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I am a burden! The self-stigmatising role of burden beliefs in the relation between negative experiences related to health problems and mental well-being outcomes

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Abstract

It has been suggested that liberal values such as lack of autonomy and burden discourses shape the public's relation and stigma towards people with health problems. However, previous research on the role of such values for one's well-being is scarce. We investigated whether the perception of being a burden mediates the impact of stigma and negative life experiences on life satisfaction and health satisfaction. Our sample, drawn from a subsample of the Swiss Household Panel survey, consisted of 156 individuals reporting a mental health problem (67.9% women, $M_{age} = 49.9$) and 283 individuals reporting a physical health problem (61.5% women, $M_{age} = 53.6$). We tested a model where perceived burden, measured with three items drawn from the Acceptance of Illness Scale, mediates the impact of perceived stigma and negative social experiences on life satisfaction and health satisfaction. Analysis of direct and indirect paths provide partial evidence for our hypothesis and the model showed a good fit to the data both for persons with a mental health problem and for persons with a physical health problem. However, given the correlational nature of our data and the acceptable fit of alternative mediational models, we propose that these rather inconclusive

results invite for the development of further research regarding the role of burden beliefs on stigma and well-being. Please refer to the Supplementary Material section to find this article's Community and Social Impact Statement.

KEYWORDS
autonomy, life satisfaction, neoliberalism, social representations, stigma

1 | INTRODUCTION

Stigma of mental and physical health conditions is an issue of major importance both for social justice and for public health, since it impacts the inclusion and the rights of individuals, as well as their overall mental and physical health (Rüsch, Angermeyer, & Corrigan, 2005). In effect, research has systematically provided ample evidence on lower opportunities to find a job (Javed et al., 2021), its impact on social relations (Pescosolido, Martin, Lang, & Olafsdottir, 2008), as well as the influence of stigma on the outcome of mental disorders (Sickel, Seacat, & Nabors, 2014), the relatively higher risk for depression (Corrigan, Bink, Schmidt, Jones, & Rüsch, 2016), and even suicide (Schomerus et al., 2015).

Most works on stigma have focused on the public's negative stereotypes (Fox, Earnshaw, Taverna, & Vogt, 2018), while in another influential line of work, authors have focused on the consequences of perceived stigma, such as the internalisation of stigma processes by stigmatised individuals, among others. Concepts such as perceived stigma and "self-stigma" (Corrigan et al., 2016) or "internalized stigma" (Boyd, Adler, Otilingam, & Peters, 2014) were proposed in order to capture the processes related to this internalisation. Moreover, this self-stigmatising process has systematically been associated with negative health and psychological outcomes, such as reduced recovery (Oexle et al., 2018) and lower life satisfaction (Chan & Mak, 2014).

It should be noted here that self-stigma is not simply a sociopsychological property or trait of individuals that stems from personality characteristics and neither is it just the result of a certain diagnosis or label that has been applied to individuals by medical institutions. As early authors on stigma and labelling processes have underlined, it is through socialisation and social learning that individuals experience the social significance and consequences of their "problem" (Goffman, 1986). If individuals perceive stigma and experience negative social consequences from their health problem, they might end up interiorising negative stereotypes and a negative social value attached to their diagnosis or problem.

1.1 | The role of stereotypes and their association with the ideological context

Negative stereotypes are at the heart of the stigma process, both from the side of the public's beliefs and knowledge and on the side of internalised or self-stigma (Link & Phelan, 2013; Rüsch et al., 2005). As social representations (Moscovici & Marková, 1998) theorists have insisted, stereotypes need to be examined in light of the social objects to which they are attached and especially in relation to complex social dynamics and issues of power and ideology that encompass and shape them (Lampropoulos, Fonte, & Apostolidis, 2019; Staerklé, Clémence, & Spini, 2011).

Concerning the social object to which stereotypes are associated, in the case of mental disorders, different negative stereotypes are related to stigma of depression (e.g., weakness) compared to the ones attributed to schizophrenia (e.g., dangerousness, unpredictability, madness etc.) (Angermeyer, Millier, Rémuzat, Refaï, & Toumi, 2013) and present different intensity, with schizophrenia being for instance more stigmatised than depression (Pescosolido,

Medina, Martin, & Long, 2013; Wood, Birtel, Alsawy, Pyle, & Morrison, 2014). Moreover, if one compares mental to physical health problems, then once again negative stereotypes related to stigma process are of a different nature. For instance, it is mostly for mental disorders that one finds stereotypes of instability and dangerousness as well as a higher attribution of personal responsibility and control for the development of the disorder (Monteith & Pettit, 2011). Likewise, research suggests that more social distance is desired from persons with mental disorders than with physical illness (Husain et al., 2020).

