can be crucial for coping with difficult social situations, such as stigmatization, which affects the entire recovery.

Key words: schizophrenia, resources, stigma, community-based support system.

Mental illness is a multidimensional disorder of different course and final state. Due to their recurrent nature, they require holistic treatment – a combination of modern pharmacotherapy with therapeutic and rehabilitation as well as

community-based measures. In recent years, Poland has seen the development of community-based support systems for mentally ill people. This is especially true for people with diagnosed schizophrenia finding support in local communities (Bronowski et al. 2017, pp. 221–235). Modern support systems enable the continuation of therapeutic and rehabilitation measures after stays in medical facilities. There is ample evidence that participation in community-based support programs, such as Occupational Therapy Workshops (OTW), Community Self-Help Centers (CSHC), Community Treatment Teams (CTT), Clubs, Sheltered Housing and Employment Support Programs, strengthens the recovery process and improves psychosocial functioning (Bronowski, 2018). The modern approach to understanding the essence of mental illness implies the need to supplement the diagnosis of deficits in various areas of functioning with an assessment of resources (strengths). Their identification promotes the process of healing and strengthening in health (Lloyd et al. 2017, pp. 1061–1072).

Important resources for the people with mental disorders include: self-esteem, basic hope, self-efficacy and optimism (Rozya et al. 2019, pp. 93–104). They are important for satisfactory mental functioning and good quality of life (Pietras-Mrozicka 2016, pp. 19–38). The results of studies involving people with mental disorders suggest that the strengths help to recover, improve cognitive functioning, and strengthen the effectiveness of psychotherapeutic and rehabilitation measures (Potempa, Krupka-Matuszczyk 2014, pp. 259–276; Langer et al. 2017, p. 233). The importance of resources for the course of mental illness was also demonstrated: low self-esteem was associated with the persistence of psychopathological symptoms such as auditory hallucinations and depressive moods (Fannon et al. 2009, pp. 174–180; Gawęda et al. 2012, s. 933–949; Watson et al. 2002, pp. 185–197). A higher self-efficacy was associated with the use of effective disease coping strategies (Puchalska et al. 2013, pp. 65–76), with better psychosocial functioning (pre-disease and current) and lower intensity of negative symptoms in schizophrenia (Pratt et al. 2005, pp. 187–197). Other reports stress the importance of hope as one of the strongest predictors of the successful outcome of the psychotherapy process (Chamodraka 2008; Trzebiński, Zięba 2003). Currently, there is an increased interest in the use of positive psychotherapy aimed at strengthening the resources of mental disorders people, people suffer from schizophrenia (Sawicka, Żochowska 2018, p. 239-247). However, this approach is in its development phase, hence little research on the importance of the level of resources for the functioning of this group of people.

The issue of stigmatization of people experiencing mental crisis is still an important research problem. Effective methods of dealing with its negative consequences are still being sought. People with mental disorders experience stigma from society and their family (Quinn et al. 2015, pp. 103–108). This has a negative impact on recovery and psychosocial functioning (Markiewicz, Hintze 2016, pp. 147–158; Podogrodzka-Niell, Tyszkowska 2014, pp. 1201–1211; Świtaj et al.

2010, pp. 269–274). It has been shown that self-stigma among the people with mental disorders contributes to low self-efficacy, decreased self-esteem, depression and low quality of life (Pasmatzi et al. 2016, pp. 243–252; Lien et al. 2018, pp. 176–185). It also leads to hiding one's illness, social withdrawal, inactivity, and, as a consequence, to abandoning one's life goals (Corrigan et al. 2009, pp. 75–81). The stigmatization is also related to the high level of loneliness among people experiencing psychotic crisis (Chrostek et al. 2016, pp. 190–199; Świtaj et al., 2014, pp. 733–740). The World Health Organization (WHO 2001) recommends community-based support methods as the most effective in combating stigma and improving the quality of life of people with mental disorders. Research has shown that being a participant in such programs reduces the number of hospitalizations, improves well-being, provides support in difficult situations (Bronowski et al., 2009, pp. 421–434) and reinforce social networks of social networks (Bronowski, 2018). The impact of this support on feelings of stigma and development of resources is, however, unknown. For this reason, it is extremely important to study the effectiveness of community-based programs and their impact on the recovery of people with mental illness.

