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Original Article

Internalized stigmatization and social functioning in psychiatric patients

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Abstract

Aim: This study was conducted to determine the relationship between with sociodemographic characteristics, internalized stigmatization and social functioning in psychiatric patients.

Material and Method: The research was conducted as cross-sectional study. The population of the study consisted of 170 patients. The research sample consisted of 119 patients in the hospital during 2015. An information form, the Social Functioning Scale (SFS) and Internalized Stigma of Mental Illness (ISMI) Scale were used to collect data. Evaluation of data was performed with the use of percentages, regression analyses and Pearson correlation.

Results: It was seen that 52.9% of the patients taking part in the study were female and 47.1% were male, 33.6% were educated to high school level, and 83.2% lived with their families. It was determined in the study that those who were married, those with university level education, those whose income and expenditure were in balance and those whose income levels were high, those whose duration of illness was 1-5 years, and females rather than males had better social functioning ($p<0.05$).

Conclusion: It was shown that in most patients, their illness affected their social functioning and stigmatization. It was determined that as stigmatization increased in patients, social functioning was reduced. It is thought that psychiatry nurse who is working in this area should attempt to increase functioning of the patients in cooperation with institutions and patients family.

Keywords: Psychiatric Patients; Internalized Stigmatization; Social Functioning; Psychiatric Nurse.

INTRODUCTION

Stigmatization is a well-recognized phenomenon in mental health field for a long time. Generally, it is described as the status loss and discrimination triggered by negative stereotypes about individuals labelled as having mental illness. Stigma withholds recovery process by eroding individuals' morale. Therefore, stigma has a negative impact on the self-esteem, social functioning and hope levels of patients with the psychiatric disorders. Internalized or self-stigmatization causes a person to accept the negative judgement of society and to withdraw from society with such feelings as worthlessness and shame, and to cause significant trauma (1,2). In those who are mentally ill, internalized stigmatization hinders adherence to treatment and recovery (2,3).

In mental disorders, factors such as mental distress, social functioning, family load, attempts at self-harm, negative care-givers' attitudes and living away from home have been found to be the most important indicators of quality of life and stigmatization (4).

As approaches to reduce stigmatization, nurses can achieve change by sharing information in places such as schools and work places. These nurses can perform activities and education in different units. Activities carried out by a nurse and education can reduce stigmatization (2). They must work to determine internalized stigmatization, which affects an individual's life in many areas such as the treatment process of individuals with mental illness, social interaction, self-esteem and relationships. Psychiatric nursing includes the planning and practice of actions to reduce internalized stigmatization and is an important part of the mental health team. This study was conducted to determine the relationship between with sociodemographic characteristics, internalized stigmatization and social functioning in heterogeneous psychiatric patients.

MATERIALS and METHODS

Subjects

The research was conducted as cross-sectional study. The research was conducted between January and

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October 2015 in Psychiatric Clinic of Atatürk Teaching and Research Hospital of Izmir Katip Çelebi University. A total of 119 patients were included in the study. Patients (n=22) who did not want to participate in the study and patients with severe psychiatric symptoms (n =29) were not included in the study.

Criteria for inclusion in the study

- An age of 18-65 years
- Literate
- A psychiatric diagnosis according to DSM-V
- No seriousness of symptoms of patients
- Cognitive capacity sufficient to complete the scales
- Willingness to participate in the study

Criteria for exclusion in the study

- Smaller than 18 years
- Agite
- Affective
- No motivational request fort he study.

Procedure

The research was conducted between January and October 2015. Three trained master students were designators and assistants in the data gathering.

They handed out the information forms, consent forms and surveys to the patients. Questionnaire applied to patients by master students. Patients who had difficulty reading the questionnaires were helped. Especially, the patients who need to wear glasses were helped.

Questionnaire

Three forms were used in the research

1. Patient information form: This form was included questions on individuals' gender, age, education level, occupation. Also, included questions about diagnosis of disease, duration of illness, internalized stigmatization status, separation from work due to mental illness, suicidal thinking, due to mental illness damage to others.

