Stigmatization in the long-term treatment of psychotic disorders
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Key words: psychotic disorders, stigmatization, self-stigmatization and bipolar illness

Summary
Stigma is linked with negative prejudices without examining whether there is any justification for such behavior. Over time various efforts have been made to reduce the prejudice toward people with mental illness. Yet, the World Health Organization (WHO) World Health Report still accept stigma as one of the greatest obstacles to the treatment of mental illness. While, schizophrenia among other mental illnesses is the most stigmatized one even to the point that the name of the illness wanted to be hidden or changed, there are signs that patients with bipolar illness may also be exposed to stigma. The degree of stigmatization has been found to be positively associated with the severity of the mental disorder and stigma is carried out not only by patients, but also by their families in correlation with the severity. Tragically, people with mental illness themselves are as negative in their opinions about mental illness as is the general public and concerns about stigma adversely affect self-esteem and adaptive social functioning. There are many programmes for the fight with stigmatization in all over the world and they are continuing in clear recognition of the fact that stigma can only be successfully eliminated if the programme, become a normal part of the health server rather than campaigns of limited duration.

Introduction
It is written that “And God said, Let us make man in our image” in the Bible (Genesis 1:26). In 1996 Pope John II and the pontifical council convened an international conference with the title “In the image and likeness of God: always?” and asked the question “Are mentally ill people also created in the image of God?” in order to draw the attention to the terrible situation in which people with mental disorders find themselves - despised, discriminated and abused in many ways as if their illness made them no longer be in the image of God.

Everybody seemed to agree that the answer of this question was yes; but did not answer what were the reasons for stigmatization and how those were present [18]. The main dilemma of a psychiatrist is to reconcile the task of bringing attention of the public to the needs of people with mental illness and the task of preventing their stigmatization by such illnesses. Stigma, unfortunately being attached to mental illness, is not only a consequence of mental illness but also a risk factor for mental and physical disease and a direct cause of disability or handicap [17]. The word 'stigma' is of Greek origin and means 'to pierce, to make a hole.' The word was also used, however, to mean branding a criminal with a hot iron to mark infamy of crime. So as to make it possible for all to avoid those marked. In more recent years, stigma has been used linked to certain diagnoses such as tuberculosis, leprosy, cancer and mental illness. Stigma is linked with negative prejudices reflecting the readiness of people to act in a negative way towards the object of the prejudice without examining whether there is any justification for such behavior. There are numerous prerequisites for prejudice to develop, like recognition and social acceptance of the objects of prejudice with lack of personal knowledge about them (www.openthedoors.com). Over time various efforts have been made to reduce the prejudice toward people with mental illness. Despite these attempts, stigma, discrimination, and misconceptions about mental illness continue to be pervasive [2]. Although stigma and its consequences vary between different population groups defined by gender, age, ethnical origin etc. it affects all people with mental illness or impairment,
their families, mental health professionals to treat them and institutions in which treatment is given. Many people contribute to a different degree and often unconsciously to stigmatization of those with mental illness including medical professionals (even psychiatrists) the politicians, the media, social organizations (even religious institutions), as well as the people affected by the illness and families. Stigma’s effects are surprisingly most pernicious when they are least conscious [7]. The 2001 the World Health Organization (WHO) World Health Report accept stigma as one of the greatest obstacles to the treatment of mental illness [14].

Stigmatization and Schizophrenia
Schizophrenia among other mental illnesses is the most stigmatized one even to the point that the name of the illness wanted to be hidden or changed. In 2002, the Japanese Society of Psychiatry and Neurology and the national family organization, Zenkaren, succeeded in changing the name of schizophrenia in order to diminish its stigmatizing effect. This is a good example that reveals the general public and even health professionals’ tendency to hold a stereo-typed image of those with schizophrenia. The stigma that attaches to schizophrenia extends beyond the individual with illness to encompass everything and everyone associated with them; even includes the medications and other treatments that maybe used to control symptoms [19]. This is something common for almost every country in the world. Emil Kreapelin recognized the importance of this issue and made a trip to Far-East. Kreapelin’s visit to Java in 1904 was motivated by his wish to study the existence and expression of dementia praecox in a population of distinctly different origins and culture from his own European experience [11]. Since then, undoubtedly with his great contribution, schizophrenia has been the mental illness of special attraction to the psychiatrists not only with the course and treatment of illness, but with the stigmatization process in trans-cultural setting. Although, the core symptoms of the illness, as it was defined by ICD and DSM criteria or by special definitions such as in Schneider’s first rank symptoms, schizophrenia in clinical or social course varies in national settings; and this course is found to be more benign in some nations [10]. In the 1970’s, WHO carried out a major international collaborative study on schizophrenia. The study demonstrated that schizophrenia found in US, UK, India, Colombia, Nigeria, Denmark, Czechoslovakia, USSR and China while, the incidence did not show much difference amongst them. Only, the course and outcome of schizophrenia was better in developing than the developed countries, as it was also confirmed by some other studies [16, 24]. The frequency of stressful events or expressed emotions of family members did not help explaining this difference. Maybe the different forms and levels of stigmatization in Third World countries cause the difference; but it was not put forward with a study, yet. It is clear that people with mental illness are highly stigmatized in the West. In developing countries certain forms of mental illness have been well tolerated, possibly because of the popular beliefs about their causation (e.g. that the curse has been put on someone by enemies) In recent years, the situation has been changing in the countries – in part because of increased urbanization and the influence of mass media and in part because of the breakdown of the traditional family structure, which allowed the care for an ill member in the large households. However, the authors of a WHO follow-up study of schizophrenia suggest that one of the factors contributing to good outcome in schizophrenia in Cali, Colombia is the high level of tolerance of relatives and friends for symptoms of mental disorder, which is a factor that can help the readjustment to life and work in the community, after the acute phase of the illness.

