# A comparative study of internalized stigma and its correlates among different psychiatric disorders in remission

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## Abstract

**Introduction:** Stigma is the negative stereotyping and bias a person with mental illness is subjected to. Internalized stigma is a part of personal stigma and occurs by internalizing the public stigma. There are a number of reported consequences of internalized stigma that play a role in recovery and rehabilitation. The commonly reported consequences are the loss of self-esteem and self-efficacy, disempowerment, demoralization, loss of income and non-adherence to medication

**Aims and Objectives:** To study and compare the internalized stigma among patients with schizophrenia, bipolar and anxiety disorders in remission.

To understand the clinical and sociodemographic correlates of the same.

**Materials and Methods:** A total of 120 outpatients fulfilling criteria for the study were taken. Semi -structured proforma for sociodemographic and clinical variables and the internalized stigma of mental illness (ISMI) scale for internalized stigma were used.

**Results:** 60% showed stigma. 23% showed moderate stigma. Females and patients who were involuntarily admitted had significantly more stigma. Stigma however did not differ significantly among the various diagnostic groups.

**Conclusion**: A significant number of females and involuntarily admitted patients irrespective of their diagnosis experienced internalized stigma.

**Keywords:** Internalized stigma, Schizophrenia, Bipolar, anxiety.

## Introduction

Stigma is a social phenomenon in which there is a negative view of a particular group of individuals, perceiving them as inferior or threatening, resulting in unequal treatment of such individuals.[1]

Stigma operates at three levels: public, structural and personal. Public and structural stigma operate at group levels whereas personal stigma as the name suggests operates at an individual level.

Public stigma refers to the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatized group, like people suffering from mental illness. Structural stigma refers to the rules and policies of the entities in positions of power that restrict the rights and opportunities of people with mental illness.[2]

The personal stigma acting at an individual level can be further classified as perceived stigma, experienced stigma and internalized stigma. Perceived stigma is what the individual thinks are society's beliefs about the stigmatized group. Experienced stigma is the actual discrimination experienced, whereas internalized stigma refers to the process in which an individual accepts the society's negative evaluation and incorporates the consequences into his or her own personal value system and sense of self.[3]

There is a lot of research on public stigma. However, studies in the last few years have increasingly focused on internalized stigma and its consequences. The commonly reported consequences are the loss of self-esteem and self-efficacy, disempowerment, demoralization, loss of income and non-adherence to medication,[4] thereby underlining the role of internalized stigma on rehabilitation and recovery.

Various sociodemographic, psychosocial and clinical factors thought to be influencing internalized stigma have been studied. Conflicting results on the role of sociodemographic factors like gender, education, and employment in internalized stigma have been reported.[5] Study of psychosocial factors has shown a significant and a negative correlation between internalized stigma and self-esteem, self-efficacy, hopelessness, social integration and quality of life.[6] Of the various clinical variables studied, a higher level of internalized stigma was associated with greater psychiatric symptom severity, prior hospitalization and poorer treatment adherence.[6,7] Comparing internalized stigma among various psychiatric disorders, Indian studies have shown internalized stigma to be 28 % in both bipolar disorders and schizophrenia and stigma to be higher in schizophrenia[8,9]

## Aims and Objectives

With this background we proposed to study the internalized stigma among various psychiatric disorders in remission and the various sociodemographic and clinical variables associated with internalized stigma.

## Materials and Methods

This was a cross-sectional study conducted at the outpatient department of the Institute of Mental health Hyderabad. Method of sampling was convenience sampling. Sample size of 120 was calculated taking the prevalence of stigma to be 28% and p value significant at less than 0.05. Data was collected over a period of one month till a total of 120 was reached.

**Inclusion criteria:** Patients between the ages of 18-65 years, willing to give written informed consent and accompanied by a reliable informant, fulfilling the criteria for schizophrenia, bipolar or anxiety disorders as per international classification of diseases (ICD 10)[10] and in remission were taken for the study. Remission for the purpose of this study was defined as those patients who were on regular medication and had not needed a change in medication or its dosing in the last two months, did not require hospitalization and scored 2 or less on the objective version of the clinical global impressions -severity scale (CGI-S).[11] Reliable informant was used as an inclusion criteria in order to corroborate some of the socio demographic variables.

**Exclusion criteria:** Those with organic brain syndrome, mental retardation, comorbid drug dependence, and those suffering from serious physical problems interfering with giving information were excluded from the study.