2. Internalized Stigma of Mental Illness (ISMI) scale

The ISMI scale, developed by Ritsher et al. (2003) and tested for reliability and validity by Ersoy and Varan (2007), consists of 29 items and is a self-reporting scale for the assessment of internal stigma (1, 5). The scale consists of five sub-dimensions. These are 1. Alienation (6 items), 2. Sterotype endorsement (7 items), 3. Perceived discrimination (5 items), 4. Social withdrawal (6 items), and 5. Stigma resistance (5 items). Response to the items on the scale are given on a four-way Likert type scale: "I definitely disagree" (1 point), I do not agree (2 points), I agree (3 points), I definitely agree (4 points).

Stigma resistance is scored in the opposite way. The ISMI total item score ranges from 1 to 4. The level of stigmatization experienced shown on the ISMI scale is as follows: 2 or less: minimum; 2-2.49: slight; 2.5-3: medium; and 3 or above: severe. The total ISMI score, obtained by adding the scores of the five sub-scales, varies between 4 and 91. A high score on the ISMI scale indicates that a person's internalized stigmatization is more severe (1,5).

3. Social Functioning Scale (SFS)

The Social Functioning Scale (SFS) is an instrument evaluating the role functions which necessitate judgement made on a person's total social role. The SFS assesses basic capacities from the quantitative direction of social behaviour. The scale was developed in 1990 by Birchwood et al., and tested for validity and reliability by Erakay in 2001 (6,7). The scale is made up of seven sub-dimensions. These are 1. Social withdrawal, 2. Interpersonal functioning, 3. Pro-social activities, 4. Use of free time, 5. Independence-competence, 6. Independence-performance, 7. Work/occupation.

With regard to the scoring of the sub-dimensions, social withdrawal has five items and the lowest score is 0 and the highest is 15. Interpersonal functioning has four items but items 1 and 2 are added, so that the lowest possible score is 0 and the highest is 9.

For independence-competence the lowest is 0 and the highest is 39; for independence-performance the lowest is 0 and the highest is 39; for use of free time the lowest is 0 and the highest is 45; for pro-social activities the lowest is 0 and the highest is 66.

For the area of work and occupation two items are completed if they are appropriate for the person, but these are omitted if the individual has not worked in the previous six months (6,7).

The lowest and highest scores which can be obtained on this scale are 0 and 223, and a high total score obtained from a subscale shows a progression towards the positive in functioning (8).

Statistical Analysis

The Statistical Package for the Social Sciences version 15 (SPSS15) was used to statistical analysis the data. In statistical analysis such as frequencies, means, standard deviations, proportions and multiple regression analysis were examined. Pearson correlations were used to examine the moderating effect of the Social Functioning Scale on the ISMI.

Ethical Considerations

For the study permission received from the ethics committee Manisa Celal Bayar University Medical Sciences faculty (17.12.2014/20478486-407).

Received permission from the hospital for study. From the patients participating to study was taken oral and written permission.

In Table 1 patients' descriptive characteristics were given. The mean age of the 119 patients who participated in the study was 42.27±14.19 years; 52.9% were female and 47.1% were male; 44.5% were unmarried, 36.1% were married; 19.4% were widowed-separated- wife dead; 33.6% were educated to high school level and 32.7% to the level of basic literacy or primary school, and and 58.8% had an income which was equal to their expenditure (Table 1).

