

# Self-stigmatization in patients with bipolar disorder

Klara LATALOVA<sup>1</sup>, Marie OCISKOVA<sup>1,2</sup>, Jan PRASKO<sup>1</sup>, Dana KAMARADOVA<sup>1</sup>, Daniela JELENOVA<sup>1</sup>, Zuzana SEDLACKOVA<sup>2</sup>

<sup>1</sup> Department of Psychiatry, Faculty of Medicine and Dentistry, University Palacky Olomouc, University Hospital Olomouc, Czech Republic

<sup>2</sup> Department of Psychology, Faculty of Philosophy, Palacky University Olomouc, Czech Republic

*Correspondence to:* Klara Latalova  
Department of Psychiatry, Faculty of Medicine and Dentistry,  
University Palacky Olomouc, University Hospital Olomouc, Czech Republic.  
E-MAIL: klaralat@centrum.cz

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## Abstract

**BACKGROUND:** Prejudicial beliefs, emotions, and behaviours cause discrimination against people labeled as mentally ill. This stigmatization is sometimes internalized by the patients, leading to self-stigmatization. Specific features and impacts of stigmatization and self-stigmatization in patients with bipolar illness are the subjects of this review.

**METHOD:** Studies were identified through PUBMED, Web of Science and Scopus databases as well as existing reviews. The search terms included “bipolar disorder”, “stigma”, “self-stigma” psychoeducation“, “psychotherapy“, “psychosocial treatment“. Key articles listed in reference lists were searched.

**RESULTS:** Considerable recent evidence indicates that bipolar patients and their families are stigmatized, and that this stigmatization affects their quality of life as well as social functioning. The severity of stigmatization in bipolar disorder is greater than that in people with depression. There is also evidence of self-stigmatization which further decreases the quality of life. Stigmatization and self-stigmatization were shown to be one of the barriers that delay or prevent effective treatment, and thus exert adverse effects on the outcomes of bipolar disorder.

**CONCLUSION:** Stigma affects the experience of illness as well as social functioning in patients with bipolar disorder. The impact of stigma on the lives and treatment outcomes of patients with bipolar disorder mandates intensive effort of mental health research and policy to address this problem. Much has been done against the stigmatization of the mentally ill. But the fight against stigma remains a fundamental objective of health programs for mental health.

## INTRODUCTION

Mental illnesses strike with two-edged swords. On one hand, there are the psychological distress and psychiatric disabilities that exclude people from accomplishing and enjoying life goals. On the other hand, it is the public's reaction to mental illness. A lot of prejudicial beliefs, emotions, and behaviours cause discrimination against people labeled as mentally ill (Corrigan & Watson 2007).

Regarding mental disorder, stigma could be perceivable or veiled, such as diagnostic label, use of psychiatric medication or a history of psychiatric treatment (Stuart *et al.* 2005). Family members report feeling stigmatized as a result of their association with a loved one with mental illness (Matza *et al.* 2004; Kleinman *et al.* 2005).

People with mental illness often feel stigmatized. They feel helpless, they feel as objects of ridicule, sometimes tend to apathy (Elgie & Morselli 2007; Nilsson *et al.* 2010). They often have limited employment opportunities, and sometimes they are even denied basic rights (Lauber & Sartorius 2007).

Bipolar disorder (BD) is defined by recurrent periods of 'highs' (i.e. mania, hypomania) and 'lows' (i.e. depression) of mood, thinking and activity. These heights and lows are of different severity, duration and frequency, and can be combinations of opposite polarity symptoms (i.e. manic/hypomanic and depressive) in the same episode (the mixed states) (Benazzi 2007). Bipolar disorder cause more disability-adjusted life years (DALY) than all forms of cancer or major neurological conditions such as epilepsy and Alzheimer disease (World Health Organization 2002). Individuals with BD are four times more disabled than the general population (Morgan *et al.* 2005).

A substantial source of the disease burden in BD is suicide-related (Angst 2004). Researchers estimate that between 25% and 60% of individuals with BD will attempt suicide at least once in their lives and between 4% and 19% will complete suicide (Goodwin & Jamison 2007). A significant amount of bipolar patients denies their illness, thereby delaying the start of effective treatments. Avoidance to seek professional help (Hirschfeld *et al.* 2003), for some, may be because of the stigma associated with BD (Michalak *et al.* 2007).