However, here we consider stereotypes not only as cognitive phenomena, but also as related to moral stakes of "what matters most" in a given social context (Phelan, Link, & Dovidio, 2008; Yang et al., 2007), since stigma is encompassed by the "generic ends" of maintaining and enforcing social norms (Phelan et al., 2008). Moreover, ideological and power issues are profoundly associated with which identity is stigmatised at a certain context, with authors suggesting that a common objective of stigma situations is maintaining social hierarchies and social order (Lampropoulos, Chatzigianni, Chryssochoou, & Apostolidis, 2021; Lampropoulos, Wolman, & Apostolidis, 2017; Phelan et al., 2008). Inspired by this idea, it has recently been suggested that there is a "blind spot" in the stigma research, regarding the role of liberal ideology and its values on stigma processes (Schomerus & Angermeyer, 2021). For instance, researchers and theorists from various disciplinary background have insisted on the importance of values such as autonomy and self-activation for both the inclusion and the exclusion of persons with disabilities and autonomy is a central ideal and therapeutic goal for recovery and rehabilitation ices, often associated with the care of persons with disabilities (Rose, 1998). Meanwhile, the idea that disorders constitute a burden to societies, national economies and even work and family environments has been encompassing political discourses (Lampropoulos, Aim, & Apostolidis, 2022; Lampropoulos & Apostolidis, 2021; Rose & Novas, 2005).

Speaking of a culture of "ableism" (Young, Goldberg, Struthers, McCann, & Phills, 2019) or more structurally, of neoliberal ideology and ethos of the "entrepreneurial subject" (Teghtsoonian, 2009) these works have underlined the possibility that this ethos can have stigmatising outcomes and impact the well-being of persons with mental and physical health conditions, especially when considered in terms of a belief to be a burden. For instance, it has been argued that in neoliberal times, "as the burden of health care is reduced from the shoulders of the state, it is then placed upon the consciousness of individual citizens" (Ayo, 2012, p. 100). The whole burden rationale that is central for neoliberal health policies (Lupton, 2013), becomes a moralising imperative that can have stigmatising consequences (Peacock, Bissell, & Owen, 2014). However, this hypothesis has only recently started receiving attention and not many studies have focused on the impact of the internalisation of these liberal beliefs on the well-being of people with health problems (Widmer & Spini, 2022).

Thus, with this current paper, we wish to demonstrate that despite the disparities in negative stereotypes concerning mental and physical health disorders, in advanced liberal societies the internalisation of the social value attached to the belief that one is a burden might be a central element in the process in which perceived stigma leads to decreased well-being for people with health conditions. Going thus back to ideas stemming from Gofman's seminal work, we believe that negative social cues (e.g., perception of discrimination) and experienced negative consequences of the stigmatised condition on different life domains (e.g., social and economic life, as well as perceived stigma) will increase the probability to internalise that one is a burden. This internalisation is especially to be expected when perceived negative life consequences include one's relations with friends or colleagues, work and financial aspects.

In a similar perspective, an experimental work on identity priming and autonomy activation (Wang & Dovidio, 2011) showed that students whose disabled identity was made salient, when more conscious of stigma regarding their condition, would demonstrate higher cognitive activation of words relative to autonomy and dependency. However, this work has not focused on the impact of this cognitive activation of autonomy loss and dependency on well-being.

In the current work, given the negative impact of self-stigmatising beliefs on well-being and previous qualitative works suggesting that the "ableist" pressure for autonomy and resilience can impact well-being (Hassouneh &

Fornero, 2021), we make the hypothesis that the internalisation of burden beliefs would be associated with worse health-psychological outcomes.

In other words, we claim that the more individuals with a health problem, experience negative life and social consequences related to their (stigmatised) condition (e.g., perceived stigma and relational, social and economical outcomes), the more they interiorise the belief of being a burden, and this interiorisation leads to lower well-being. Schematically, we make the hypothesis that negative consequences in different life domains and perceived stigma associated with one's disease or disorder will be associated with lower health and life outcomes and that this association will be mediated by burden beliefs (i.e., the self-stigmatising belief that the person is a burden) (Figure 1).

2 | METHODS

2.1 | Sample selection

Respondents were regularly participating in the Swiss Household Panel survey (SHP; Tillmann et al., 2021), which is a yearly longitudinal study conducted with members of a representative sample of Swiss households run by FORS, the Swiss Centre of Expertise in the Social Sciences. Participants were contacted if they had reported to have experienced a mental or physical health problem between the years 2003 and 2014 in the annual core questionnaire of the SHP, without further specification of disease or disorder. They furthermore had to be between 18 and 80 years old and live in the French or German part of Switzerland (for sample size reasons the Italian part of Switzerland was excluded). Details regarding the sample selection process and data cleaning are described in a methodological article (Klaas, Morselli, Tillmann, Pin, & Spini, 2019).

