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Original Article

Internalized stigmatization and quality of life in patients with bipolar disorders and schizophrenia

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Abstract

Aim: In this study the aim was to compare internalized stigmatization and quality of life between bipolar disorder and schizophrenia patients who were in remission.

Material and Methods: Patients who were admitted to the psychiatry outpatient clinic of Gaziantep University Faculty with a diagnosis of bipolar disorder or schizophrenia according to DSM-5 were included in this cross sectional study. Assessment tools were the Internalized Stigma of Mental Illness Scale and the World Health Organization Quality of Life Measurement Instrument Short Form.

Results: Schizophrenia and bipolar disorder groups were compared according to assessment tools. 58 bipolar disorder and 52 schizophrenia patients were included in the study. The Quality of Life of patients with bipolar disorder was found to be higher than patients with schizophrenia according to mental domain ($p = 0.006$) and social relationships domain ($p = 0.050$). Internalized Stigma of schizophrenia patients was higher than patients with bipolar disorder ($p = 0.030$). Internalized Stigma was higher in female patients with schizophrenia than female patients with bipolar disorder ($p = 0.006$). There were no significant differences between male schizophrenia patients and patients with bipolar disorder according to quality of life.

Conclusion: Internalized stigmatization is a problem that should be considered in schizophrenia patients, especially in female schizophrenia patients. Internalized stigmatization may result in decreased quality of life in schizophrenia.

Keywords: Internalized stigmatization; quality of life; bipolar disorders; schizophrenia

INTRODUCTION

According to the DSM-5 classification system, schizophrenia belongs to the category of Schizophrenia and Other Psychotic Disorders. It is defined as the presence of at least two of the symptoms of delusions, hallucinations, disorganized speech, grossly disorganized behavior or catatonic behavior and negative symptoms lasting at least one month (1). Bipolar disorder belongs to the category of Bipolar and related disorders. It is defined as a chronic disease which presents with irregular mixed recurrent depressive and manic episodes after which the individual can return to a completely healthy mood (euthymic state) between these episodes (1).

The comprehensive concept of the quality of life might be defined as satisfaction with life in consequence of the fulfilling of personal basic needs and societal expectations and the ability to benefit from the opportunities offered by society (2,3). The quality of life concept has two different dimensions. Expressions such as satisfaction with one's own life and feeling good identify the subjective dimensions of this concept. On the other hand, expressions such as living freely, social communication and productivity constitute the objective dimension of the concept of quality of life (2,4).

The studies indicate that there is an apparent attitude in society that marginalizes and stigmatizes individuals with mental disorders (5). Exclusionary and isolating attitudes towards such patients cause the patients to receive less social support, experience feelings of inadequacy, avoid social relationships, have increased feelings of guilt and embarrassment, and have feelings of diminished self-worth. In consequence of the stigmatization, such individuals avoid starting therapy or receiving treatment

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with psychiatric services, conceal their condition, lose their job, suffer homelessness and have a diminished quality of life (5,6).

Attitudes resulting in stigmatization of those suffering a mental illness may be passed on from generation to generation unconsciously, although often not directly through verbal means, but rather through certain cultural responses or body language. Patients who are aware of this situation may have internalized it from childhood, blame themselves for having such an illness and develop an attitude resulting in detachment from society. The internal dimension of stigmatization was identified when it was observed that individuals with mental disorders felt stigmatized even when they did not suffer stigmatization, exclusion or discrimination. This is referred to as "internalized stigmatization" and is defined as the situation in which an individual endorses and accepts negative stereotypes within society (7). Thinking that he/she is marginalized, the patient detaches himself/herself from society and suffers social isolation accompanied by negative feelings such as worthlessness, shame and guilt. This situation limits the opportunities that are available to the individual and may sometimes even prolong the treatment process (7).

Bipolar disorder and schizophrenia are the most common conditions in psychiatric practice. Internalized stigmatization and its impact on the quality of life in cases of these conditions are important factors affecting adherence to treatment and the treatment processes of these patients (8,9). Most of the studies have been focused self-stigmatization in schizophrenia. But there are few studies showed that bipolar disorder is related self-stigmatization (10,11). This study aimed to compare internalized stigmatization and its impacts on the quality of life in the two groups, i.e. bipolar disorder and schizophrenia patients.