Other studies have shown that the families of patients with schizophrenia made fewer negative and critical comments about patients’ behaviors than families in Denmark [7].
Axes of Stigmatization
Research over the past four decades has compellingly demonstrated that individuals diagnosed as having mental illness are socially stigmatized or discriminated against on several dimensions by key individuals in their communities. For example, studies have found that employers, families of patients, mental health workers, and prospective landlords all endorsed devaluing statements about or discriminated against mentally ill individuals [12]. The degree of stigmatization has been found to be positively associated with the manifest severity of the mental disorder; however, even persons who have minimal signs of mental illness, that is, those who appear "troubled," may be stereotyped and rejected. Link and colleagues have argued that because people with mental illness internalize the devaluing and discriminatory attitudes of society at large, they anticipate discrimination or rejection by others and develop coping strategies, such as secrecy about their illness or withdrawal from social interaction, in an effort to avoid the rejection [22]. It is also stated by some investigators that to avoid discrimination and rejection patients with mental illness may limit their social interactions including their family members [13]. This, however further contribute to the array of stigmatized behaviors such patients have.

Stigma is carried out not only by patients, but also by their families. Often, families feel themselves not accepted by their extended family and friends when a relative is identified as having schizophrenia. The fear that schizophrenia or any mental illness in general, makes people aggressive and violent isolates the family even more. An interesting research was conducted by Polat and her colleagues in Turkey with the relatives of schizophrenic and bipolar patients. They examined perceptions of and reactions to stigma among parents and spouses of the patients with schizophrenia and bipolar disorder and found that most family members did not perceive themselves as being avoided by others or as having problems in the neighborhood because of their relatives’ illness, in both groups. Despite this, 63% of schizophrenics’ relatives and 56% of bipolar relatives were more likely to conceal the illness and did not tell anybody other than close family members. Fifty-two percent of schizophrenics’ and 33% of bipolar patients’ relatives felt that “the illness might be their fault”. Parents tend to conceal the illness more than the spouses and were worried more because “people would blame them for the patient’s problems”. Level of family stigma and the negative response of other people directly correlated with the number of hospitalizations. The study group showed that most of the families disguise their relative's illness at least to some degree because of the fear of stigmatization and rejection. They also stated that in Turkey, stigmatization is not only the problem of patients with schizophrenia and their relatives but also of patients with other psychiatric diagnoses [16].

Stigmatization of Bipolar Illness
Most studies of the stigma associated with mental illness have focused on patients with schizophrenia or chronic mental illness; however, as the study above indicated, there are signs that patients with bipolar illness may also be exposed to stigma [6]. Results from a mental illness awareness survey done in 1999 show that a significant gap exists between people's perceptions and awareness of mental illness, and in particular, bipolar disorder. The Opinion Research Corporation survey done by telephone interviews conducted among 1008 adults residing in the US, conducted on behalf of the National Alliance for the Mentally Ill (NAMI) and the National Depressive and Manic-Depressive Association (NDMDA), found that 67 percent of those surveyed were unable to accurately describe manic depressive illness (www.nami.org). Only 33 percent correctly characterized manic depressive illness as wide swings in emotion or mood. Thirty-three percent incorrectly believe manic depressive illness is a more serious form of depression and only 43 percent
were able to identify symptoms of mania. Social stigma dictates many people's attitudes toward mental illness: 44 % agreed that people with manic-depressive illness are often violent, and another 25 % thought that people who have mood disorders or manic-depressive illness are different from other people. Twenty-one percent of those surveyed said they would feel uncomfortable being in the presence of a manic-depressive person. Many believed that mental illness is a personal failure, not a disease: nineteen percent of those surveyed felt that individuals with depression or bipolar disorder are personally responsible for the development of their own illness. Forty-six percent of those surveyed said they know someone who exhibits signs of manic-depressive illness.