## METHOD

Studies were identified through PUBMED, Web of Science and Scopus databases as well as existing reviews. The search terms included "bipolar disorder", "stigma", "self-stigma" psychoeducation", "psychotherapy", "psychosocial treatment". The search was performed by repeated use of the words in different connections without language and time constraints. The articles were collected, sorted by their relevance and key articles listed in reference lists were searched. Reference

lists of publications identified by these procedures were enriched by manually traced the relevant citations.

## STIGMA AND ITS IMPACT IN PSYCHIATRIC DISORDERS

Sociologist Erving Goffman (1963) in his classical sociological publication analyzes the stigma and illustrates, that the individual with stigma is most frequently defined as a "worse than a man". That's why the stigmatization was often misused for ideological purposes.

We have distinguished between public stigma and self-stigma (Corrigan *et al.* 2002).

There are conceptual models where stigma leads to additional stress and to the worsening of mental disorder, in a vicious cycle of stigmatization (Alonso *et al.* 2009).

A progressive model of self-stigma contains four parts which create decreased self-esteem and hope: appreciate of associated stereotypes, agreeing with them, applying the stereotypes to one's self, and suffering lower self-esteem (Corrigan *et al.* 2011).

Stigma of mental disorder is connected with a lack of knowledge about psychiatric disorder, fear, prejudice and discrimination of the patients (Thornicroft *et al.* 2007). Stigma is a general term that consists of three key components: ignorance (problem of absence of knowledge), prejudice (problems with attitude) and discrimination (problem with behavior).

Stigmatization of patients with mental disorder is often presented like a stereotypical anticipation of unpredictability and danger, irresponsibility, and uncontrollability. The stereotype of the image of the mentally ill appropriates the role of a deviant. Consistent with these negative anticipations, the behavior of the environment to the patient changes and the general public as a group keep a significant distance. The patient becomes isolated with his problems. However fictitious it may be, once adopted, the image is resistant to modification. Such persistence of this fictitious image in time is also called "a stereotypical image of the mentally ill" in which a "career of the mentally ill" is expected (Janik 1987).

Labeling a person as mentally ill often results in several forms of repression, as well as a social and existential threat. Not surprisingly, people object against being labeled and they avoid psychiatrists or, if possible, struggle to reduce the consequences of the labeling.

One might think that negative attitudes have improved with greater public awareness about mental illness. Unfortunately, research suggests the contrary – namely, that stigmatizing attitudes have actually worsened over the past 30 years (Pescosolido *et al.* 1999).

Families worrying about stigma often keep patient from early psychiatric intervention. Labeling mentally ill patients is quite often done by health care workers, especially physicians, who can exaggerate or underestimate the level of problems.

The general lay conviction that psychiatric disorders are not true illnesses when compared to the somatic ones leads to mistrust of psychiatric treatments. Anti-psychiatric movements also damaged the reputation of the discipline and contributed to the image of mental illness as being unapproachable by methods of treatment that psychiatry could offer.

Stigma of mental illness, based on stereotypes, has been transmitted to the young generation and has been extensively promulgated by the media. Public attitudes are changing very slowly. The perception of mentally ill people as violent and aggressive is longstanding.

Stigma of a disease often indicates that the persons who suffer from that disease are dangerous, likely to infect or otherwise harm others, that they are incurable, and that they are of little or no value to society. The discovery of a treatment that cures the disease changes such perceptions and signals that it is worth investing in treatment because it will return the sick individuals to useful roles in society. It also signals that persons affected by the disease have not become valueless because they have the illness (Beldie *et al.* 2012). Many felt that the lack of effective treatments was the main cause of stigmatization related to mental illness and that the discovery of effective treatment will decrease stigma. However, this change in perception, unfortunately, did not happen in psychiatry. This may be in part due to the fact that treatments for mental disorders are usually not curative. Of course, limited effectiveness of treatments for common chronic diseases such as diabetes or atherosclerosis is accepted by the public without any stigmatization of the patients.

## STIGMA AND GENERAL PUBLIC

The general public often expresses displeasure towards psychiatrists (Prasko *et al.* 2011). They are ironically labeled as “madmen as well” and may arouse mistrust in general, especially in less educated people. The mistrust in the potential help and the fear, “they can see inside me too much” and “they could find something on me”, contribute to feelings of insecurity in the presence of a psychiatrist. One of the ways of dealing with that insecurity is to laugh. That’s why the jokes about the psychiatrists are so rewarding. Psychiatrists are often presented as freaks and eccentrics in the movies.