2.2 | Procedure

The study was approved by the Swiss cantonal Ethics Committee on research involving humans responsible for uni-center-studies directed from the canton of Vaud (CER-VD). Data were collected by an independent research institute which conducts the SHP survey annually. In between two regular waves of the annual SHP core survey, respondents received a letter in order to participate in an additional online auto-administered questionnaire survey on the topic of health and the role health problems play for people's lives. An incentive of 10 CHF was added to the letter. After 1 month, respondents who had not reacted yet received one reminding letter to which a paper–pencil questionnaire was added. The initial response rate was 60.17%, after data coding and cleaning
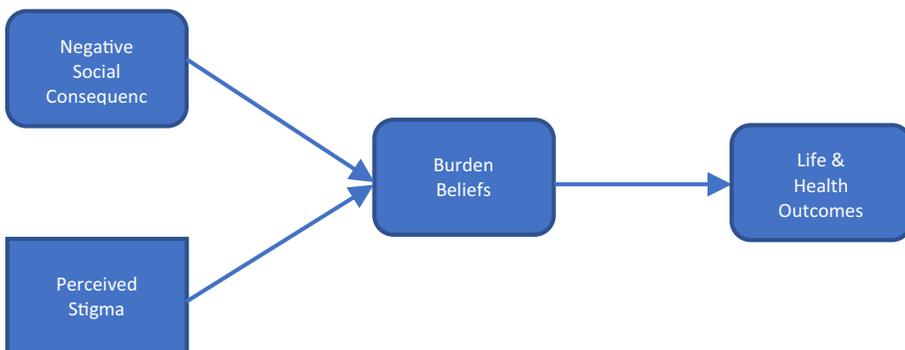

FIGURE 1 A sociopsychological model of internalisation of burden beliefs and self-stigma.

47.83% could be used for analyses (see Klaas et al., 2019). Because this article is concerned with measurements that refer to how one deals with an ongoing health problem, we are concerned only with participants who indicated that they were affected at the moment by the health problem, which corresponds to 64.56% of the sample.

2.3 | Questionnaire

The duration for the completion of the questionnaire was about 30 min. The languages of the questionnaire were French and German. The questionnaire was developed in French, English scales were translated to French and back-translated. After cognitive pre-tests, the questionnaire was translated into German and revised by two experienced bilingual survey researchers. After an introductory part on the meaning of well-being and health-related norms, respondents were asked to report their past illnesses and answered specific questions regarding either one ongoing mental or one ongoing physical health problem (if one had reported a mental health problem one was automatically asked specific questions on this health problem; if respondents reported several either mental or physical health problems, they were asked to indicate the most important one).

2.3.1 | Mental health problem

Respondents had to answer the following question: "Have you ever been diagnosed with one of the following psychological or neurological health problems by a medical doctor?" Then, a list of health problems was provided along with DSM-5 diagnostic categories, as well as a category "other" where further health problems could be reported that were coded into diagnostic categories afterwards.

2.3.2 | Physical health problem

A list of frequent physical health problems was provided that was developed according to lists used in health surveys and with two medical doctors, who served as experts. There was also a category "other" that was afterwards coded into diagnostic categories. One hundred and fifty six individuals answered questions on an ongoing mental health problem, 283 individuals on an ongoing physical health problem. Table 1 lists the self-reported health problems of our sample.

2.4 | Measures

All the scales were measured on 5-point-Likert scales ranging from "not at all" to "a great deal."

2.4.1 | Perceived negative life consequences

In order to assess the currently experienced negative consequences of the HP, we asked the extent to which negative consequences were perceived for life in general, as well as regarding five specific subdomains (relations with close ones, relations with colleagues [work or volunteering activities], professional [or volunteering activity] development, personal development, living comfort including financial situation). Also, one item assessing the current impact of the health problem ("To what extent does the health problem affect you today?") correlated highly with the items measuring negative consequences; thus, this item was included when computing the mean value measuring

TABLE 1 Diagnostic characteristics of participants.

