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Race Moderates the Relation between Internalized Stigma and Suicidal Thoughts and Behaviors in Youth with Psychosis-Risk Syndromes and Early Psychosis

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Abstract

Suicide is a leading cause of death among youth on the psychosis spectrum. Internalized mental health stigma is one risk factor for suicide that may be particularly salient for youth with psychosis-risk syndromes and early psychosis. Among this population, Black youth may face exposure to racism-related stressors that may exacerbate the negative effects of internalized stigma. This study examined whether internalized stigma and race interact to predict suicidal thoughts and behaviors (STB) in a help-seeking sample of Black and White adolescents with psychosis-risk syndromes and early psychosis. Findings suggest that Black youth with early psychosis spectrum disorders may be particularly vulnerable to the negative effects of internalized stigma as they pertain to STB. Internalized stigma may therefore represent an important treatment target in suicide prevention efforts among this population.

Keywords

clinical high risk; early psychosis spectrum; suicidal thoughts and behaviors; internalized stigma; race

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Conflict of Interest

All authors declare that they have no conflicts of interest.

Introduction

Suicide is a leading cause of death among youth with early psychosis spectrum disorders, and suicidal thoughts and behaviors (STB) are highly prevalent within this population (Pelizza et al., 2019; Sicotte et al., 2021). Recent research has also indicated that suicide rates are increasing among Black youth (Bridge et al., 2018; Lindsey et al., 2019), though few have studied potential explanatory mechanisms. Internalized stigma of mental illness is one well-established risk factor for STB, and studies have demonstrated that youth with attenuated or early psychosis symptoms may experience elevated rates of internalized stigma, including perceived discrimination and feelings of shame and rejection associated with their symptoms and/or diagnosis (Colizzi et al., 2020). Among this group, different forms of stigma – for example, prejudice and discrimination related to both race and mental health – may be compounded for youth of color (e.g., Anglin et al., 2016). In addition to individual-level stigma, Black youth may also be more likely to experience structural stigma in the form of systemic oppression and exclusion from opportunities and resources that might be available to their White peers (Anglin et al., 2021). Black youth are also more likely than White youth to be exposed to social, economic, and political adversity and other racism-related stressors (Anglin et al., 2021) that may confer additional vulnerability and contribute to heightened risk for suicide (Baiden et al., 2020; Lindsey et al., 2019).

Despite evidence that stigma contributes to STB and may be compounded for those with multiple marginalized identities, as well as calls to consider how intersectionality affects both mental health stigma and risk for suicide (Oexle & Corrigan, 2018; Opara et al., 2020), no known studies have directly examined whether the relation between internalized mental health stigma and STB varies as a function of race in youth with psychosis-risk syndromes and early psychosis. Gaining a better understanding of how stigma and race intersect to influence STB may be important in informing suicide prevention efforts among this population.

The Current Study

This study examined whether internalized stigma and race interact to predict STB in a help-seeking sample of Black and White youth with psychosis-risk syndromes and early psychosis ($N = 34$). As stigma and associated stressors may be heightened among Black youth, we hypothesized that the effect of internalized stigma on STB would be more pronounced among Black versus White participants. Further, as STB has been linked to affective symptoms in CHR and early psychosis (Pelizza et al., 2019; Taylor et al., 2015; Ventriglio et al., 2016), we opted to control for the presence of a mood disorder diagnosis in our analyses.

Method

Participants

Participants ages 12 to 18 were recruited through the Strive for Wellness clinic, affiliated with the University of Maryland, Baltimore County (UMBC), and the University of Maryland, School of Medicine (UMSOM), and referred for suspected psychosis-risk

symptoms and related mental health concerns. The current study included only those who met criteria for a psychosis-risk syndrome (i.e., those at clinical high-risk for psychosis, or CHR) or early psychosis (EP). CHR/EP status was determined via a gold standard clinical interview for assessing psychosis spectrum symptoms (see below for more detail).

Procedure

All participants were accompanied by a legal guardian. Participants and their caregivers provided written assent and informed consent prior to study participation. Following the consent process, participants and their caregivers each completed a series of clinical interviews and self-report questionnaires. Study procedures were approved by the Institutional Review Boards at UMBC and UMSOM.

Measures

Demographics—Race, age, and binary gender were self-reported by participants. The sample was limited to participants who identified as either Black (including three participants who identified as biracial or multiracial – i.e., Black and one or more other races[1]) or White.

Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version (K-SADS-PL)

STB was assessed via the K-SADS-PL, a clinical interview that assesses for Diagnostic and Statistical Manual (DSM-4 and DSM-5) diagnoses in youth ages 6–18 (Kaufman et al., 1997). The KSADS suicide screener was used to assess for lifetime STB in the forms of 1) recurrent thoughts of death, 2) suicidal ideation, and 3) suicidal acts/attempts. Items were rated as “no information” (0), “not present” (1), “sub-threshold” (2), or “threshold” (3) and separately administered to participants and caregivers. A total STB score was then calculated by summing scores on each of the three items (e.g., Koren et al., 2019). The highest lifetime score (chosen from either parent, child, or summary ratings[2]) was used in analyses.

Mood disorder diagnosis was assessed via the KSADS and represents any lifetime depressive and/or bipolar spectrum diagnoses.

Internalized Stigma of Mental Illness Inventory (ISMI)

Internalized stigma was assessed using the ISMI, a 29-item measure that evaluates feelings of self-stigma in people with mental health concerns (Ritsher et al., 2003). Items were rated on a 4-point Likert scale (“Strongly Disagree” to “Strongly Agree”), with higher scores indicating greater stigma. Participants also had the option to endorse “Don’t Know,” which was subsequently coded as missing data. ISMI total scores were calculated using the mean of the total number of answered items. Reliability of the ISMI in our sample was $\alpha = .92$.

[1]Although no group should be conceptualized monolithically, research has suggested that individuals who identify as Black and one or more other races are often racialized as Black and may experience similar social consequences (25, 26).
[2]Summary ratings are determined by the interviewer and consider all sources of available information (e.g., parent, child, other informants).

Structured Interview for Psychosis-Risk Syndromes (SIPS)

CHR/EP status was determined via the SIPS, a clinical interview that assesses for psychosis spectrum symptoms and psychosis-risk syndromes, and was based on severity ratings (ranging from 0, or "not present" to 6, or "severe") on any of five positive symptom domains (McGlashan et al., 2010). Participants were categorized as CHR if they endorsed symptoms at the level of a 3 or above, with the symptoms meeting SIPS frequency/duration criteria, or if they met criteria for schizotypal personality disorder and/or had a first-degree relative with psychosis, accompanied by a significant decline in functioning. Participants with EP endorsed symptoms at the level of a 6 or above, with the symptoms occurring for a prolonged duration and/or considered to be "seriously disorganizing or dangerous."

Results

Preliminary Analyses

The final analysis sample consisted of 34 participants with data on the ISMI, STB, and mood disorder measures (see Table 1 for descriptive statistics and group differences by race). All variables were within acceptable limits of normality and without outliers. Apart from internalized stigma and STB being moderately correlated in the expected direction (r = .35), no other significant correlations among internalized stigma, race, STB, and mood disorder diagnosis were observed.

Primary Analyses

A multiple regression analysis estimated the effects of internalized stigma (centered prior to the analysis), race (coded as 0 = Black, 1 = White), mood disorder diagnosis (coded as 0 = no, 1 = yes), and the interaction between internalized stigma and race on STB. The overall model was significant, R^2 = .31, $F(4, 29)$ = 3.27, p = .025. Mood disorder diagnosis had a non-significant effect on STB (b = 0.55, $t(29)$ = 0.80, p = .428, f^2 = 0.02). There was a significant interaction between internalized stigma and race (b = −4.27, $t(29)$ = −2.76, p = .010, f^2 = 0.26), suggesting that, when controlling for mood disorder diagnosis, the relation between internalized stigma and STB differed by race. The simple effects of internalized stigma were therefore probed for Black and White youth. We observed a large effect of internalized stigma on STB for Black participants (b = 4.72, $t(29)$ = 3.42, p = .002, f^2 = 0.40), with higher levels of internalized stigma significantly predicting higher levels of STB. By contrast, there did not appear to be a significant effect of internalized stigma on STB for White participants (b = 0.46, $t(29)$ = 0.68, p = .504, f^2 = 0.02).

Discussion

Although preliminary given the small sample, findings support the idea that within the psychosis-risk and early psychosis population, even though Black and White youth do not appear to differ significantly in the amount of internalized stigma they report, Black youth may be particularly vulnerable to the negative psychological effects of stigma as they relate to STB. Some have pointed to higher levels of public stigma associated with psychosis among communities of color (Rao et al., 2007), with Campbell and Mowbray (2016) suggesting that heightened mental health stigma in Black communities may reflect

the “precarious social status of Black Americans in the United States” (p. 225) rather than specific cultural beliefs and practices per se. In other words, for a person of color, mental illness may be associated with further loss of status in ways that are more damaging than for someone in a more privileged group. As it pertains to our findings, Black youth experiencing internalized stigma in the context of psychosis spectrum symptoms might also experience higher levels of distress related to the implications of these symptoms for their position in society broadly speaking, which might then contribute to higher rates of STB.