**Scales used:**

**A semi structured proforma** designed for this study was used to record sociodemographic and clinical variables. Sociodemographic details included age, gender, education, occupation, family type (nuclear/joint), family income and marital status. The clinical variables included diagnosis, total duration of illness, treatment taken from faith healers, insight, and family history of mental illness. Details of hospitalization during the course of illness was also noted. The system adopted by Kaplan and Sadock in their *Comprehensive Textbook of Psychiatry* (2000) was used to grade the patient's insight level.[12] Insight was considered to be absent when it was found to be below Grade III. Patients found to be having insight above Grade III level were considered as having insight.[13]

**Internalized stigma of mental illness scale (ISMI)** was used to assess the internalized stigma.[14] It is a tool to assess internalized stigma, from the perspective of stigmatized individuals. It comprises 29 questions with 4 answering options (strongly disagree -.1, disagree -.2, agree – 3, and strongly agree -.4) divided into five components (alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance. The scale has strong internal consistency ($\alpha$=0.90) and test–retest reliability(r=0.92). Stigma is measured by overall ISMI scores and on individual factors. The scoring pattern is dependent on the mean scores with scores <2 showing minimal stigma, 2-2.5 low stigma, 2.5-3 moderate stigma, 3+ strong stigma .
Brislins back translation method was used to translate the scale into telugu.[15]

**The CGI-Severity (CGI-S)** was used to assess the severity of illness. It is a clinician rated scale and is rated on how ill the patient is at the time of interview on a seven-point scale: 1=normal, not at all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.This rating is based upon observed and reported symptoms, behavior, and function in the past seven days.[16]

**Statistical analysis**

A total of 120 patients were taken for the study by means of convenience sampling. The participants' sociodemographic and clinical factors for the overall sample were analyzed using descriptive statistics. The difference in the mean ISMI scores across theses variables was calculated by ANOVA and the unpaired t-test. The mean ISMI scores and mean scores of all the five factors were compared between three diagnostic groups using ANOVA. A post –Hoc analysis was done to find the difference in ISMI scores in between groups. All statistical tests were considered acceptable at 5% level of statistical significance.

The study was approved by the ethical committee of Osmania medical college.

## Results

The data from 120 patients fulfilling the inclusion and exclusion criteria was analyzed. Males constituted 63% of the sample and the mean age of the sample was 32.8 years, 50% of them were married and majority had education of 10$^{th}$ and above. Majority of the sample (79%) were living in nuclear families and were mainly employed in unskilled and semi-skilled labor.

The clinical variables showed that 51% had schizophrenia, 28% bipolar and 21% anxiety disorders. 70% had insight into their illness and 23% had been admitted by involuntary admission. Majority (53%) had their illness ranging from 1-5 years. (Table-1)

**Table 1: Sociodemographic and clinical variables**

| Sociodemographic variables | N=100(%) |
|---|---|
| Age | Mean-32.8 years(sd-8.89)(range 18-60) |
| Gender | Male=76 (63.3)<br>Female=44(36.7) |
| Education | Illiterate=22 (18.3)<br>Primary=21(17.5)<br>Tenth=23(19.2)<br>**Intermediate=28 (23.3)**<br>**Degree and above=26 (21.7)** |
| Marital status | **Married=60 (50)**<br>Unmarried=48 (40)<br>Others=12 (10) |
| Family type | **Nuclear=95(79.2)**<br>Joint =25(20.8) |
| Family income | Less than 5000=17(14.2)<br>5-10,000=36(30)<br>>10,000=67(55.8) |
| Occupation | Unemployed=28(23.5)<br>**Unskilled=30(25.2)**<br>**Semi-skilled=33(27.7**)<br>Skilled=7(5.9)<br>Housewife=22(17.6) |
| **Clinical variables** | |
| Diagnosis | **Schizophrenia=61(50.8)**<br>Bipolar=34(28.3)<br>Anxiety disorders=25(20.8) |
| Insight | Absent =36(30)<br>**Present=84(70)** |
| Faith healers | **Yes=59 (49.2)**<br>No=61(50.8) |
| Iinvoluntary admission | Yes =29(22.9)<br>**No =91(77.1)** |
| Family history of mental illness | Yes=38(31.7)<br>**No=82(68.3)** |
| Total duration illness | < 1 year=6 (5)<br>1-**5 years=64(53.3)**<br>6-10 years=41(34.2)<br>> 10 years=9(7.5) |

The mean ISMI scores was found to be 59.2.Categorisng ISMI scores to detect mild and moderate stigma shows that 35% have mild stigma, whereas 23% had moderate levels of stigma.(Table 2)

**Table 2: ISMI scores for the entire sample**

| ISMI | 59.2(sd-14.36) |
|---|---|
| Mean ISMI | |
| Less than 2 (minimal stigma) | 50(41.7%) |
| 2-2.5(low stigma) | 42(35%) |
| More than 2.5 (moderate stigma) | 28(23.4%) |

ISMI score were compared across the sociodemographic and clinical variables of the sample and was found that the stigma was significantly more in females and in those who were admitted involuntarily. (Table 3)