Mental health problem	n	Percent	Physical health problem	n	Percent
Depression	60	38.46%	Orthopaedic problems	120	42.40%
Burnout	17	10.90%	Allergies	46	16.25%
Anxiety disorders	27	17.31%	Cardiological	39	13.78%
Neurological (e.g., epilepsy, Parkinson's, multiple sclerosis)	13	8.33%	Neurological (stroke, migraine)	18	6.36%
Substance dependence	11	7.05%	Cancer	10	3.53%
Adjustment disorders	6	3.85%	Endocrinological problems	17	6.01%
Eating disorders	8	5.13%	Gastrointestinal problems	9	3.18%
Bipolar disorder	7	4.49%	Respiratory	9	3.18%
Hyperactivity/attention disorders	2	1.28%	Dermatological	6	2.12%
Schizophrenia/psychotic disorders	1	0.64%	Auditory	4	1.41%
Personality disorders	2	1.28%	Nephrological	2	0.71%
Sleep disorders	1	0.64%	Sleeping	2	0.71%
Sexual identity disorder	1	0.64%	Infectious	1	0.35%

perceived negative consequences (only Chapters 3 and 5). Hence, perceived negative consequences were calculated by computing the mean of the six items asking for negative consequences and one item asking for the current impact of the HP. CFA showed a good fit to the data for a one-factor solution ($\chi^2 = 19.53$, df = 8, $p = .012$, CFI = 0.98, RMSEA = 0.10, SRMR = 0.04 for mental health and $\chi^2 = 16.13$, df = 7, $p = .02$, CFI = 0.99, RMSEA = 0.07, SRMR = 0.02 for physical health). Cronbach's alpha was: physical HP: .9, mental HP: .91.

2.4.2 | Perceived stigma

The degree of experienced stigmatisation due to the health problem was assessed by the Stigma Scale (King et al., 2007; Morandi et al., 2013). We used the items from the discrimination subdimension which were: "I am angry with the way people have reacted to my health problem," "People have avoided me because of my health problem" and "People have insulted me because of my health problem." A CFA revealed a good data fit for both samples ($\chi^2 = 1.34$, df = 1, $p = .246$, CFI = 1.00, RMSEA = 0.05, SRMR = 0.02 for mental health and $\chi^2 = 1.25$, df = 1, $p = .263$, CFI = 1.00, RMSEA = 0.03, SRMR = 0.02 for physical health). The alpha was: .85.

2.4.3 | Burden beliefs

To assess this, we took three items of the Acceptance of Illness Scale (Felton, Revenson, & Hinrichsen, 1984). One item asks directly whether the individual considers herself as being a burden while two others offer a more indirect formulation of whether the individual considers herself as over-reliant and not enough self-dependent. More precisely, the items were: "This health problem makes me rely on others more than I want to," "This health problem makes me a burden for my family and friends," "I will never be self-dependent to the extent I would like to be." A CFA showed a good adjustment to the data for both samples ($\chi^2 = 0.84$, df = 1, $p = .359$, CFI = 1.00, RMSEA = 0.00, SRMR = 0.02 for mental health and $\chi^2 = 2.04$, df = 1, $p = .154$, CFI = 1.00, RMSEA = 0.06, SRMR = 0.02 for physical health). The Cronbach's alpha after aggregation was: .79.

Both *health and life satisfaction* were measured with single items. We chose this option for several reasons. First, we had to be parsimonious as the study was part of a general population study and we wanted to reduce the probability of attrition. In the yearly SHP questionnaire itself life and health satisfaction are also measured for this reason with single items. Furthermore, studies indicate both for life satisfaction (Cheung & Lucas, 2014) and for health satisfaction (Atroszko, Baginska, Mokosinska, Sawicki, & Atrozsko, 2015) that single item indicators show good validity.

For health satisfaction the wordings were: "How satisfied are you with your health at the moment?" and similarly, for *life satisfaction*, participants answered the item "How satisfied are you with your life at the moment?".

2.5 | Control variables

Several control variables were part of our analysis. First, we included sex, age and occupation, information that we derived from the yearly SHP questionnaire. The percentage of female participants was slightly higher in the mental (67.95%) than in the physical illness sample (61.58%). In both samples, about two thirds were active in the labour market (mental: 67.31%; physical: 67.14%). Participants with a mental illness were slightly younger ($M = 49.87$, $SD = 13.07$) than those with physical problems ($M = 53.58$, $SD = 14.66$).

We also controlled for several illness characteristics: In order to have an indicator of the objective burden of the reported health problem, we included the degree of disability for each illness cause ranging from 0 ("no disability") to 1 ("complete disability") (Salomon et al., 2015), and the years of life lost that are generally lost due to disability (Murray et al., 2012). While the disability weights were similar in both groups (mental: $M = 0.27$, $SD = 0.11$; physical: $M = 0.24$, $SD = 0.14$), the physical health problems were associated with more years of life lost due to disability (mental: $M = 1.20$, $SD = 4.55$; physical: $M = 5.48$, $SD = 11.41$), but also showed more variation. Furthermore, we controlled for time since onset of the illness and whether a person experienced only one or several episodes. In both groups, persons had been suffering from their illness for a long time with considerable variation (mental: $M = 15.53$, $SD = 13.05$; physical: $M = 16.72$, $SD = 13.14$). In both groups, illnesses were chronic in the sense that symptoms were constantly ongoing rather than people experiencing frequent episodes (physical: 14.23%; mental: 21.15%).