When asked if they have ever approached such a person offering help, 40 % said no. Ninety-three percent of respondents agreed that manic depressive illness is a medical condition requiring professional treatment. Yet, only 35 % would consult a mental health professional if they were to be ill themselves or if they knew someone else experiencing symptoms of mania or depression. Although the majority of respondents (54%) accurately stated that manic-depressive illness most often occurs in teens and 20s, this age group was the least likely to seek help. An overwhelming 81% of those aged 18-24 said that if they were experiencing symptoms of manic-depression they would try to solve the problem themselves rather than consulting to someone about symptoms. Forty-two percent of those aged 25-34 would avoid asking for help because they wouldn't want to admit there was a problem. Twenty-five percent believe manic depressive illness can be self-controlled. An overwhelming 81 % agreed that people suffering manic-depressive illness are often misdiagnosed. When asked about treatment options for manic-depressive illness, 56 % mentioned medication, 53 % said consultation with a therapist, psychologist or psychiatrist and 21 % noted group therapy. Fifty-six percent of those surveyed said that treatment for manic depressive illness includes taking medication of some sort. The results of this survey clearly indicate the need to increase the awareness of the general public about bipolar disorder. The general public is uncertain about the symptoms of the disease, sees patients as potentially violent or ‘different’ from other people. Although respondents believed that MDD is a disease that should be treated medically, they were reluctant to seek help in case they experienced the symptoms of the illness.

The experience of patients with MDD confirms the results of this survey. The World Federation for Mental Health (WFMH) announced results of a global bipolar disorder consumer survey [19] of 687 patients, conducted across Canada, Germany, Greece, Italy, Spain, United Kingdom and United States, at the World Congress of Biological Psychiatry in 2005. The survey revealed that almost half (47%) of all people with bipolar disorder - or ‘consumers’ as they prefer to be called - feel that their disease has had a highly negative impact on their quality of life. Further to this, more than a third (35%) of respondents stated they have been discriminated against as a result of their condition, usually within the context of everyday social relationships. The survey also revealed 26% of respondents never tell people they have bipolar disorder. Fear of social stigma is a key reason why people do not share this information with others. Seventy percent of people with bipolar disorder who were surveyed believe that the public does not understand their illness and that ignorance may be causing the stigma that many feel.

Another self administered survey was done in 11 EU countries on bipolar patients. Impact of the stigma in bipolar patients' life was found in a range between 34 to 98 %. The condition was found to have a negative impact on work, interpersonal and leisure activities [15]. The concerns about stigma were shown to have effects on social adaptation among persons with a diagnosis of bipolar affective disorder, also in a study comprised 264 persons with bipolar I, bipolar II, or schizoaffective disorder. Patients were evaluated with
clinical scales and a measure of perceived stigma. People who had concerns about stigma showed significantly more impairment on the social adjustment scale. Concerns about stigma predicted higher avoidance of social interactions with people outside the family and psychological isolation [5].

**Self Stigmatization in the Course of Illness**
Tragically, people with mental illness themselves accept the stereotype of their own condition. A number of studies have shown that mental patients are as negative in their opinions about mental illness as is the general public. Some reports, indeed, indicate that mentally ill patients are more strongly rejecting those with mental illness than family members or hospital staff. The perception of stigma by people with psychosis is associated with enduring negative effects on their self-esteem, well-being, mental status, work status and income [12]. Self-stigmatization which is not taken into consideration as often as other forms of stigmatization may be of particular importance in illnesses with an episodic course, such as mood disorders and cycloid psychoses. Studies of self-stigmatization have been few, and the results concerning factors associated with such stigma are controversial [1, 17]. In a study from Taiwan using the Self-Stigma Assessment Scale, the authors evaluated 247 outpatients with depressive disorders to determine their levels of self-stigmatization. Twenty-five percent of the patients had high levels of self-stigma. Patients who had more severe depression and less education had higher levels of self-stigma [21].

Concerns about stigma adversely affect the recovery of people with mental illness. These concerns affect self-esteem and adaptive social functioning outside the family, and influence the willingness of outpatients to take the medications that their psychiatrists prescribe for them. Adherence is affected by "the complex interplay of illness features, personal values, interpersonal supports, and environmental conditions," and successful interventions must address these issues in their behavioral complexity [9]. Therefore, non-compliance or non-adherence to prescribed medicine due to fear of stigmatization is a significant problem in the long-term treatment of mental disorders. Self-stigmatization has a special and deep impact in mood disorders specifically. The findings of the studies reported here suggest that clinicians need to be aware that concerns about stigma may reduce adherence to the medications they prescribe or may delay recovery of self-esteem and adaptive social functioning, even under conditions of optimal psychopharmacologic response.