MATERIAL and METHODS

The study was performed as a descriptive, cross-sectional study. Before starting the trial, written approval was obtained from the Clinical Trials Ethics Committee of Gaziantep University and the Presidency of Gaziantep University Faculty of Medicine where the study would be undertaken. The effect size was determined as 0.4 (d = 0.4) for the study to be statistically significant, whereas the minimum required number of patients with schizophrenia was 50, patients with bipolar disorder was 55 in order to investigate the predisposition to bipolar disorder in art students (α=0.05, 1-β=0.80).

The study population consisted of bipolar disorder and schizophrenia patients who were admitted to the outpatient clinic of the Department of Psychiatry for bipolar disorder and schizophrenia at Gaziantep University University Hospital between June 1, 2013 and November 1, 2013, and who met the inclusion criteria. This outpatient clinic is specific for patients with bipolar disorder on Monday and patients with psychotic disorders on Tuesday. Patient follow-up data is recorded regularly in this clinic of Department of Psychiatry. During the 6-month study period, consecutive patients with bipolar disorder and schizophrenia who were found to be in remission and met inclusion criteria by two psychiatrists were asked to participate in the study. The following remission criteria and scales were evaluated by the same psychiatrist and reviewed by the second psychiatrist.

Patients, who were 18-65 years old, diagnosed with bipolar disorder or schizophrenia according to Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria and in remission were included. In the case of bipolar disorder, the remission patients were in the euthymic state during the examination and scored fewer than seven points according to the Hamilton Depression Rating Scale and Young Mania Rating Scale. In schizophrenia patients, remission was evaluated according to the criteria defined by Andreason et al. These criteria are interpreted as a score of ≤ 3 in The Positive and Negative Syndrome Scale for each item. These criteria are delusions, concept disorganization, hallucinatory behavior, unusual thought content, mannerisms and posturing, blunted affect, passive/apathetic social withdrawal and lack of spontaneity and flow of conversation (12). Inclusion criteria were being 18-65 years old, diagnosed with bipolar disorder or schizophrenia according to DSM-5 criteria and being in remission according to criteria that defined by Andreason et al (12). Patients with alcohol and drug addiction, a history of alcohol and drug use, severe medical disorders, active psychiatric conditions, severe neurological conditions (epilepsy, cerebrovascular event, Parkinson's disease, etc.), mental retardation and cooperation disorder with inability to respond to questions were excluded from the study.

Patients to be included in the study were informed of the study, and informed verbal and written consent was obtained from the patients who agreed to participate. 110 out of 124 consecutive patients who met the study criteria during the study period agreed to participate in the study. 14 of them didn't accept to participate. 58 of the participants had bipolar disorder and 52 of them had schizophrenia.

Data Collection Tools

The Internalized Stigma of Mental Illness (ISMI) Scale and World Health Organization Quality of Life Scale (WHOQOL-BREF-TR) were used with personal information forms prepared by the investigator. Data was collected by stating the purpose and requirement of the study in face-to-face interviews with the participants. In this interview; patients were informed about study and PANSS performed by psychiatrist but other scales were performed by patient him/herself.

The Internalized Stigma of Mental Illness (ISMI) Scale

The scale which was developed by Ritsher et al. (2003) was translated to Turkish by Ersoy and Varan (2007), and its validity and reliability studies have been conducted for various psychiatric disorders. Cronbach's alpha value was found to be 0.93.The scale is a 29-item self-reporting

questionnaire evaluating internal stigmatization (13, 14). The scale consists of five subscales of alienation, stereotype endorsement, perceived discrimination, social withdrawal and stigma resistance. The items on the questionnaire are answered on a 4-point Likert scale. The items on the "stigma resistance" subscale are scored inversely. Total ISMI score obtained by summing the scores of the five subscales ranges from 4 to 91 points. High scores indicate greater and negative internalized stigmatization of the individual (14).

World Health Organization Quality of Life Scale (WHOQOL-BREF-TR)

This scale developed by the World Health Organization for the subjective evaluation of quality of life comprises 26 items (15). The validity and reliability of the scale's Turkish version were tested by Eser et al. for older adult and this version has been used in several studies (16). Cronbach's alpha value was found to be between 0.68-0.88. The Turkish version comprises 27 items and five domains. These domains are physical, mental, social relationships, environment and national environment. Only 27th Question is about national environment. The physical domain evaluates the ability to maintain daily activities, dependence on treatment, levels of activity and sleeping patterns. The mental domain evaluates positive or negative feelings, self-esteem, bodily image, personal beliefs and concentration capacity. The social relationships domain evaluates communication with other individuals, social support and sexuality; and the environment domain evaluates living conditions, safety, economic opportunities, social activities, physical environment and transportation. In this study 26 items were evaluated in accordance with the original scale. WHOQOL-BREF can be used for people with mental illness (17)

Each answer has five options. Domain scores ranging from 4 to 20 points are obtained by multiplying mean scores in the relevant domain by 4. The quality of life increases as the score increases (15,16).