Objective

The objectives of the presented study[1] were to compare the level of resources (self-esteem, self-efficacy, basic hope) and experiences of stigma and discrimination between people participating in two community-based support programs – Community Self-Help Centers (CSHC) and Occupational Therapy Workshops (OTW). In addition, it was assessed which of the resources is the best predictor of experiences of stigma among the participants of community-based support systems. The following research hypotheses were formulated:

1. The OTW participants have a higher level of resources compared to the CSHC participants.
2. Community-based support systems participants, regardless of the type, experience stigma and discrimination due to illness.
3. The high level of an experience of stigma among community-based support systems participants explains the reduced level of resources (self-esteem, self-efficacy and basic hope).

[1] The presented study results are part of a research project carried out within the framework of M.A. seminar and an unpublished master's thesis by Frączek, K. (2019) entitled "Zasoby oraz poczucie piętna i dyskryminacji u osób chorujących psychicznie korzystających ze środowiskowych metod wsparcia" *(Resources and experiences of stigma and discrimination in people with mental disorders using community-based support methods*), the Maria Grzegorzewska University, Warsaw. The work was awarded first place in the 16th National "Otwarte Drzwi" Competition for the best master's theses in the social rehabilitation category, organized by PFRON (2019).

Methods

Research subjects

A total of 97 people with mental disorders took part in the study. The first group consisted of 52 CSHC participants and the second group of 45 OTW participants. Sociodemographic and clinical characteristics of both groups are presented in Table 1.

Table 1. Sociodemographic and clinical characteristics of the studied groups

Variables		Diagnostic categories		Test value t/Z/x2 and significance level
		CSHC (N = 52)	OTW (N = 45)	
Age in years (mean ± standard deviation)		52.23 ±14.03	37.09 ±9.65	t(95) = 6,26 p < 0.001
Marital status (%)	Lonely person(s)/single(s)	30.9	41.2	x^2 = 11.94 p < 0.05
	In relationship	6.2	2.1	
	Divorced	9.3	2.1	
	Widow/widower	7.2	1	
Educational attainment (%)	Primary	5.2	10.3	x^2 = 3.26 p = 0.353
	Vocational	9.3	5.2	
	Moderate	28.9	22.7	
	Higher	10.3	8.2	
Age of illness onset (mean ± standard deviation)		26.83 ±13.76	22.36 ±7.46	Z = -1.15 p = 0.252
Number of hospitalizations (mean ± standard deviation)		6.67 ±6.92	5.41 ±4.29	Z = -0.47 p = 0.641
t-Student test for independent samples; x^2 test; Mann-Whitney U test				

Source: author's own research

CSHC participants were older, they were more often in relationships, had a higher level of education, became ill at a later age in comparison with OTW participants. However, these groups did not differ significantly in the number of hospitalizations (Table 1).

Among the CSHC participants, most people had schizophrenia (42 people). The remaining people were diagnosed with depression disorder and bipolar disorder (BD). In the OTW group, similarly as in the BD group, most of the participants had schizophrenia (39 people).

Tools

The following psychological methods were used to assess psychological variables:

— Polish version of the Rosenberg self-esteem scale (SES) (Dzwonkowska et al. 2008), which measures, by means of self-description, the overall level of self-esteem treated as a permanent feature rather than a temporary state. The questionnaire contains 10 statements and uses a scale of 1–4 (from 1 – "I strongly agree" to 4 – "I strongly disagree"). The higher the score in the test, the higher the self-esteem. It is characterized by good reliability (Cronbach's alpha = 0.81–0.83) and theoretical accuracy (Dzwonkowska et al. 2008).

— Generalized Self-Efficacy Scale (GSE) (Juczyński 2009). It measures the strength of an individual's general beliefs, expressing his or her perceived ability to cope with difficult situations and adversities. It contains 10 statements and uses a scale of 1–4 (from 1 – 'no' to 4 – 'yes'). This tool is characterized by good reliability (Cronbach's alpha = 0.85) (Juczyński 2000, pp. 11–24).

— Polish adaptation of the Basic Hope Questionnaire BHI-12 (Trzebiński, Zięba 2003). It measures basic hope, understood as the individual's conviction that all is well with the world which is organized, meaningful and benevolent. The tool contains 12 statements and uses a scale of 1–5 (from 1 – "I strongly disagree" to 5 – "I strongly agree"). The more points scored, the higher the level of basic hope. This tool is characterized by good internal consistency, reliability (Cronbach's alpha = 0.70) and theoretical accuracy (Trzebiński, Zięba 2003).