Table 1. An examination of patients' descriptive characteristics

Descriptive Characteristics	n	%
Mean Age	X = 42.27±14.19	
Gender		
Female	63	52.9
Male	56	47.1
Marital Status		
Single	53	44.5
Married	43	36.1
Widowed	6	5.0
Separated	13	10.9
Other	4	3.4
Educational Level		
Literate / Primary school	39	32.7
Middle school	22	18.5
High school	40	33.6
University	18	15.2
Income		
Income less than expenditure	49	41.2
Income and expenditure balanced	70	58.8
TOTAL	119	100.0

The distribution of patients' descriptive characteristics relating to their illness. It was found that 51.3% of the patients were being treated for mood disorders, 35.3% for psychosis, and 9.2% for anxiety disorders. It was determined that the duration of illness of 51.3% of the patients was 1-5 years, 49.6% felt excluded, 26.9% had been obliged to leave work, 55.5% harmed themselves, 29.4% harmed others, 39.5% had mental illness in the family, and 56.3% stated that they were at peace with themselves and that they were happy with themselves.

Multiple regression model was established to show the effect of sociodemographic features on social functioning and feeling of stigmatization. In this model, sociodemographic characteristics were taken in addition to model social functioning and stigma scale score which are dependent variables. Accordingly, model social functioning and scores from stigmatization scales were included.

Income status and gender were important factors in this model in explaining the level of ındependence which was dependent variable in the Multiple Regression Analysis of Social Functioning Scale. When we look at the beta coefficients, gender was more effective than income status in this model, it was possible to say that this value was a statistically significant contribution, while the gender variable was only 13.4% (Adjusted R Square: 0.134) of the change in level of independence (Table 2).

Table 2. Multiple regression analysis of sociodemographic characteristics internalized stigmatization and Social Functioning Scale (n:119)

Multiple Regression Analysis	B	Adjusted R Square	Beta	t	p
Income status	3.082	.134	.165	1.915	p>0.001
Gender	7.352	.134	.334	3.877	p<0.001

As patients' scores on the sub-scale of internalized stigmatization rose, their social functioning fell. A negative correlation was detected (p<0.01). As patients' internalized stigmatization scale sub-scores rose, their social functioning decreased. A negative correlation was determined between them (p<0.01) (Table 3).

Table 3. Relation between internalized stigmatization scale and internalized stigmatization sub-dimensions and social functioning scale scores

	Sub-dimensions of Internalized Stigmatization Scale									
	Alienation		Stereotyping		Perceived Discrimination		Social Withdrawal		Stigma resistance	
Sub-dimensions of Social Functioning Scale	r	p	r	p	r	p	r	p	r	p
Social withdrawal	-0.19	0.03	-0.14	0.12	0.20	0.02	-0.12	0.18	-0.26	0.00
Interpersonal relations	-0.16	0.07	-0.18	0.05	-0.12	0.17	-0.13	0.13	-0.19	0.03
Stereotyping	-0.17	0.06	-0.32	0.00	-0.16	0.07	-0.27	0.00	-0.31	0.00
Pro-social activity	-0.28	0.00	-0.26	0.00	-0.30	0.00	-0.28	0.00	-0.27	0.00
Use of free time	-0.33	0.00	-0.39	0.00	-0.38	0.00	-0.36	0.00	-0.28	0.00
Level of independence	-0.21	0.02	-0.41	0.00	-0.33	0.00	-0.25	0.00	-0.24	0.00
Independence competence	-0.30	0.00	-0.52	0.00	-0.35	0.00	-0.32	0.00	-0.25	0.00

According to the mean scores of total ISMI (70.80±13.19) and the sub-scales of Alienation (15.22±3.82), stereotype endorsement (16.16±3.53), Perceived discrimination (12.04±2.86), Stigma resistance (12.39±2.76) and Social withdrawal (14.97±3.54) in this study, patients perceive internalized stigmatization above medium level. It was determined as a result of our study that the group with a diagnosis of psychotic disorder such as schizophrenia, schizoaffective disorder, other types of unidentified psychotic disorder perceived internalized stigmatization at a higher level and had lower social functioning (p<0.05). The relationship between the ISMI scale and the SFS sub-score and socio-demographic characteristics was examined. Among the patients who took part in the study, the social functioning of those whose income and expenditure were balanced and those whose income level was high and those who were university graduates was found to be better, and was found to be statistically significant from the point of view of social functioning (p<0.05). It was found that married patients experienced

more social withdrawal than unmarried or widowed patients, and this was found to be statistically significant from the point of view of stigmatization ($p<0.05$). It was determined that patients with a high school level of education experienced more stigma resistance than university graduates, and this was statistically significant from the point of view of stigmatization ($p<0.05$). It was determined that patients with an illness duration of 1-5 years had better social functioning than those with an illness duration of 6-10 years, and the same was true of females compared to males. It was found that those with an illness duration of 6-10 years experienced more stereotype stigmatization than those with an illness duration of 1-5 years, and this was found to be statistically significant from the point of view of stigmatization ($p<0.05$).