Familiarity with these disorders (either through personal experience or exposure to the illness) improve social distancing, and decrease the risk of discriminatory behaviors (Corrigan 2000). On the other side, stigma associated with psychotic disorders (like a schizophrenia) can be increasing (Sartorius & Schulze 2005; Sayce & Curran 2007). The reasons are not certain, but it is suggested that unfavorable stereotypes of individuals with schizophrenia (depicting their behavior as unpredictable and violent) have become more rather than less prevalent (Angermeyer & Matschinger 2003). The stigma of psychiatry is also one of the rea-

sons for state representatives and politicians to have little interest in investing money into the psychiatric care. Although mental illnesses are, taken together, the most important cause of disability, the budgets for services that could provide effective treatment and reduce the burden of disability hover around 2–3 % of the overall health care expenditure in most countries of the world (Beldie *et al.* 2012). Government budgets for mental health programs in no way match the magnitude of problems related to mental illness.

## STIGMATIZATION IN BIPOLAR DISORDER

Lazowski *et al.* (2012) found that bipolar patients and their family members reported higher psychosocial effect of stigma on themselves compared to unipolar depression patients.

The evidence that bipolar patients are stigmatized in society has emerged (Gonzalez *et al.* 2007; Ruiz *et al.* 2012; Vazquez *et al.* 2011) and that these patients perceive themselves as being stigmatized (Hayward *et al.* 2002; Morselli *et al.* 2004; Perlick *et al.* 2007). Clearly, this can affect their recovery (Perlick *et al.* 2001).

Awareness of stigma leads to the worse quality of life (Alonso *et al.* 2009), lower self-esteem (Hayward *et al.* 2002), decreased work e functioning (Alonso *et al.* 2009) and increased restrictions in the frequency or quality of social and leisure activities (Perlick *et al.* 2001; Alonso *et al.* 2009).

Factors such as older age at onset (Tsang *et al.* 2003), unmarried status (Depp *et al.* 2004), male sex (Morriss *et al.* 2007), low socio-economic level, lack of social supports (Keck *et al.* 1998), number of previous episodes (MacQueen *et al.* 2000), mixed episodes (Goetz *et al.* 2007), psychosis (MacQueen *et al.* 1997), longer period of the illness (Robb *et al.* 1997; DelBello *et al.* 2007) and substance abuse (Mac-Queen *et al.* 2001) have been associated not only to low-grade psychosocial functioning (Torrent *et al.* 2006, Martínez-Arán *et al.* 2007) but also with stigma (Morselli 2002). Patients who experience onset of the disorder during adolescence have a risk around 60% of impairment in social functioning (Renoue *et al.* 1997; Hirschfeld *et al.* 2000; Morselli 2002; Goldberg & Ernst 2004). Stigma may have a significant negative impact on the potential complete recovery of the individual’s social functioning (Perlick *et al.* 2001; Corrigan 2004; Greenwald *et al.* 2009; Stier & Hinshaw 2007; Lincoln *et al.* 2008).

Hospitalization represents an important break in multiple areas of a patient’s life as a result of delayed functional recovery and the stigma associated with psychiatric illness (Strakowski *et al.* 2000; Chengappa *et al.* 2005; Thome *et al.* 2012).

A population-based survey in France shows that attitudes towards bipolar disorders are less prejudicial than towards schizophrenia (Durand-Zaleski 2012).

Families may deny mental illness of one of its members for a long time. That’s why they often discourage

and impede treatment, and sometimes take over the patient's activities of daily living in order to hide his/her symptoms. Even though the family later realizes that mental illness is really present, the majority of the families demonstrate a considerable effort to harmonize the handicapped member's behavior, which means their reintegration into the group (so called integration reaction) (Chromy 1990). Restraint and hostile attitudes arise, when those efforts are not successful (so called elimination reaction). The interest in treatment may emerge both in the integration and elimination reaction. If this emergence comes in the elimination reaction and the hospitalization is the formal help, the patient is usually regarded as being deviant and the reintegration problem follows after the treatment is finished.

The negative attitudes are frequently boosted by the media, where the people suffering from mental illness are described as treacherous, aggressive, incompetent and unreasonable individuals dangerous or ridiculous to others (Angermeyer et al 2003; Nawkova et al 2008). The stigmatization also depends on the characteristics of the institution where the patient had been treated. Hospitalization in a mental hospital is usually linked with considerably more negative labeling than that at a clinic or a specialized psychiatric ward (Janik 1987).

Problems may also emerge during maintenance treatment. Many general practitioners (unfortunately some outpatient psychiatrists as well) are convinced that psychiatric patients are taking too many psychiatric medicaments (Prasko & Grambal 2011).