— The first two parts of the Consumer Experiences of Stigma Questionnaire – CESQ (used with the consent of dr. hab. n. med. Piotr Świtaj), which studies the experiences of stigma of mental illness in everyday life and relations with others, manifested by being avoided by others, worrying, negative opinions of the society, feeling offended by offensive remarks or media reports about people with mental disorders. The first part consists of 9 statements on stigmatization and the second part contains 12 statements on discrimination. Both these parts use a scale of 1–5, which determines the frequency of stigmatization (from 1 – "never" to 5 – "very often"). The higher the score, the more frequent the experiences of stigma. This tool is characterized by good reliability (Cronbach's alpha = 0.81), theoretical and factorial accuracy (Świtaj 2008).

— The author's own inventory of sociodemographic and clinical data, created for the study. It consisted of two parts, the first of which made it possible to collect general data such as: age, marital status, educational attainment and social and/or occupational activity or situation. The second part concerned information about the disease: the diagnosis made, the age of illness onset, the number of hospitalizations, medicines taken and information about the use of community-based support methods.

Procedure and conduct of the study

The study was conducted from May to October 2018 in Community Self-Help Centers and Occupational Therapy Workshops in the Mazowieckie Province. Consents to conduct the study have been obtained from the managers of community support institutions (after having familiarized them with the purpose of the study) and from their participants. They have received oral and written information about the purpose of the study and voluntary participation, anonymity and the possibility to withdraw from it at any stage without any consequences. From among all the people who gave their initial consent to take part in the study, 4 people resigned while completing the questionnaires.

Statistical analyses

The statistical description includes averages, standard deviations and percentages. The significance level $p < 0.05$ was assumed. The analysis of the shape of the distribution of variables was verified using the Shapiro-Wilk test. The one-way analysis of variance (ANOVA) (for normal distribution) or the Whitney U-Mann test (for abnormal distribution) was used to assess the significance of differences between the averages. The covariance between the selected variables was checked using the r-Pearson or rho Spearman correlation coefficient, depending on the fulfillment of normal distribution assumptions. A step-by-step regression analysis was used to assess which resource is the predictor of experiences of stigma. The analyses were performed using the IBM SPSS Statistics 25.

Results

Level of resources

The statistical analyses did not show any significant differences in the level of resources: self-esteem, self-efficacy and basic hope between CSHC and OTW participants (Table 2).

Table 2. The level of resources in CSHC and OTW participants. Differences between groups

Scale	Studied groups	Mean ± SD	Statistics value F(df)	pSignificance
SES	CSHC (N = 52)	26.19 ±4.74	F(1.95) = 2.69	p = 0.105
	OTW (N = 45)	27.78 ±4.77		
GSES	CSHC (N = 52)	25.98 ±7.30	F(1.95) = 1.06	p = 0.306
	OTW (N = 45)	27.38 ±5.86		

Scale	Studied groups	Mean ± SD	Statistics value F(df)	pSignificance
BHI-12	CSHC (N = 52)	29.75 ±4.61	F(1.95) = 1.06	p = 0.306
	OTW (N = 45)	30.71 ±4.57		
One-way analysis of variance (ANOVA)				

Source: author's own research

Experiences of stigma and discrimination

The CSHC participants j more severe stigma in comparison with OTW participants, however, the obtained value of eta^2 is characterized by a small force of effect indicating a relatively low percentage of the explained variance – 6.4%. The participants of both groups did not differ significantly in terms of the level of discrimination (Table 3).

Table 3. The level of experiences stigma and discrimination in CSHC and OTW participants. Differences between groups

Scales (CESQ Questionnaire)	Studied groups	Mean ± SD	Statistics value F(df)	pSignificance
Stigma	CSHC (N = 52)	26.73 ±6.36	F(1.95) = 6.52 eta2 = 0.064	p < 0.05
	OTW (N = 45)	23.53 ±5.90		
Discrimination	CSHC (N = 52)	23.31 ±6.37	Z = -1.51	p = 0.130
	OTW (N = 45)	20.98 ±3.77		
One-way analysis of variance (ANOVA); U-Mann Whitney test				

Source: author's own research

Resources and experiences of stigma

The statistical analyses carried out in the group of CSHC and OTW participants showed that there are significant relationships between the experiences of stigma and resources. A significant correlation was observed between stigma and self-esteem (Pearson's r = -0.391; p = 0.004), self-efficacy (Pearson's r = -0.273; p = 0.050) and hope (Pearson's r = -0.363; p = 0.008). The results suggest that the higher the self-esteem, self-efficacy and basic hope levels in CSHC participants, the less stigma they experienced.