DISCUSSION

In the study, patient's internalized stigmatization consists of stereotypes, prejudices, and discrimination. First, those who turn prejudices into themselves approve stereotypes, they say "That's right, I'm weak and I'm inadequate to look at myself." Second, personal bias leads to negative emotional responses such as low self-esteem and reduced self-efficacy. Patients feel themselves as "mental patients". Individuals with mental illness stop to have the opportunity to work or to live independently, the reason for this is not the mental illness itself, but the discriminatory behavior of the patients to themselves.

Studies have been conducted all over the world on the stigmatization which is common in mental illness, which have attempted to set out the dimensions of this topic. When our study was evaluated from this aspect, it makes an important contribution as an original study giving different results relating to a research population in this country. In this study was carried out to determine the level of internalized stigmatization with social functioning in patients monitored for psychiatric illness, a significant negative relationship was found between patients' feelings of internalized stigmatization and level of social functioning. Similar results have been reported from many studies in the literatüre (9-13). In the study was determined ISMI total (70.80 ± 13.19). This result was slightly above the internalized stigma total average score (29-116), so it can be said that the patients experienced medium level internalized stigmatization. In some studies, mental illness' levels of internalized stigmatization have been found to be high according to their illness diagnosis, while in others it was determined that patients perceived stigmatization at a medium level of the levels of internalized stigmatization (14-16). It was determined that Özçelik's patients (76.12±17.15) perceived internalized stigmatization at above medium level. This finding was similar to the results of our study. In the studies by Tel and Pınar (2012) (14), Coşkun and Güven Caymaz (2012) (15), ISMI total and subscale scores were lower than the results of this study, but it was determined that patients perceived internal stigmatization at an above medium level (14,15). In a study conducted with forensic mental illness, the self-stigmatization perceptions of patients with a diagnosis of psychotic disorder and with a high level of social withdrawal were found to be higher (11). In a study carried out in Ethiopia, it was found that approximately half of patients perceived internalized stigmatization at a medium to high level, and that living in a rural area, being unmarried, and having a high level of clear psychotic indications were related to internalized stigmatization. Half of those who did not continue with treatment left it because of perceived stigmatization; social withdrawal, perceived discrimination, alienation and routine confirmation were found to be determining factors in internalized stigmatization (17). It was determined in our study that according to their mean age patients were in the developmentally productive and creative period (42.27±14.19). It was determined that more than half of them were female, their education level was low, their income level was balanced, and more than half had never married. It was found that 35.3% of the patients had a diagnosis of psychotic disorder such as schizophrenia, schizoaffective disorder, other types of unidentified psychotic disorder, and psychotic disorder not related to a general medical condition, and 64.7% had a diagnosis of non-psychotic disorder such as affective disorder, alcohol/substance disorder, or personality disorder.