**Table 3: Comparison of ISMI scores among the sociodemographic and clinical variables**

| Variables | Mean ISMI(SD) | | Significance p |
|---|---|---|---|
| Involuntary admission | | | |
| Yes | 60.79(14.72) | | |
| No | 53.81(12.38) | 2.23(t) | .027 |
| Gender | | | |
| Male | 57.17(13.88) | | |
| female | 62.89(14.62) | -2.131(t) | 0.035 |

P<0.05

**Fig. 1: Mean ISMI scores compared across the three diagnostic groups**

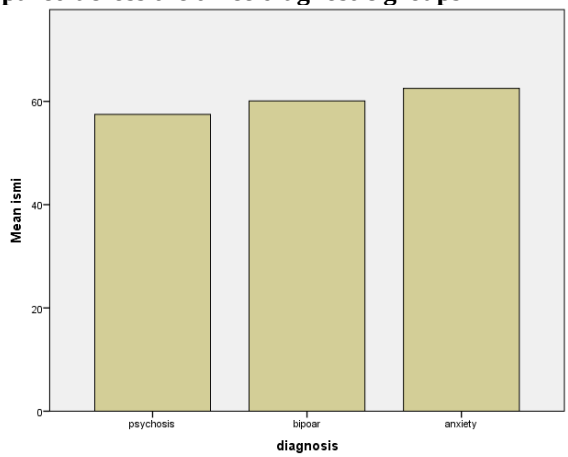


**Table 4: Comparison of ISMI scores across the three diagnosis**

| Diagnosis | Mean ISMI scores (sd) | |
|---|---|---|
| Schizophrenia | 57.48(16.07) | |
| Bipolar | 60.09(13.27) | 1.17(f),0.31(p) |
| Anxiety | 62.52(10.7) | |

When ISMI scores were compared across diagnostic groups no statistically significant difference was found. (Fig. 1), (Table 4)

## Discussion

The aim of the study was to study internalised stigma and its sociodemographic and clinical correlates and to study the difference in internalised stigma among various psychiatric diagnosis. The sociodemographic profile of patients was similar to that in the meta-analysis done by Livingston et al. Male, married, studied beyond 10th, with the most frequent diagnosis being schizophrenia were the major findings[6] The findings of our study were comparable with that of other Indian studies, as moderate levels of stigma was 23% in our study similar to 28% in study by Grover et al.[8] Study by Drapalski reported presence of stigma in 35% of the sample taken with no significant association between any socio demographic profile or diagnosis.[17] However our study like that of the GAMIAN-Europe study showed significantly higher stigma in women.[5] Studies have shown that the presence of mental illness in women interferes with their ability to fulfill their family and social obligations and the cultural held beliefs about mental illness lead to increased discrimination of people with mental illness in general and women in particular[18] increased discrimination leads to increased internalized stigma.[19]

Some studies have shown stigma to be significantly higher in schizophrenia and bipolar disorders as compared to anxiety disorders.[20] And among schizophrenia and bipolar to be higher in schizophrenia.[21] Met analysis by Livingston et al also showed no significant difference in the levels of stigma among various psychiatric diagnosis.[6] Indian studies have shown stigma to be 28% in both bipolar disorders and schizophrenia in two independent samples. Our study also did not show any statistically significant difference in stigma scores across diagnosis.

Studies have shown involuntary hospitalizations and severity of illness to be positively correlated with stigma[22] as we took stable patients who scored less than 2 in the CGI-S scale, the severity of illness was not studied in our sample. However like in previous studies, patients who were admitted involuntarily had higher levels of stigma. The possible reasons for increased internalized stigma in involuntary admitted patients in our sample could be due to the involvement of the legal system in most of these admissions. Studies have also shown that large wards with many patients increases the chances of self-rejection.[23]

In a study by Lysaker the patients with fair insight and moderate depression described a higher level of self-stigma than patients with poor insight and minimal depression. However no difference in stigma in our sample was noticed in relation to insight.[24] Unlike other studies we included the variable of having visited faith healers in the past and its relationship with internalized stigma. Our intention was to study whether a medical model of illness as evidenced by direct visit to the psychiatrist without visiting faith healers at the onset of illness would have any bearing on stigma. However the groups did not show significant difference in the level of stigma.

## Conclusion

When 60% of the sample had internalized stigma and 23 % had moderate levels of stigma, it can no longer be neglected. It appears from our study findings that internalized stigma is not so much dependent on which psychiatric condition is being diagnosed but on

the fact that a psychiatric condition is being diagnosed at all. Considering the limiting role internalized stigma has on the recovery and rehabilitation process, an independent assessment of internalized stigma in all remitted patients and means of addressing it should form an essential part of any rehabilitation process.

**Limitations and future directions**

The findings of our study must be viewed in light of its limitations. It is a single center study, done in a tertiary level psychiatric hospital where possibly the most severe cases are referred to. These findings may not be generalized to those living in the community. We have not studied the relation of psychosocial variables with internalized stigma and the effect of interventions on internalized stigma on long term follow up, which could be taken up in future studies.

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