Statistical Analysis

WHOQOL-BREF and ISMI scale were compared between 58 patients with bipolar disorders and 52 patients with schizophrenia. The Kolmogorov-Smirnov test was used in the conformity check of continuous variables to normal distribution. The Student's T-Test was used to compare the two independent groups of variables with normal distribution. Correlations between numerical variables and correlations between categorical variables were tested with the Pearson correlation coefficient and the Chi-Square test, respectively. Descriptive statistics were expressed in mean±std. deviation values, numbers and percentages (%). SPSS for Windows version 22.0 software package was used for the statistical analysis and $p<0.05$ was considered statistically significant.

RESULTS

In total 110 patients, i.e. 58 with bipolar disorder and 52 with schizophrenia patients were enrolled in the study. Among the patients with bipolar disorder, 58.6% (n=34) and 41.4% (n=24) were female and male, respectively, while among the schizophrenia patients, 42.3% (n=22) and 57.7% (n=30) were female and male, respectively (p=0.008). The mean ages of the patients with bipolar disorder and schizophrenia patients were 36.20 and 39.16 years. The comparative sociodemographic data of both patient groups are provided in Table 1.

Table 1. Comparative sociodemographic data of schizophrenia and patient with bipolar disorder groups

		Bipolar disorder	Schizophrenia	P
Mean age		36.20±10.14	39.16±10.99	0.153
Duration of illness		10.10±5.63	14±9.30	0.011
Gender	Female	34 (58.6%)	22 (42.3%)	0.008
	Male	24 (41.4%)	30 (57.7%)	
Education	Illiterate	4 (6.8%)	3 (5.8%)	0.211
	Primary school	30 (51.8%)	26 (50%)	
	High school	11 (19%)	17 (32.7%)	
	University	13 (2.4%)	6 (11.5%)	
Marital status	Married	35 (60.3%)	24 (46.2%)	0.136
	Single	23 (39.7%)	28 (53.8%)	
Children	Yes	33 (56.9%)	24 (46.2%)	0.35
	No	25 (43.1%)	28 (53.8%)	
Employment status	Unemployed	38 (56.5%)	38 (73.1%)	0.39
	Employed	20 (34.5%)	14 (26.9%)	
Hospitalization	Yes	46 (79.13%)	42 (80.8%)	0.849
	No	12 (20.7%)	10 (19.2%)	
Comorbid psychiatric disorders	Yes	2 (3.4%)	3 (5.8%)	0.901
	No	56 (96.6%)	49 (94.2%)	
Comorbid medical disorders	Yes	14(24.1%)	11(21.2%)	0.709
	No	44(75.9%)	41(78.8%)	

No significant difference was found between the 58 patients with bipolar disorder and 52 schizophrenia patients in the study in the physical (p=0.490) and environment (p=0.216) domain results of the WHOQOL-BREF (TR) Quality of Life Scale (Table 2).

Table 2. Comparison of WHOQOL-BREF (TR) Quality of Life Scale total and subscale scores between bipolar disorder and schizophrenia

	Bipolar disorder	n	Schizophrenia	n	P
Physical domain	22.72±2.81	58	23.08±2.49	51	0.490
Mental domain	19.67±2.73	57	18.19±2.71	52	0.006
Social relationships domain	9.30±2.01	57	8.47±2.34	51	0.050
Environment domain	28.98±4.57	58	27.92±4.33	52	0.216
Total	80.30±9.10	56	77.7±9.68	50	0.156

When the two patient groups in the study were compared the alienation (p<0.001), stereotype endorsement (p=0.009), perceived discrimination (p=0.006) and social withdrawal (p=0.015) results were higher in the schizophrenia patients than in the patients with bipolar disorder. Stigma resistance showed similar results in both patient groups. According to the mean ISMI scores, internalized stigmatization was greater in the schizophrenia patients compared to patients with bipolar disorder. (Table 3).