It was determined as a result of our study that the group with a diagnosis of psychotic disorder such as schizophrenia, schizoaffective disorder, other types of unidentified psychotic disorder perceived internalized stigmatization at a higher level and had lower social functioning. It has been stated in many studies that the perception of stigmatization was seen in a majority of patients with psychotic disorders, and that as the level of perception of stigmatization increases the quality of life decreases and low satisfaction with life may be an important factor in the experience of stigmatization (10,18), and that both internalization of stigmatization and avoidance of stigmatization disturbs the patient, leading to an expenditure of energy and a fall in the quality of life (10). Internalized stigmatization has a adverse effects on the quality of life due to low self-respect by increasing the symptoms of the illness and reducing social functioning (10). In another study following up patients with a diagnosis of schizophrenia, it was determined that the mean ISMI scores of these patients were significantly higher than those of patients followed up with a diagnosis of bipolar disorder, and that as self-respect and perceived social support decreased, the level of internalized stigmatization rose (10). The findings of our study are similar to the results of many studies in the literatüre (10-13,19). Significant difference was determined in our study according to gender between in terms of stigmatization. In some studies, it was found that the gender of a person with mental illness could affect stigmatization (1). In a study by Ersoy and Varan (2007) (1) with 203 outpatients with various psychiatric diagnoses, it was found that the internalized stigmatization scores of male patients were higher than those of females (1). Mental illness are

generally feared in society because they are thought to be aggressive (20). The behaviour of male patients was perceived as more aggressive or dangerous than that of female patients, with the result that men are more stigmatized than women (1,21). In another study also, no difference was determined between males and females (22). This result is similar to ours. It was thought that the different result may be because the diagnoses of the illnesses of the adult patients in the sample groups were dissimilar. It was found that the social function scores of female patients, those who were married, university graduates, those whose income was equal to their expenditure, and those in the first years of their illness were higher, and the distinct was found to be statistically significant. In another study also, it was determined that female mental illness conformed better to treatment (13,22). These results are similar to ours.

With regard to education, it was found that those with a high school education level had higher scores for stigma resistance from the sub-groups of internalized stigmatization than patients who were university graduates. It was found that as the duration of illness increased, patients experienced more stigmatization, and in those who had family members with a diagnosis of psychiatric illness, scores on stereotyping and perceived discrimination from the sub-groups of stigmatization were higher. It was determined that patients who had been obliged to leave employment experienced internalized stigmatization at a higher level and those who had harmed themselves or others, and this difference was found to be statistically significant. It has been determined in other studies that mental illness with a low education level, or who are unemployed, have low social support, or have low self-sufficiency experience greater internalized stigmatization (12,13,22). These results are similar to those of our study.

CONCLUSION

Internalized stigmatization affects many areas of life for individuals with mental illness. This study results found that the internalized stigma and social functioning was affected by patients' sex, marital status, educational background, monthly income, disease duration. This study showed that hospitalized mental illness patients with low education and low income have higher internalized stigma points and social functioning is low. It is important that the psychiatric nurses develop positive thoughts, attitudes and behaviors about individuals with mental disorders. The quality of the service offered and the positive development of the attitudes and behaviors of the society towards this disease are important to gaining awareness and sustaining. Patient relatives should provide continuous care, love, and control of the illness and increase the self-confidence of the patients. Psychiatric nurses provide continuity of family education and support programs because they contribute to the disappearance of prejudices in the society and affect the quality of life. Therapeutic approaches aimed at reducing internalized stigmatization can reverse all these negative consequences. People with mental illness should be given the message that they are not alone, and that others like themselves can accomplish what they want in life. Eventually, It is proposed to organize community-based education, support programs and social activities to maintain its continuity and to encourage patient participation in these programs.

Important Limitations of the Study

The study is limited to the patients who applied to the hospital of Atatürk Teaching and Research Hospital of İzmir Katip Çelebi University in İzmir. It is considered that the study is carried out on the western side of Turkey and that the sample consists only of persons who apply to the Research Hospital of Mental Health and Diseases Department. Studies with bigger samples will generate more information on the issue of internalized stigma. Another limitation is the fact that all participants were inpatients.