## SELF-STIGMATIZATION IN BIPOLAR DISORDER

Feeling stigmatized is common among those living with mental illness. There are differences between social and structural discrimination and self-stigmatization. Recent research even shows that the social stigma can be internalized (Livingston & Boyd 2010). Some patients believe that the social stigma is a reflection of themselves. This may be one of the reasons that mentally ill people are less likely to seek medical help and have an increased likelihood of relapse (Sirey et al. 2001; Wahl 2012) in effect aiding the perpetuation of social stigma (Sartorius 2007).

Self-stigma is a individual feedback to recognized stigma of mental disorder (Corrigan & Watson 2002). It can be described as an undesirable process in which a person loses the original or desired identity, e.g. as a parent, employee, friend, partner etc to adopt a stigmatized and devalued view of self (Yanos et al. 2008).

It is important to emphasize that not everyone suffering from serious mental illness will internalize stigma. The self-stigmatization comes from within the person suffering with bipolar disorder themselves in that they adopt the stereotypes prevailing in society about people with psychiatric illness. A qualitative study of stigma by Dinos et al. (2004) suggests that individuals with mood

disorders may perceive and feel the stigma otherwise than patients suffering from psychotic disorders.

In studies of patients with a diagnosis of bipolar disorder or depression, self-stigma has been associated with reduced quality of life, lower self-esteem (Ritsher & Phelan 2004), reduction of moral (Ritsher & Phelan 2004) and increased avoidance behaviours (Kanter et al. 2008; Manos et al. 2009).

Work on perceived devaluation-discrimination implied that self-stigma is a progressive phenomenon (Corrigan et al. 2006; Watson et al. 2007; Corrigan et al. 2011) The GAMIAN-Europe study (Brohan et al. 2011) describes the levels perceived discrimination, self-stigma, stigma resistance, and empowerment reported in a patient suffering from bipolar disorder or depression across Europe. Data were collected from 1182 people with bipolar disorder or depression. Moderate or high levels of self-stigma reported 21.7% patients. Moderate or high stigma resistance reported 59.7% patients, moderate or high empowerment reported 63% patients, and 71.6% patients reported moderate or high perceived discrimination.

## THE IMPACT OF STIGMA UPON FUNCTIONING

Perceived stigma (self-stigma) in people with bipolar disorder was related to reduced social functioning and impaired functioning in the workplace (Perlick et al. 2001; Hayward et al. 2002).

Vazquez et al. (2011) revealed that higher scores of self-perceived stigma were correlated with lower scores of functioning. Bipolar patients with concerns about stigma may adapt their social behavior to avoid exposure to rejection or discrimination (Perlick et al. 2001). Also, loss of functioning may lead to embarrassment and discrimination, which contributes to a high level of perceived stigma. Thus, the relationship between perceived stigma and functioning seems to be bidirectional (Vazquez et al. 2011). These findings suggest that interventions that oppose stigmatization have positive effects on functioning in remitted bipolar patients.

Cerit et al. (2012) found that three variables are strong predictors of future functioning in bipolar patients. There are: severity of depression, perceived social support, and internalized stigmatization. The study of Thome et al. (2012) also found a correlation between stigma and poor functioning in 60 bipolar disorder patients.

## IMPACT ON THE TREATMENT OF BIPOLAR DISORDER

The stigma attached to mental illness and psychiatry results in the discrimination of people with mental disorders which is the major obstacle to early and successful treatment. Many people with bipolar disorder which might have the benefit from mental health services

will not pursue them or fail fully participate (Beldie *et al.* 2012). The process of self-stigmatization has great impact to treatment. Stigma and self-stigmatization have high impact on individual's decision to seek treatment and lead to delaying or avoiding treatment (Corrigan & Watson 2002; Cooper *et al.* 2003). Patients avoid psychological or psychiatric treatment. Many people who might benefit from mental health services will not seek help or fail fully participate. Unfortunately, prejudice and self-stigmatization may create similar barriers to life opportunities and achievements (Corrigan *et al.* 2002).

Self-stigmatization may affect the "path to help" in several dimensions (Eisenberg *et al.* 2006). In this case the defensive mechanisms of denial and repression operate intensively, because of concerns about stigmatization. The handicapped person is trying to find another underlying causes, especially somatic ones. In those who do seek treatment, stigma may be partially responsible for non-adherence to treatment regimens (Sirey & Bruce 2005). Patient and the family tend to wait for the symptoms to disappear spontaneously, or for a vacation, relaxation or anything more "natural" to help. Even when this is not effective, the waiting usually continues.