In turn, correlation analyses in the group of OTW participants showed one significant relationships between the experiences of stigma and self-esteem (Pearson's r = -0.439; p = 0.003). The results suggest that the higher the self-esteem of OTW participants, the less stigma they experienced. However, no significant link was found in this study group between stigma and self-efficacy and basic hope.

Clinical factors and resources, experiences of stigma and discrimination

In the CSHC group, there was a positive correlation between the number of hospitalizations and basic hope (Spearman's rho = 0.329; p = 0.033). The higher the number of hospitalizations, the higher the level of basic hope. In the OTW group, no significant relationships between variables and the number of hospitalizations was found.

The predictors of experiences of stigma

Since a low value of the strength of the effect was obtained when evaluating the difference in experienced stigma between the groups, in order to verify which of the resources may be the best predictor of experiences of stigma, a step-by-step regression analysis was carried out for the whole study group, without any division into the type of support method (WOT vs. CSHC). Among people who use community-based support systems, only the level of self-esteem, which explains 18% of the variability in the level of experiences of stigma, proved to be an important predictor. The higher the self-esteem of the subjects, the lower the experience of stigma (Table 5).

Table 5. Predictors of experienced stigma in the entire study group

Stigma	Beta	t Value and p-significance	Coefficient of determination r^2	F(df) and p-significance
Model 1 SES	-0.44	-4.71 p = 0.000	0.18	F(1.95) = 22.19 p = 0.000

Source: author's own research

Discussion

The results of the conducted studies indicate that persons using two types of community-based support systems: CSHC and OTW are characterized by a similar level of resources in terms of self-esteem, self-efficacy and basic hope. It should be stressed that these institutions differ in terms of the specificity of the programs. CSHCs are aimed at improving daily functioning, preventing relapses and subsequent hospitalizations. OTWs focus on encouraging people to work and strengthening independence (Bronowski et al. 2017, pp. 221–235). Therefore, the task of community-based support systems, especially OTW, is to prepare a person for occupational activity by acquiring new social skills that improve daily functioning

in different roles. Occupational and creative therapy techniques are used for these purposes, including social skills training for daily activities, maintaining independence, developing interpersonal skills, as well as a sense of value. The realization of these goals requires the cooperation of therapeutic-rehabilitation teams consisting of psychologists, special educators and social workers (Podgórska-Jachnik, Pietras 2014, p. 74; Banaszczyk 2018, pp. 70–86). Occupational therapy, defined as professional treatment through work and various activities (Malinowska 1982 as cited in: Sikorska 2013, pp. 134–145), is an important element of professional activation of disabled people in community-based support systems. According to Piechowicz-Witoń (2013, pp. 187–198), striving for employment is an important part of rehabilitation of people with disabilities. Work has a profit-making, socializing and rehabilitation function. It is an important element of self-image, sense of meaning in life and prevents social exclusion. Professional activation of people with mental illness is also an important aspect of mental health promotion, and its lack may increase the risk of a recurrence of the crisis (Szczupał 2015, pp. 179–193). Therefore, it can be assumed that the therapeutic programs implemented in both types of facilities were tailored to the needs and capabilities of participants, thus strengthening and developing their resources.

So far in Poland there have been no studies comparing the level of resources among people with mental disorders using different community-based programs. However, it has been shown that being their participants improves social functioning, also in terms of the number of social networks and the overall quality of life (Bronowski 2018; Bronowski et al. 2017, pp. 221–235). Moreover, it reduces the number and duration of subsequent hospitalizations in psychiatric wards (Bronowski et al. 2009, pp. 421–434; Załuska, Paszko 2002, pp. 953–966). The lack of differences in the level of strengths among beneficiaries can also be explained by the period of participation in community-based programs, which for CSHC and OTW participants was about 7 years. Several years of use of the facilities could contribute to the restoration and strengthening of resources. An important benefit of participation in these programs is also to prevent loneliness. In our study, the vast majority of beneficiaries of CSHC and OTW were single people. This conclusion seems important in the context of the published results (Chrostek et al. 2016, pp. 190–199; Świtaj et al. 2014, pp 733–740), indicating a relationship between loneliness and stigmatization among patients of psychiatric wards. Thus, preventing loneliness through participation in community-based support programs is becoming one of the important factors reducing experiences of stigma. In this respect, it is also important to create a positive image of the mental disorders in the local community, which would promote acceptance. This is one of the primary tasks of special education to try to integrate the mental illness into society (Krause, 2010; as cited in: Vitusik et al. 2015, p. 73).