3 | RESULTS

Descriptive and correlational analyses were carried out with IBM SPSS 27 and in order to test our hypotheses, we conducted a structural equation modelling (SEM) with IBM Amos 27.

3.1 | Hypotheses test

Mean values and inter-correlations of our constructs are displayed in Table 2.

In order to test our model, we conducted a SEM, with Life Satisfaction, Health Satisfaction as dependent variables, Perceived Stigma and Negative Consequences as independent variables and Burden Beliefs as a mediator. Moreover, our independent variables were only indirectly associated with our dependent variables and were analysed as latent variables, as was our mediator (see Figures 2 and 3). Finally, we allowed two item errors from the negative life consequences scale to correlate, given the theoretical and semantic proximity of these items. The first correlation concerned two items measuring the negative consequences of the problem on the relationships between the participant and their (a) family and friends and (b) their work colleagues (or people they met during other activities, e.g., volunteer activities). The error of this second item was also allowed to correlate with the item measuring the negative consequences of the health problem on the participant's "professional activities (or other activities, for example volunteer activities)." Two separate models, one for self-reported mental health problems and one for

TABLE 2 Mean values and intercorrelation of variables.

	Variable	M	SD	1.	2.	3.	4.	5.
Mental health	1. Negative life consequences	2.59	0.97	1.00	0.43***	0.72***	−0.43***	−0.52***
	2. Perceived stigma	1.97	1.07		1.00	0.52**	−0.28***	−0.29***
	3. Burden belief	2.07	0.98			1.00	0.27**	0.32**
	4. Life satisfaction	3.29	0.82				1.00	0.46***
	5. Health satisfaction	2.97	0.88					1.00
Physical health	1. Negative life consequences	1.72	0.78	1.00	.42***	−0.69***	−0.26***	−0.43***
	2. Perceived stigma	1.20	0.51		1.00	0.47***	0.02	−0.06
	3. Burden belief	1.39	0.70			1.00	−.22***	−0.37***
	4. Life satisfaction	3.77	0.67				1.00	0.47***
	5. Health satisfaction	3.47	0.74					1.00

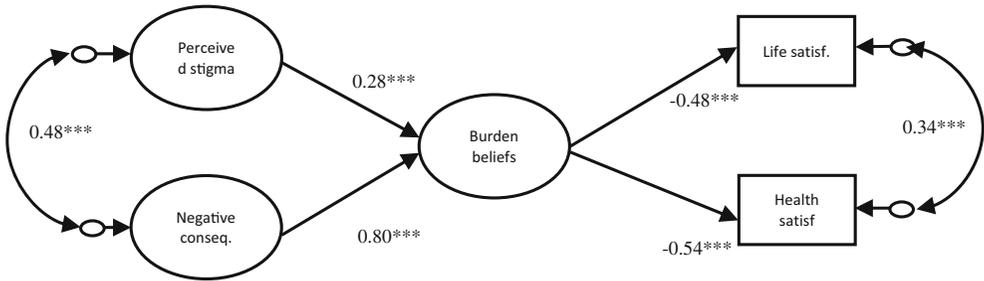*$p < .05$; **$p < .01$; ***$p < .001$.

FIGURE 2 A mediational self-stigma model of burden beliefs applied to people with self-reported mental health diagnosis. The number next to each connector is the value of the standardised regression weights and their significance is represented with asterisks: *$p < .05$; **$p < .01$; ***$p < .001$. $\chi^2 = 162.04$, df = 121, $p = .008$, CFI = 0.96, RMSEA = 0.05, SRMR = 0.05.
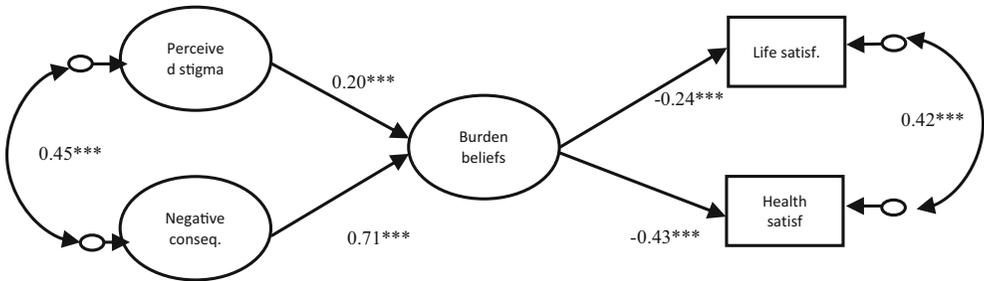