Treatment-related disparities and medical mistrust may also play a role in the relation between internalized stigma and STB for Black youth on the psychosis spectrum. In one community sample of Black adults, participants associated mental health care with forced treatment and discussed historical and personal examples of racism within healthcare settings (Mishra et al., 2009). These messages may affect the caregivers of Black youth with early psychosis spectrum symptoms and may also be transmitted intergenerationally to affect help-seeking attitudes among Black youth themselves. Black youth may also face reduced access to treatment, perpetuated by logistical barriers, inconsistencies in quality of care, and a lack of culturally sensitive interventions (Oluwoye et al., 2021). Experiences of internalized stigma in this group may therefore exacerbate feelings of hopelessness, with the mental health system not perceived as a solution for psychosis-related symptoms, possibly increasing STB. Internalized stigma may also lead to maladaptive coping in the form of STB, that is less likely to be offset by positive treatment experiences.

Black youth may face increased exposure to other micro-level (e.g., personal experiences of prejudice and discrimination) and macro-level (e.g., social, economic, and political violence) stressors that are directly tied to systemic racism in the United States. Links between racism-related stress and negative mental health outcomes are well-documented among youth of color (Priest et al., 2013), and prior studies have found that perceived racial discrimination has both direct and indirect (e.g., through the increased prevalence of mental health concerns such as depression) effects on STB among Black youth (Arshanapally et al., 2018). There has also been increasing attention to vicarious experiences of racial trauma through exposure to race-related violence in the media (Tynes et al., 2019). For youth of color, it may be that multiple and often overlapping experiences of stigma associated with both psychosis and race, combined with their resulting psychological and social consequences, lead to increased risk for STB.

Limitations

The cross-sectional design prevents establishing temporal relations among variables and geographical location may limit complete generalizability. The small sample size may have limited our ability to detect small- to moderate-sized, and potentially clinically meaningful, effects. For instance, contrary to existing research, we did not detect a significant relation between internalized stigma and STB in our White participants. Sample size may also have implications for reliability of findings, though data distributions did not suggest that findings were driven by outliers. Furthermore, although Black and White participants did not differ statistically on levels of internalized stigma or prevalence of a mood disorder, these variables were numerically – and perhaps clinically meaningfully – different between groups, and

lack of power may have obscured effects with possible implications for the main findings. Future research should aim to replicate our findings in larger samples of youth with early psychosis spectrum disorders, while also being mindful of the potential effects of relevant covariates. Our race variable categorized participants as either “Black” or “White,” failing to capture the significant amount of diversity that exists within these groups. Importantly, racial differences observed in this study are a product of social forces (e.g., systems of oppression) rather than inherent differences between racial groups (Guess, 2006). STB was conceptualized as a singular continuous variable, though there are likely distinct processes within this construct.

Conclusion and Future Directions

Findings suggest that compared to their White peers, Black help-seeking youth with early psychosis spectrum disorders may be particularly vulnerable to the negative effects of internalized stigma as they pertain to suicidal thoughts and behaviors. Potential explanatory mechanisms include increased psychosis-related public mental health stigma among Black communities, decreased help-seeking behavior and access to effective and culturally sensitive treatment interventions, and increased exposure to a host of racism-related stressors that, when considered in conjunction with psychosis-related stigma, directly and indirectly impact STB. Our findings suggest that internalized stigma may represent an important treatment target in suicide prevention efforts for Black youth. Future research should continue to explore the role of other potential mediating and moderating variables among internalized stigma, STB, and race within youth with early psychosis spectrum disorders.

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Table 1

Descriptive Statistics and Group Differences by Race

	Black (*N* = 12)	White (*N* = 22)	
	***n* (%) / *M* (*SD*)**	***n* (%) / *M* (*SD*)**	**Group Differences**
Clinical Status			
CHR	7 (58%)	15 (68%)	$p = .711$, Fisher's exact test
EP	5 (42%)	7 (32%)	
Age (years)[a]	15.78 (2.45)	17.96 (3.08)	$t(32) = -2.11$, $p = .043$
Binary Gender			
Female	7 (58%)	10 (45%)	$p = .721$, Fisher's exact test
Male	5 (42%)	12 (55%)	
Internalized Stigma (scale range: 1–4)	1.89 (0.40)	2.14 (0.60)	$t(32) = -1.29$, $p = .206$
STB (scale range: 3–9)	6.25 (2.63)	6.50 (1.77)	$t(32) = -0.33$, $p = .743$
Mood Disorder[b]	6 (50%)	16 (73%)	$p = .265$, Fisher's exact test

Note. $N = 34$.

[a] Black youth were more likely to be younger than White youth, though age was not significantly correlated with any other study variables of interest and was therefore not considered in analyses.

[b] Coded as (0 = no mood disorder, 1 = mood disorder). Mood disorders included both depressive and bipolar spectrum disorders.