In the presented study there was no difference in the level of discrimination between the CSHC and OTW groups. The only difference was in experiences

of stigma, but due to the low strength of the effect, analyses were carried out for all beneficiaries to determine the predictor of experiences of stigma. Self-esteem turned out to be the most important predictive factor. People with higher self-esteem experienced less intense stigma. This result corresponds to the results of research in which self-stigmatization was associated, among others, with reduced self-esteem (Corrigan et al. 2006, pp. 875–884; Pasmatzi et al. 2016, pp. 243–252; Watson et al. 2007, pp. 1312–1318; Lien et al. 2018, pp. 176–185). It should be noted, however, that these studies did not strictly concern experiences of stigma, but the attribution of stereotypes (self-stigmatization). Other reports indicated that low self-esteem sustained symptoms of mental illness (Fannon et al. 2009, pp. 174–180; Gawęda et al. 2012, pp. 933–949; Watson et al. 2002, pp. 185–197) and self-stigmatization contributed to a low level of self-efficacy (Pasmatzi et al. In the presented studies, significant relationship between resources and experiences of stigma among two groups of community-based support systems participants were shown. CSHC participants with a higher level of self-efficacy, basic hope and self-esteem experienced less stigma. Among OTW participants there was one such relationship between self-esteem and experiences of stigma. In the CSHC group, there was also a correlation between the number of hospitalizations and basic hope. The more often people were hospitalized, the higher the level of basic hope they had. This result can be understood in the context of applied therapeutic measures during hospitalization, e.g. in psychiatric rehabilitation wards. The therapeutic measures were likely to have a positive effect on the understanding of one's own illness and to show the possibility of overcoming it, which may have raised hopes for recovery. Hope as a resource may be important for people suffering from schizophrenia, because it contributes to the improvement of functioning (Libman-Sokołowska, Nasierowski 2013, pp. 933–946), reduction of psychopathological symptoms (Waynor et al. 2012a, pp. 299–311; Waynor et al. 2012b, pp. 345–348), motivates to take action assessed as feasible e.g. to overcome the illness (Noh et al. 2008, pp. 69–77).

For years people with mental disorders have been labeled as "inferior" by society, which negatively affects interpersonal relations, professional activity, the process of healing, the effectiveness of therapeutic measures and social functioning of people with mental illness (Babicki et al. 2018, pp. 93–102; Markiewicz, Hintze 2016, p 147–158; Świtaj, 2008). This highlights the value of the presented results in both cognitive and practical terms. The data obtained suggest that there is a need to strengthen the resources of community-based support system participants in order to reduce experiences of stigma. This conclusion is consistent with the observations of Matyjas and Grzyb (2013, pp. 345–352), which showed that creating a positive image of mental illness CSHC participants counteracts self-stigmatization. Few reports suggest that the best destigmatizing effect can be obtained by the spread of knowledge about mental disorders by stigmatized people themselves (Liberadzka et al. 2011). In addition to self-esteem, self-efficacy and hope are im-

portant resources in the healing by mental illness people. This is also confirmed by reports in which higher sense of self-efficacy was associated, among other things, with lower levels of negative symptoms in people suffer from schizophrenia (Pratt et al. 2005, pp. 187–197). Hope was associated with self-efficacy, which can reduce experiences of stigmatization (Landeen et al. 2007, pp. 64–68; Villagonzalo et al. 2018, pp. 354–360), and also had a positive impact on engaging in social relations and sustaining them (Lencucha et al. 2008, pp. 330–355). Available studies suggest the importance of enhancing self-efficacy, self-esteem and hope of people with mental disorders, but more research is needed in this area.

The results of the study indicate that self-esteem is of the utmost importance to counteract the stigma of people with mental illness using different community-based programs. This result underlines the importance of psychotherapeutic work in obtaining adequate self-esteem in people with mental illness. Experience from clinical work suggests that people with mental illness often have a significantly reduced self-esteem, because after getting ill they judge themselves in terms of diagnosis, labeling themselves "I am schizophrenic" (Hintze 2015, pp. 350––379). An important action, which strengthens self-esteem, is also the involvement of people with mental illness in self-help movement, as already confirmed by the studies (Omeni et al. 2014). An example of a self-help group, actively operating in Mazovia, is the Support Group for Persons with Mental Disease Experience TROP (Witusik et al. 2015, p. 102; Bronowski, Bednarzak 2018, pp. 35–44). It is formed mainly by people suffering from schizophrenia and allies. The TROP Support Group cooperates on many levels with the Maria Grzegorzewska University in Warsaw. The most important anti-stigmatization effects of the Group include conducting destigmatization lectures for pupils and students and meetings for various organizations and institutions.