FIGURE 3 A mediational self-stigma model of burden beliefs applied to people with self-reported physical health diagnosis. The number next to each connector is the value of the standardised regression weights and their significance is represented with asterisks: *$p < .05$; **$p < .01$; ***$p < .001$. $\chi^2 = 227.29$, df = 82, $p < .001$, CFI = 0.94, RMSEA = 0.08, SRMR = 0.06.

physical health problems were created and their model fit was assessed following the established cutoff criteria (i.e., CFI > 0.90; RMSEA < 0.06; SRMR < 0.08) (Hu & Bentler, 1999).

Initially, we compared the two models in order to test whether χ^2 differences in model fit revealed a structural difference depending on the type of main disorder (mental or physical). Multigroup comparison testing structural invariance of χ^2 showed a significant χ^2 difference between the unconstrained model (i.e., paths are allowed to be different between the two samples) and the structural weights model (i.e., paths are not allowed to be different between the two samples) ($\Delta\chi^2 = 174.65$; $p < .001$, $\Delta df = 32$). Model comparison analysis of distinct direct paths showed that there was no statistically significant difference for the paths from the independent variables to the mediator, while there were statistically significant differences for the association between burden beliefs and life satisfaction ($\Delta\chi^2 = 5.41$; $p < .05$, $\Delta df = 1$) and between burden beliefs and health satisfaction ($\Delta\chi^2 = 4.23$; $p < .05$, $\Delta df = 1$). We also checked for statistically significant differences between indirect effects defining estimands for all possible mediations and using the bootstrap method (bootstrap $N = 1,000$). Unsurprisingly, due to the lack of statistically significant differences in the paths between independent variables and the mediator, results showed no significant differences for any of the indirect paths. Thus, given the differences observed, we proceeded to the analysis of two distinct models.

As it can be seen in Tables 3 and 4, as well as in Figures 2 and 3, the hypothesised relations were all statistically significant and in the expected direction. Negative life consequences ($\beta = .80$, $p < .001$ for mental health; $\beta = .69$, $p < .001$ for physical health) and perceived stigma ($\beta = .28$, $p < .001$ for mental health; $\beta = .20$, $p < .001$ for physical health) were both positively associated with burden beliefs, which were in turn was negatively associated with life ($\beta = -.50$, $p < .001$ for mental health; $\beta = -.24$, $p < .001$ for physical health) and health satisfaction ($\beta = -.57$, $p < .001$ for mental health; $\beta = -.42$, $p < .001$ for physical health). In terms of control variables, they mostly showed non-significant associations with our dependent variables, with notable exceptions the positive relation of being unemployed to perceived burden ($\beta = .14$, $p < .01$) for the mental health sample and in the case of people with a reported mental health problem, participants' clinical characteristics demonstrated a significant association with self-reported life satisfaction ($\beta = -.18$, $p < .05$ for years of life lost due to disability; $\beta = .19$, $p < .05$ for time since onset; $\beta = -.18$, $p < .05$ for frequency of episodes; $\beta = .28$, $p < .001$ for disability weight). For physical health problems these variables showed no association to outcome variables. Sex and age of participants showed no significant associations to our outcome variables. Control variables that did not show any significant association with the outcome variables were excluded from our models.

After removal of non-significantly related control variables from our models, we assessed model fit for each model. Both models showed a good fit to the data ($\chi^2 = 162.04$, df = 121, $p = .008$, CFI = 0.96, RMSEA = 0.05, SRMR = 0.05 for mental health and $\chi^2 = 227.29$, df = 82, $p < .001$, CFI = 0.94, RMSEA = 0.08, SRMR = 0.06 for physical health).

Further, we tested for indirect effects of our independent variables with the bootstrap function of Amos (bootstrap $N = 1,000$). As hypothesised, results showed significant indirect effects for both independent variables for both groups (see Table 4). More precisely, we found a significant indirect effect on life satisfaction for both negative life consequences ($\beta = -.39$, 95% CI [-0.53, -0.25] for mental health; $\beta = -.17$, 95% CI [-0.31, -0.06] for physical health) and for perceived stigma ($\beta = -.14$, 95% CI [-0.23, -0.05] for mental health; $\beta = -.05$, 95% CI [-0.11, -0.01] for physical health). We also found significant indirect effects of negative life consequences ($\beta = -.44$, 95% CI [-0.57, -0.31] for mental health; $\beta = -.30$, 95% CI [-0.44, -0.18] for physical health) and of perceived stigma ($\beta = -.15$, 95% CI [-0.26, -0.07] for mental health; $\beta = -.09$, 95% CI [-0.17, -0.02] for physical health) on health satisfaction.