The general population may also stigmatize specific types of treatment or methods. The family and the patient may have specific attitudes – labels applied to psychiatric treatment. They may regard medicaments as poisons which change the psyche, and psychotherapy as brain-washing. The ill individual should pull himself together, eat well and have enough sex. The nerves coated with fat are considered to be immune against mental illness. Certain types of treatment are preferred and certain are rejected by various populations. There are some regional differences. For example, in Germany, a large sample of the population showed that the majority accepted psychotherapy and people treated by this method, while refusing pharmacotherapy. Interestingly in the western Germany the psychoanalysis has highest reputation, while in the eastern part the group psychotherapy is in the lead (Angermeyer *et al.* 1996).

## EXPRESSED EMOTION AND MANAGING THE FAMILY ATTITUDES TO THE PATIENT

Several studies have found that adult bipolar patients who have high expressed emotion (high-EE) relatives (parents or spouses with high levels of criticism, hostility, and/or emotional overinvolvement) or who have relatives who are critical and/or hostile in face-to-face verbal interactions with the patient (negative affective style) have poorer outcomes than bipolar patients in low expressed emotion or benign affective style environments (Honig *et al.* 1997; Miklowitz *et al.* 1988, 2000). EE is a particularly robust risk factor for mood disorders (Butzlaff & Hooley 1998). For example, one study examined EE among people with bipolar disorder

over the course of 9 months and reported a relapse rate of 90% among patients returning from the hospital to high EE homes compared with a relapse rate of 54% for patients returning to live in low EE home environments (Miklowitz *et al.* 1986). Another study extended previous findings by showing that compared to low EE, high EE, as measured by the Five Minute Speech Sample (FMSS), predicted a five-fold increase in the risk of depressive recurrence over a 1-year period, after controlling for prior symptom severity (Yan *et al.* 2004). EE has also been found to predict depressive symptoms among patients enrolled in treatment for bipolar disorder (Kim & Miklowitz 2004).

Research findings have indicated that, compared to relatives who are low in EE, relatives who are high in EE tend to view patients as having control over their symptoms (Barrowclough & Hooley 2003). Such relatives often make internal, personal, and controllable attributions, also referred to as blaming attributions, about the patients' behaviors, such as, "You do things just to be difficult". Support for this pattern has been documented in a study of bipolar disorder (Wendel *et al.* 2000).

Criticism appears to be the most robust predictor of functioning patient suffering from bipolar disorder. (McMurrich & Johnson 2009). Criticism in the family is frequently connected with low self-esteem and high level of self-stigmatization (Perlick *et al.* 2001; Hayward *et al.* 2002; McMurrich & Johnson 2009; Durand-Zaleski *et al.* 2012). Program which decreased EE with given in 21 outpatient sessions of psychoeducation, communication enhancement training, and problem solving skills training improved the 2-year course of adolescent bipolar disorder in a randomized controlled trial (Miklowitz *et al.* 2004).

Many family psychoeducation programs for psychiatric disorders have been created with the goal of decreasing EE, particularly criticism and hostility, towards the ill relative. These programs have been designed based on the theory that attributions people make about the illness and related behaviors can lead to blame, which often results in critical comments and hostile attitudes. Providing psychoeducation should lead, theoretically, to changes in attributions and fewer critical comments. Although such programs have yielded changes on many outcome measures (Bland & Harrison 2000; Fristad *et al.* 2003), they have failed to produce changes in EE or negative behaviors (Fristad *et al.* 2003; Simoneau *et al.* 1999), with one exception (Honig *et al.* 1997).

Single multifamily group sessions have been shown to offer several advantages (Moltz & Newmark 2002), including reductions in stigma (Miklowitz 2004) and providing an opportunity to build a support network with other families going through the same experience (Anderson *et al.* 1986). Nevertheless, Eisner and Johnson (2008) study based on previous psychoeducation interventions means by added acceptance component

created for reducing of anger and blaming in family members of bipolar patients. Twenty eight family members attended a 1-day or 2-evening group workshop. It showed, that participants had more knowledges about bipolar disorder, but anger, propensity to blaming, and level of criticisms remained unchanged.

## CONCLUSION

Perception, awareness and feelings of stigma are for patients with bipolar disorder very important factors that affect their functioning in life.

Effect of stigma on patients with bipolar disorder is huge and shows why it is necessary to solve the problem of stigmatization intensely. Until now, it was done a lot for the fight against stigmatization, but anti-stigma programs should remain the essential tasks of programs for mental health.

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