Conclusions

From the results obtained, it can be concluded that self-esteem plays a key role in dealing with difficult situations in the form of rejection and stigmatization. However, the development of adequate self-esteem is a process that requires long-term therapeutic measures. For this reason, community-based systems should be more focused on strengthening specific resources, as well as on developing various abilities and interests of people experiencing mental crisis.

References

[1] Babicki M., Kotowicz K., Piotrowski P., Stramecki F., Kobyłko A., Rymaszewska J., 2018, *Obszary stygmatyzacji i dyskryminacji osób chorujących psychicznie wśród respondentów internetowych w Polsce*, „Psychiatria Polska", 52(1), s. 93–102.

[2] Banaszczyk M., 2018, *Pedagogika wobec schizofrenii,* „Kultura i Wychowanie", 2, s. 70–86.
[3] Bronowski P., 2018, *Środowiskowe systemy wsparcia w procesie zdrowienia osób chorych psychicznie*, Wydawnictwo Akademii Pedagogiki Specjalnej, Warszawa.
[4] Bronowski P., Bednarzak J., 2018, *Grupa Wsparcia TROP – pięć lat doświadczeń*, „Zeszyty Pracy Socjalnej", 23(1), s. 35–44.
[5] Bronowski P., Chotkowska K., Rowicka M., 2017, *Patient's Clubs – underestimated support programmes*, „Postępy Psychiatrii i Neurologii", 26(4), s. 221–235.
[6] Bronowski P., Sawicka M., Kluczyńska S., 2009, *Charakterystyka populacji objętej środowiskowym systemem rehabilitacji i wsparcia społecznego*, „Psychiatria Polska", 43(4), s. 421–434.
[7] Chamodraka M., 2008, *Hope Development in Psychotherapy: A Grounded Theory Analysis of Client Experiences*, McGill University, Montreal.
[8] Chrostek A., Grygiel P., Anczewska M., Wciórka J., Świtaj P., 2016, *The intensity and correlates of the feelings of loneliness in people with psychosis*, „Comprehensive Psychiatry", 70, s. 190–199.
[9] Corrigan P.W., Larson J.E., Rüsch N., 2009, *Self-stigma and the „why try" effect: impact on life goals and evidence-based practices*, „World Psychiatry", 8(2), s. 75–81.
[10] Corrigan P.W., Watson A.C., Barr L., 2006, *The Self–Stigma of Mental Illness: Implications for Self–Esteem and Self–Efficacy*, „Journal of Social and Clinical Psychology", 25(8), s. 875–884.
[11] Dzwonkowska I., Lachowicz-Tabaczek K., Łaguna M., 2008, *Samoocena i jej pomiar: Polska adaptacja skali SES M. Rosenberga. Podręcznik*, Pracownia Testów Psychologicznych, Warszawa.
[12] Fannon D., Hayward P., Thompson N., Green N., Surguladze S., Wykes T., 2009, *The self or the voice? Relative contributions of self-esteem and voice appraisal in persistent auditory hallucinations*, „Schizophrenia Research", 112(1-3), s. 174–180.
[13] Gawęda Ł., Holas P., Kokoszka A., 2012, *Dysfunkcjonalne przekonania metapoznawcze oraz lęk, depresja i samoocena u osób zdrowych psychicznie mających doświadczenia podobne do omamów*, „Psychiatria Polska", 46(6), s. 933–949.
[14] Hintze B., 2015, *Poradnictwo psychologiczne dla osób z poważnymi zaburzeniami psychicznymi i dla ich rodzin*, [w:] *Poradnictwo psychologiczne*, (red.) C. Czabała, S. Kluczyńska, Wydawnictwo Naukowe PWN SA, Warszawa.
[15] Juczyński Z., 2000, *Poczucie własnej skuteczności – teoria i pomiar*, „Folia Psychologica", 4, s. 11–24.
[16] Juczyński Z., 2009, *Narzędzia pomiaru w promocji i psychologii zdrowia*, Pracownia Testów Psychologicznych, Warszawa.
[17] Landeen J., Seeman M., Goering P., Streiner D., 2007, *Schizophrenia: Effect of perceived stigma on two dimensions of recovery*, „Clinical Schizophrenia & Related Psychoses", 1(1), s. 64–68.
[18] Langer Á.I., Schmidt C., Mayol R. et al., 2017, *The effect of a mindfulness-based intervention in cognitive functions and psychological well-being applied as an early intervention in schizophrenia and high-risk mental state in a Chilean sample: study protocol for a randomized controlled trial*, „Trials", 18.
[19] Lencucha R., Kinsella E. A., Sumsion T., 2008, *The formation and maintenance of social relationships among individuals living with schizophrenia*, „American Journal of Psychiatric Rehabilitation", 11(4), s. 330–355.