3.2 | Testing alternative models

Moreover and especially since our data are correlational, we tested alternative mediational models in order to further test the validity of our model (Fiedler, Harris, & Schott, 2018). More precisely, we tested a model of common effect

TABLE 3 Structural equation model regression estimates: unstandardised coefficients, standard errors and standardised coefficients.

Dependent variable	Independent variables	Mental health			Physical health		
		B	SE	β	B	SE	β
Burden beliefs	Negative life consequences	0.75	0.12	.80***	0.73	0.08	.69***
	Perceived stigma	0.22	0.06	.28***	0.31	0.09	.20***
	Control variables						
	Sex	−0.01	0.10	−.02	−0.15	0.07	−.10*
	Age	−0.00	0.00	−.06	0.00	0.00	.04
	Occupation status	0.23	0.11	.14*	0.13	0.09	.08
	Years of life lost due to disability	−0.01	0.00	−.12	−0.00	0.00	−.08
	Time since onset	0.00	0.00	.08	0.00	0.00	.05
	Frequency of episodes	−0.05	0.12	−.03	0.01	0.00	.06
	Disability weight	0.73	0.42	.11	−0.00	0.00	.01
Life satisfaction	Burden beliefs	−0.55	0.10	−.50***	−0.22	0.06	−.24***
	Control variables						
	Sex	−0.03	0.14	−.02	−0.00	0.08	−.00
	Age	−0.01	0.01	−.16	0.00	0.00	.05
	Occupation status	0.14	0.15	.08	0.04	0.11	.03
	Years of life lost due to disability	−0.01	0.00	−.18*	−0.00	0.00	.03
	Time since onset	0.01	0.01	.19*	−0.00	0.00	−.08
	Frequency of episodes	−0.36	0.16	−.18*	−0.00	0.00	−.02
	Disability weight	2.08	0.56	.28***	0.01	0.01	.07
Health satisfaction	Burden beliefs	−0.67	0.12	−.57***	−0.42	0.07	−.42***
	Control variables						
	Sex	0.06	0.15	.03	0.08	0.09	.05
	Age	−0.01	0.01	−.17	−0.00	0.00	−.03
	Occupation status	0.05	0.17	.03	−0.05	0.11	−.03
	Years of life lost due to disability	−0.00	0.01	−.02	0.00	0.00	.01
	Time since onset	0.01	0.01	.10	0.00	0.00	.02
	Frequency of episodes	0.10	0.18	.05	0.00	0.01	.00
	Disability weight	0.64	0.61	.08	−0.00	0.01	−.03

*$p < .05$; **$p < .01$; ***$p < .001$.

(no mediation but the mediator as well as an independent variable) and a model of inverse mediation for both samples, with the mediator (perceived burden) becoming the dependent variable and the dependent variables becoming the mediators. The common effect model showed a slight increase for mental health ($\chi^2 = 158.23$, df = 118, $p = .008$, CFI = 0.97, RMSEA = 0.05, SRMR = 0.05) and a big decrease in model fit for physical health ($\chi^2 = 406.36$, df = 79, $p < .001$, CFI = 0.86, RMSEA = 0.12, SRMR = 0.22). Regarding the inverse mediation model, there was a slightly decreased model fit for mental health, while for physical health model fit was slightly improved ($\chi^2 = 182.87$, df = 130, $p = .002$, CFI = 0.95, RMSEA = 0.05, SRMR = 0.05 for mental health and $\chi^2 = 203.66$, df = 82, $p < .001$, CFI = 0.95, RMSEA = 0.08, SRMR = 0.05 for physical health).

TABLE 4 Bias-corrected unstandardised and standardised indirect effects of the structural model (bootstrap $N = 1,000$).

Dependent variable	Independent variables	Mental health			Physical health		
		B	β	CI	B	β	CI
Life satisfaction	Negative life consequences	−0.40	−.39**	(−0.53, −0.25)	−0.16	−.17**	(−0.31, −0.06)
	Perceived stigma	−0.12	−.14**	(−0.23, −0.05)	−0.07	−.05**	(−0.11, −0.01)
Health satisfaction	Negative life consequences	−0.49	−.44**	(−0.57, −0.31)	−0.32	−.30**	(−0.44, −0.18)
	Perceived stigma	−0.14	−.15**	(−0.26, −0.07)	−0.14	−.09*	(−0.17, −0.02)

*p < .05; **p < .01; ***p < .001.

4 | DISCUSSION

With the current research we hypothesised that one's perceived burden mediates the relation between negative life experiences and perceived stigmatisation and life and health satisfaction/satisfaction outcomes. Our results, both in terms of direct and indirect effects, as well as in terms of the adjustment of our data to our theoretical model, provide some partial evidence to our hypothesis.