Table 3. Comparison of ISMI total and subscale scores between bipolar disorder and schizophrenia

	Bipolar disorder	n	Schizophrenia	n	P
Alienation	12.56±2.36	58	14.33 ±2.39	52	<0.001
Stereotype endorsement	14.43±3.13	57	15.94±2.71	52	0.009
Perceived discrimination	10.72±2.52	58	12±2.25	52	0.006
Social withdrawal	13.40±3.07	58	14.83±2.95	52	0.015
Stigma resistance	14.78±1.89	58	15.02±1.95	52	0.508
Total	36.18±10.75	57	42.08±9.68	52	0.030

The alienation (p<0.001), stereotype endorsement (p=0.014), perceived discrimination (p=0.018) and social withdrawal (p=0.013) results were higher in the female schizophrenia patients than in the female patients with bipolar disorder. Stigma resistance had similar results in both patient groups (p=0.885). Stigmatization was greater among the female schizophrenia patients than the female patients with bipolar disorder (p=0.006). (Table 4).

Table 4. Comparison of ISMI total and subscale scores between female bipolar disorder and schizophrenia patients

	Bipolar disorder	n	Schizophrenia	n	P
Alienation	12.26±2.69	34	14.86±2.70	22	<0.001
Stereotype endorsement	13.97±3.50	34	16.32±3.18	22	0.014
Perceived discrimination	10.41±2.73	34	12.14±2.36	22	0.018
Social withdrawal	13.00±3.32	34	15.32±3.21	22	0.013
Stigma resistance	14.88±1.84	34	14.95±1.79	22	0.885
Total	34.76±12.01	34	43.68±10.58	22	0.006

When the results of the change in scores of the WHOQOL-BREF Quality of Life Scale according to the conditions of the female patients participating in the study were examined, it was seen that the quality of life results in the mental domain (p<0.001) and social relationships domain (p = 0.005) were higher in the patients with bipolar disorder. The quality of life results in the physical (0.668) and environment (0.136) domains were similar. Female patients with bipolar disorder (n=33) had better quality of life scores than female schizophrenia patients (n=22) (p=0.019) (Table 5).

Table 5. Comparison of WHOQOL-BREF (TR) Quality of Life Scale total and subscale scores between female bipolar disorder and schizophrenia patients

	Bipolar disorder	n	Schizophrenia	n	P
Physical domain	22.29±2.50	34	22.59±2.54	22	0.668
Mental domain	19-94±2.28	34	17.45±1.97	22	<0.001
Social relationships domain	9.61±2.05	33	8.00±1.88	22	0.005
Environment domain	29.29±4.86	34	27.36±4.35	22	0.136
Total	80.76±7.87	33	75.41±8.22	22	0.019

No significant difference was found in the comparison of the Internalized Stigma Scale Results by Conditions in the participating male patients (p=0.280). There was no significant difference between the WHOQOL-BREF (TR) Quality of Life Scale results of the male patients in either patient groups (p=0.940).

A moderate negative correlation was found between quality of life and internalized stigma levels in the overall scores of both patient groups (p<0.001, r:-0.568). A moderate negative correlation was found between quality of life and internalized stigma levels in the patients with bipolar disorder (p<0.001, r:-0.504). A strong negative correlation was found between quality of life and internalized stigma levels in the schizophrenia patients (p<0.001, r:-0.622).

DISCUSSION

It is known that patients with mental disorders are subject to stigmatization (18). The studies particularly on schizophrenia patients reveal discriminative and stigmatizing attitudes towards this condition (19,20). This study hypothesized that internalized stigmatization, which is defined as the endorsement and acknowledgement of negative stereotypes, differed in bipolar disorder and schizophrenia patients. As a result of the study, it was seen that internalized stigmatization was significantly greater in schizophrenia patients. Moreover, there was no difference between the two groups in overall assessment of the quality of life while schizophrenia patients had a lesser quality of life in the mental domain and the social relationships domain. In separate evaluations by gender, it was seen that internalized stigmatization was greater and the quality of life was lower in the female schizophrenia patients whereas there was no difference in the male patients in terms of stigmatization and the quality of life having regard to both conditions. A negative correlation was found between the quality of life and internalized stigmatization.

Chung et al. (2009) emphasized that the effect of the perception of stigmatization on mood disorders had recently been placed on the agenda (21,22). Although there are many studies on the levels of stigmatization in schizophrenia patients, the number of such studies on patients with bipolar disorder is significantly less (23,24). Although the levels of internalized stigmatization were higher in schizophrenia patients in our study, the scale scores of the bipolar patients should also be taken into consideration.