[20] Liberadzka A., Szuba M., Cechnicki A., Kaszyński H., Bielańska A., 2011, *Through education to social inclusion: The anti-stigma program implemented by community psychiatry workers and users in Krakow*, „Psychiatrische Praxis", 38.

[21] Libman-Sokołowska M., Nasierowski T., 2013, *Rola nadziei w zmaganiach ze schizofrenią*, „Psychiatria Polska", 47(5), s. 933–946.

[22] Lien Y.J., Chang H.A., Kao Y.C., et al., 2018, *Insight, self-stigma and psychosocial outcomes in Schizophrenia: a structural equation modelling approach*, „Epidemiology and Psychiatric Sciences", 27, s. 176–185.

[23] Lloyd H., Lloyd J., Fitzpatrick R., Peters M., 2017*, The role of life context and self-defined well-being in the outcomes that matter to people with a diagnosis of schizophrenia*, „Health Expect", 20, s. 1061–1072.

[24] Markiewicz A., Hintze B., 2016, *Piętno a wsparcie społeczne – podobieństwa i różnice w grupach kobiet chorujących przewlekle*, „Postępy Psychiatrii i Neurologii", 25(3), s. 147–158.

[25] Matyjas B., Grzyb A., 2013, *Formy aktywizacji osób niepełnosprawnych intelektualnie i z zaburzeniami psychicznymi (na przykładzie środowiskowego domu samopomocy)*, „Pielęgniarstwo i Zdrowie Publiczne", 3(4), s. 345–352.

[26] Noh C., Choe K., Yang B., 2008, *Hope from the perspective of people with schizophrenia (Korea)*, „Archives of Psychiatric Nursing", 22(2), s. 69–77.

[27] Omeni E., Barnes M., MacDonald D., Crawford M., Rose D., 2014, *Service user involvement: Impact and participation: A survey of service user and staff perspectives*, „BMC Health Services Research", 14.

[28] Pasmatzi E., Koulierakis G., Giaglis G., 2016, *Self-stigma, self-esteem and self-efficacy of mentally ill*, „Psychiatriki", 27, s. 243–252.

[29] Piechowicz-Witoń D., 2013, *Trener pracy jako skuteczna metoda aktywizacji zawodowej osób z niepełnosprawnością*, [w:] *Pedagogiczne, medyczne i ekonomiczne aspekty niepełnosprawności*, (red.) R. Czepczarz, W. Duczmal, S. Śliwa, Wydawnictwo Wyższej Szkoły Zarządzania i Administracji w Opolu, Opole.

[30] Pietras-Mrozicka M., 2016, *Posiadane zasoby osobiste (optymizm i poczucie własnej skuteczności) a ocena jakości życia. Analiza współzależności*, „Acta Universitatis Lodziensis. Folia Sociologica", 57, s. 19–38.

[31] Podgórska-Jachnik D., Pietras T., 2014, *Praca socjalna z osobami z zaburzeniami psychicznymi i ich rodzinami*, Centrum Rozwoju Zasobów Ludzkich, Warszawa.

[32] Podogrodzka-Niell M., Tyszkowska M., 2014, *Stygmatyzacja na drodze zdrowienia w chorobach psychicznych – czynniki związane z funkcjonowaniem społecznym*, „Psychiatria Polska, 48(6), s. 1201–1211.

[33] Potempa K., Krupka-Matuszczyk I., 2014, *Prozdrowotna rola optymizmu u osób z zaburzeniami psychicznymi*, „Psychiatria i Psychologia Kliniczna", 14(4), s. 259–276.

[34] Pratt S.I., Mueser K.T., Smith T.E., Lu W., 2005, *Self-efficacy and psychosocial functioning in schizophrenia: A mediational analysis*, „Schizophrenia Research", 78, s. 187–197.