Our work draws from what critique-oriented authors have been suggesting, namely that the liberal ideal of self-autonomy and neoliberal burden discourses can, through a process in which individuals internalise these beliefs, have negative implications for the quality of life of individuals with a health problem and a "spoiled" identity. Therefore, our results suggest that this negative side of liberal ideology does not only concern the public's attitudes towards people with diagnoses (Lampropoulos & Apostolidis, 2022), but that the internalisation of this autonomy ideal and more precisely of the belief to be a burden can also have negative consequences on one's well-being, in line with empirical research on self-stigma (Corrigan et al., 2016). Moreover, our results suggest that this role of one's perceived burden applies to people with different conditions, in the case of our research both for people with mental health and physical health problems. Moreover, the hypothesised relations between perceived burden and life and health satisfaction are stronger for participants with a mental disorder, suggesting an even stronger relevance of this internalised belief for persons with mental disorders. We consider thus that our model calls for further investigation of a common core of interiorised stereotypes related to the ambient ideological climate of liberal societies and their impact on social groups and individuals.

However, caution is needed in the interpretation of our results. For instance, it should be noted that given the cross-sectional design of our research, causality cannot be inferred. Moreover, testing alternative models showed that different mediation paths can have an adequate fit, putting further into question the direction of our hypothesised model. Further, since our measures were self-reported, subjective constructs of both social experiences and psychological outcomes, they could be associated with social desirability bias. Moreover, life satisfaction and health satisfaction were assessed with single items, in order to have a more "economic" scale for participants but at the same time, leading to a decrease in measurement robustness. Future research could include more objective and robust constructs for the assessment of one's social experiences and psychological outcomes.

Further, based on our results and our theoretical premises, future research could look into other areas of (neo) liberal subjectivity and its impact on health stigma, such as self-responsibilisation for one's disorder and recovery (Lampropoulos & Apostolidis, 2021), or even the endorsement of competitiveness beliefs for oneself (Lampropoulos et al., 2021). Moreover, our measure of burden beliefs involves an item that is close to perceived autonomy, a concept that could be further developed and separated from burden beliefs. In addition to this, our construct only focused on quotidian and interpersonal aspects of burden and did not include any items on how individuals might

perceive themselves as burdens to the economy or society. Further, our model shows that although burden beliefs mediate the relationship between perceived stigma and life satisfaction, not everyone develops burden beliefs from negative social experiences. Future research should identify the variables that lead to an internalisation of these beliefs from some people, but not for others. We suggest that social support and social groups could play a crucial role here (Carter, Dennis, Williams, & Weston, 2023). Finally, longitudinal research could be applied in order to establish causal links among variables such as the ones of our theoretical model.

Besides, regarding further research development, as we have argued in the introduction section and as our multigroup comparison results suggest, the two samples should not be treated interchangeably. Further research should investigate ways that burden beliefs can be associated to different stereotypes and outcomes for people with mental disorders compared to people with physical conditions. Does for instance perceived burden lead to dangerousness-related stereotypes for mental disorders, associated thus with emotional reactions such as anger or fear, while leading to more benevolent or even "paternalistic" reactions for the case of physical conditions? This could offer a possible explanation to the rather smaller effects of the independent variables on burden beliefs, as well as of the burden beliefs on health and life satisfaction. Future research could also investigate the paths that lead from the endorsement of burden beliefs to well-being outcomes. According to the self-stigma literature, further research could look into the mediating effect of psychosocial constructs such as the "why try" effect (Corrigan et al., 2016) as well as more traditional constructs such as empowerment, self-esteem and depression (Dubreucq, Plasse, & Franck, 2021). Finally, our testing of alternative models showed that other mediational paths could also prove valid and future research could test alternative models longitudinally, while keeping the distinction between mental and physical health.

Our results suggest the need to take into consideration the influence of one's perceived burden for recovery-oriented practise and stigma prevention. Psychosocial interventions addressing self-stigmatising beliefs such as the narrative enhancement and cognitive therapy (Roe et al., 2014) could integrate the influence of ideological imperatives very central to the recovery process on one's own recovery and identity construction. Further, practicians working within a recovery paradigm should integrate in their practices with the reflexive questioning of values and norms central to the recovery process, that could negatively impact the well-being and identity of people with a health problem.

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CONFLICT OF INTEREST STATEMENT

The authors do not have any conflicts of interest to report.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are currently being transferred to SWISSUbase, the new Swiss platform for data deposit. They are available on request from the second author. The data are not publicly available due to privacy or ethical restrictions.

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