Internalized stigmatization was compared in schizophrenia and unipolar depression patients, and the level of internalized stigmatization was found to be higher in cases of schizophrenia (25). The level of internalized stigmatization was highest in the schizophrenia patients when comparing schizophrenia, bipolar disorder and anxiety disorder patients (26). The results in this study are in accord with the results of previous studies and can be explained as a result of the higher level of internalized stigmatization in schizophrenia associated with greater stigmatization towards schizophrenia patients (27). Stigmatization may be more common in schizophrenia patients because of the destructive mental pattern (28) in schizophrenia patients which negatively affects social relationships.

Both male and female schizophrenia patients suffer stigmatization (29). In consequence of this study, gender differences stand out in schizophrenia patients. It was reported in a study that female schizophrenia patients were more likely to be subject to stigmatization (30). This study also indicates that female schizophrenia patients suffer stigmatization more than female patients with bipolar disorder. These results may be able to be attributed to the impact of cultural differences on stigmatization (29). Greater expectations from and greater oppression of women in Turkey, such as in the relationship of daughter-in-law and mother-in-law,(31) may increase internalized stigmatization in female patients with schizophrenia, particularly in those with negative withdrawals. Althought stigmatization in female bipolar disorder is also considerable and these stigmatization were found to be negative correlate marital compliance and family functions (32).

The stigma resistance results did not differ between the schizophrenia and bipolar disorder groups, and were high in both groups. Although it has been reported that stigma resistance is associated with less internalized stigmatization (33), schizophrenia patients with greater internalized stigmatization did not have less stigma resistance in this current study.

Patients with bipolar disorder answered the question "How satisfied are you with your health?" more positively than schizophrenia patients. According to these results, it appears that patients with bipolar disorder accept their health condition more readily than schizophrenia patients. This result may be influenced by the fact that the patient returns to a completely healthy state in the absence of episodes in the course of the progress of bipolar disorder.

Many studies have demonstrated the relationship between internalized stigmatization and functionality (34,35). Akvardar et al. compared patients with schizophrenia, bipolar disorder, alcohol addiction, diabetes mellitus and controls in terms of quality of life, and observed that schizophrenia patients had lower scores than other groups in the mental, social and physical domains(4). Similar to our study Fernando et al. found that care burden was higher in patients with schizophrenia than in affective disorders, but in this study affective disorders were not separately evaluated as bipolar disorder and depression(36). It can also be seen in this current study that schizophrenia patients, who had higher levels of internalized stigmatization, had lower quality of life scores in the mental and social relationships domains. Internalized stigmatization may result in more social withdrawal in the case of schizophrenia patients. Studies showed that self-esteem has a mediating role between internalized stigmatization and quality of life (37, 38). And self-stigma was found to lower self-esteem (39). Alternatively such patients may be more subject to stigmatization in social relationships since social withdrawal is greater. A moderate negative correlation was found between quality of life and the internalized stigma levels overall in the patient groups. Negative correlation between quality of life and internalized stigma levels was stronger in the schizophrenia patients. It can be seen that internalized

stigma had more negative correlation with quality of life in the schizophrenia patients compared to the patients with bipolar disorder. In a similar study found negative correlation between quality of life and self-stigma (40).

The limitations of the study are that the scale was a self-reporting questionnaire, the participants sometimes preferred generally accepted options instead of the correct ones, or they stated generally accepted behavior. The number of previous manic or depressive episodes for bipolar disorder, presence of social support, duration of untreated psychosis, adherence to treatment may affect prognosis of the patients and there may be patients with bad prognosis and good prognosis in study group so this may affect the functionality and probably internalized stigmatization. Due to the low number of patients in the groups in the evaluation by gender, larger studies are needed. Moreover, gender distribution was significantly different in the groups. Also no structured interview, such as SCID, was conducted, but at least 2 psychiatrists reviewed the diagnoses according to DSM 5 definition. Another limitation of the study is the absence of a healthy control group. More studies in which patients have similar durations of conditions and similar gender distribution with healthy control groups are necessary.

CONCLUSION

In conclusion, it was seen that internalized stigmatization was significantly greater in the schizophrenia patients. The quality of life was found to be lower in the schizophrenia patients in both the mental and social relationship domains. It was demonstrated that female schizophrenia patients had greater internalized stigmatization and lower quality of life while male patients showed no difference in terms of stigmatization and quality of life in the case of both conditions. Increasing the psychosocial support system against stigma may help to improve the quality of life of the patients.

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