REFERENCES

1. Ersoy MA, Varan A. Reliability and validity of the Turkish version of the internalized stigma of mental illness scale. Turk Psikiyatri Derg 2007;18:163-71.
2. Çam O, Çuhadar D. Stigma Process and Internalized Stigma among Individuals with Mental Illness. J of Psychiatric Nurs 2011;2(3):136-40.
3. Fung KM, Tsang HW, Cheung WM. Randomized controlled trial of the self-stigma reduction program among individuals with schizophrenia. Psychiatry Res 2011;189(2):208-14.
4. Huang RR, Chen YS, Chen CC, Chou FH, Su SF, Chen MC, et al. Quality of life and its associated factors among patients with two common types of chronic mental illness living in Kaohsiung City. Psychiatry Clin Neurosci 2012;66(6):482-90.
5. Ritsher JB, Otilingam PG, Grajales M. Internalize Stigma of mental illness: Psychometric properties of a new measure. Psychiatry Res 2003;121(1):31-49.
6. Birchwood M, Smith J, Cochrane R, Wetton S, Copestake S. The social functioning scale, The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. Br J Psychiatry 1990;157:853-9.
7. Erakay SY. Investigation of validity and reliability of Turkish form social functioning scale in patients with schizophrenia. Unpublished Expertise Thesis. Atatürk Training and Research Hospital, Izmir, 2001.
8. Aydemir Ö, Köroğlu E. Clinical scales used in psychiatry. Physicians Publishing Association 2009;93-335.
9. Razali SM, Hussein S, Ismail TAT. Perceived stigma and self-esteem among patients with schizophrenia. International Medical Journal. 2010;17:255-60.
10. Özge G, Baysal D. Stigmatization and Mental Health. Archive Source Browsing Journal 2013;22(2):239-51.
11. Baysan AL, Başoğul C, Büyükbayram A. Social functionality and internalized stigmatization levels of forensic psychiatry patients. Anatolian Journal of Psychiatry 2015;16(2):113-21.
12. Howland M, Levin J, Blixen C, Tatsuoka C, Sajatovic M. Mixed-methods analysis of internalized stigma correlates in poorly adherent individuals with bipolar disorder. Compr Psychiatry 2016;70:174-80.

13. Chrostek A, Grygiel P, Anczewska M, Wciorka J, Switaj P. The intensity and correlates of the feelings of loneliness in people with psychosis. Compr Psychiatry 2016; 70:190-9.
14. Tel H, Pınar ŞE. Internalized Stigma and Self-Esteem in Outpatients with Psychiatric Illness. J of Psychiatric Nurs 2012; 3(2):61-6.
15. Coşkun S, Güven Caymaz N. Comparison of Internalized Stigma Level Among Patients Attending a Public Versus Private Psychiatric Institution. J of Psychiatric Nurs 2012;3(3):121-8.
16. Ozçelik EK. Patients with schizophrenia, family atmosphere, internalized stigma and quality of life. Master Thesis. Erzincan University, Institute of Health Sciences. Erzincan 2015.
17. Assefa D, Shibre T, Asher L, Fekadu A. Internalized stigma among patients with schizophrenia in ethiopia: A Goldner -sectional facility-based study. BMC Psychiatry 2012;12:239.
18. Switaj P, Wciorla J, Smolarska-Switaj J, Grygiel P. Extent and predictors of stigma experienced by patients with schizophrenia. Eur Psychiatry 2009;24(8):513-20.
19. Holubova M, Prasko J, Hruby R, Latalova K, Kamaradova D, Marackova M, et al. Coping strategies and self-stigma in patients with schizophrenia-spectrum disorders. Patient Prefer Adherence 2016; 24(10):1151-8.
20. Bostancı N. The Stigma Towards to Individual with Mentally ill Patients and Practices About Reducing this Situation. Dusunen Adam The J of Psychiatry-Neurological Sciences 2005;18(1):32-8.
21. Dickerson FB, Sommerville J, Origoni AE, Ringel NB, Parente F. Experiences of stigma among out-patients with schizophrenia Schizophrenia Bulletin 2002;28(1):143-53.
22. Kamaradova D, Latalova K, Prasko J, Kubinek R, Vrbova K, Mainerova B, et al. Connection between self-stigma, adherence to treatment, and discontinuation of medication. Patient Prefer Adherence 2016;10:1289-98.