When thinking about stigma, psychiatrists and mental health workers usually think about personal stigma, the prejudicial attitudes and discriminatory behavior concerning an individual with mental illness. Sociologists, unlike psychiatrists or psychologists, are more concerned with structural stigma, a term used to describe the situation in which an institution, contributes to stigmatization, e.g. by broadcasting stigmatizing messages. In a study conducted by Corrigan et al (2005), the investigators surveyed 3353 newspaper stories and found that 39% of all stories focused on dangerousness and violence [3].

The recognition of the adverse impact of stigma is only a first step toward curing the problem. Continuing efforts to educate public so as to provide it with a more accurate and less prejudiced view of mental illness, and work with people with mental illness to develop strategies for coping with stigma that do not lead them to avoid social and treatment settings are among necessary ingredients of the fight against stigma. The creation of public awareness that mental illness is a treatable biological illness similar to other more accepted medical conditions for example diabetes mellitus or hypertension is also among useful technique for a mental health service in reducing stigma. The experiences of people
with bipolar patients may provide important clues for starting points in anti-stigma campaigns. Patients have vast and valuable knowledge about many topics, for example how to explain gaps in one's resume, how to obtain medical care without being labeled a "psychiatric patient," how to explain one's depression to family members (when these oppose the use of medications and insist that one is simply "not trying hard enough"), how to manage side effects such as tremor and weight gain that are difficult to conceal, and how to cope with loneliness and isolation from the mainstream culture [13]. Goodwin and Jamison stated that, individuals with manic-depressive illness feel ashamed and humiliated because of by their illness, their bizarre and inappropriate behavior, violence, financial irregularities, and sexual indiscretions. This feeling of shame can lead to self-stigmatization that may follow the patient as a dark and inescapable shadow, for many years. As they quote from a bipolar patient: “There is a particular kind of pain, elation, loneliness and terror involved in this kind of madness... And always, when will it happen again? Which of my feelings are real? Which of the me is me?”

Fight Against Stigma
The World Psychiatric Association (WPA) Programme to Reduce Stigma and Discrimination because of schizophrenia, which was launched in 1996, has established projects to fight stigma in 20 countries, using a variety of techniques [20]. At each site, the first step was to conduct a local survey of perceived stigma- the experiences of patients and their families since the illness has occurred. On the basis of these surveys, the local committees selected interventions targeted at some social groups (such as students, workers and criminal justice personnel). Messages for the target groups as well as the methods to convey them were carefully selected and tested. The project produced an array of useful experiences and suggestions about ways of combating stigma. The programmes are continuing in clear recognition of the fact that stigma can only be successfully eliminated if the programme, become a normal part of the health server rather than campaigns of limited duration.

Conclusion
Three sets of conclusions can be made about the stigma of mental illness: a) mental illness stigmatizes more than physical illness, b) stigma and in particular stereotyped ideas about the dangerousness and lack of self-responsibility led to discrimination, and c) familiarity with people who have a mental illness is among the interventions that can reduce the stigma [7].

The change in attitude through personal contact and giving accurate information present avenues to the reduction of stigma for people with mental illness that health workers should take to and increases chance for better outcome of treatment and their patients' integration into the community. In so doing psychiatrists should not forget that patients and the community are learning a lot in this age of information, that the treatment of people with mental illness has changed a lot, and that patients do not fit the old roles they were previously given. That means, as William Ashdown, the president of a non-governmental organization of people with affective disorders stated: “a new paradigm is emerging because there is a reduction in the attitudes of helplessness; fuelled by internet; contact with others; gaining strength and political power; based on more equal and balanced relationship” [1]. Physicians must expect patients know a great deal more about their illness and treatments. Sometimes they will know more than we do. The challenge of the physicians is they have to learn more to work with patients, because as Fromm-Reichman had stated [8], our patients could even be more informed than us this should lead us to be braver than them. The increased insistence on achieving recovery or full remission, instead of only response can be an important contribution to efforts to overcome self-
stigmatization. As Bryan L. Court, a bipolar patient, stated stigma due to the illness is a feeling or sense of disgrace, dishonor, shame or discredit with the impression of being blemished or stained in an ugly, undesirable way [4]. “Stigma comes in form of newspaper articles that misrepresent the truth and movies that make fun of the mentally ill. Nobody wants to be like the characters in the movies or newspapers. For the most part, everyone who is uneducated and unsympathetic to those with bipolar disorder instills a sense of stigma in us. Who takes stigma and puts it in us? We do! Why do we let that happen? We can’t change what others think of us, but we don’t have to accept and absorb their views of this illness as our own. I can change only the way I think about myself. I can choose to remove the stigma from myself and let the perpetrators keep it... The God I choose to believe in loves me and accepts me unconditionally and I choose to believe what He says about me... And if God says I’m OK, I can love and accept myself without stigma...”

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Acknowledgements: Author thanks to S. Demirkiran and A. Üçok for their contribution.