[35] Puchalska L., Tartas M., Wichowicz H., Wasilewko I., 2013, *Strategie radzenia sobie opiekunów osób chorych na depresję*, „Annales Academiae Medicae Gedanensis", 43, s. 65–76.

[36] Quinn D.M., Williams M.K., Weisz B.M., 2015, *From discrimination to internalized mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma*, „Psychiatric Rehabilitation Journal", 38(2), s. 103–108.

[37] Rozya P., Sawicka M., Żochowska A., Bronowski P., 2019, *Mocne strony osób chorych na schizofrenię i osób zdrowych – podobieństwa i różnice,* „Psychiatria Polska", 53(1), s. 93–104.
[38] Sawicka M., Żochowska A., 2018, *Positive Interventions in the Therapy of Schizophrenia Patients*, „Current Problems of Psychiatry", 19(4), s. 239–247.
[39] Sikorska A., 2013, *Wielowymiarowa rehabilitacja osób niepełnosprawnych w warsztatach terapii zajęciowej*, [w:] *Pedagogiczne, medyczne i ekonomiczne aspekty niepełnosprawności*, (red.) R. Czepczarz, W. Duczmal, S. Śliwa, Wydawnictwo Wyższej Szkoły Zarządzania i Administracji w Opolu, Opole.
[40] Szczupał B., 2015, *Aktywizacja społeczno-zawodowa i zatrudnienie osób z zaburzeniami psychicznymi – wybrane uwarunkowania i rozwiązania praktyczne*, „Annales Universitatis Mariae Curie-Skłodowska, sectio J – Paedagogia-Psychologia", 28(1), s. 179–193.
[41] Świtaj P., 2008, *Doświadczenie piętna społecznego i dyskryminacji u pacjentów z rozpoznaniem schizofrenii*, Instytut Psychiatrii i Neurologii, Warszawa.
[42] Świtaj P., Grygiel P., Anczewska M., Wciórka J., 2014, *Loneliness mediates the relationship between internalised stigma and depression among patients with psychotic disorders*, "International Journal of Social Psychiatry", 60(8), s. 733–740.
[43] Świtaj P., Wciórka J., Grygiel P., Smolarska-Świtaj J., Anczewska M., Chrostek A., 2010, *Częstość doświadczeń stygmatyzacji u chorych na schizofrenię w porównaniu do pacjentów z innymi problemami zdrowotnymi*, „Postępy Psychiatrii i Neurologii", 19(4), s. 269–274.
[44] Trzebiński J., Zięba M., 2003, *Kwestionariusz Nadziei Podstawowej – BHI-12. Podręcznik*, Pracownia Testów Psychologicznych PTP, Warszawa.
[45] Villagonzalo K.A., Leitan N., Farhall J., Foley F., McLeod B., Thomas N., 2018, *Development and validation of a scale for self-efficacy for personal recovery in persisting mental illness*, „Psychiatry Research", 269, s. 354–360.
[46] Watson A.C., Corrigan P.W., Larson J.E., Sells M., 2007, *Self-Stigma in People With Mental Illness*, „Schizophrenia Bulletin", 33(6), s. 1312–1318.
[47] Watson D., Suls J., Haig J., 2002, *Global self-esteem in relation to structural models of personality and affectivity*, „Journal of Personality and Social Psychology", 83, s. 185–197.
[48] Waynor W.R., Gao N., Dolce J.N., 2012a, *The paradoxical relationship between hope and the educational level of people in recovery*, „American Journal of Psychiatric Rehabilitation", 15(3), s. 299–311.
[49] Waynor W.R., Gao N., Dolce J.N., Haytas L.A., Reilly A., 2012b, *The relationship between hope and symptoms*, „Psychiatric Rehabilitation Journal", 35(4), s. 345–348.
[50] Witusik A., Leszto S., Podgórska-Jachnik D., Pietras T., 2015, *Schizofrenia w kontekście nauk społecznych: osoba chora na schizofrenię w obszarze zainteresowań pedagogiki specjalnej*, Wydawnictwo Continuo, Wrocław.
[51] World Health Organization, 2001, *Mental Health Report 2001. Mental health: new understanding, new hope*, World Health Organization, Genewa.
[52] Załuska M., Paszko J., 2002, *Znaczenie środowiskowych placówek rehabilitacji i oparcia społecznego dla ograniczenia hospitalizacji psychiatrycznych*, „Psychiatria Polska", 36(6), s. 953–966.