

The Impact of Stigma on Bipolar Individuals

Mental health/Mood Disorder Stigma in general

Johnstone (2001) reported that people with mental health issues are some of the most vulnerable members of our society while also being some of the most disadvantaged, marginalised, discriminated against and stigmatised.

Overton & Medina (2008) the false assumptions and negative connotations associated with mental illness may be more harmful than the mental illness itself.

Johnstone (2001) Mental health stigma limits the opportunities of people with mental health disorders.

Corrigan et al (2001) a report from the surgeon general stated that the effects of stigma are a key factor in determining the outcomes for someone with a psychiatric diagnosis.



What is Bipolar?

American Psychiatric Association (2001) Bipolar disorder is a serious mental illness the symptoms of which can be characterised as episodes of either mania (BD-1) or hypomania (BD-2) and episodes of major depression.

How BD stigma impacts Functioning

Vazquez et al (2011) conducted a study the goal of which was to determine the effect of BD stigma on general functioning. The researchers recruited 241 individuals with BD and used the functioning assessment short test (FAST) in order to determine their overall functioning level and the inventory of stigmatizing experiences (ISE) in order to determine the impact of perceived stigma. The results showed that there was a significant correlation between internalized stigma, stigmatizing experiences and overall functioning.

Cerit et al (2012) showed similar results. The study found that in 80 bipolar individuals overall functioning was inversely correlated with self-stigma.

Thome et al (2012) looked at how stigma impacted specific spheres of functioning. The research showed that there was a correlation between stigma and all six assessed domains of functioning, leisure, interpersonal financial cognitive, occupational and their level of autonomy. Stigma seemed to have a particularly strong effect on a bipolar individual’s ability to function cognitively and in leisure, the largest effect size was found in the interpersonal functioning domain (r=.51).

Perlick et al (2001) studied how people with BD experienced stigma after recently experiencing an affective episode. Using multiple regression analyses the researchers showed that an individual experiencing a high level of stigma early after an episode could significantly predict the leisure and social functioning of an individual up to seven months after the affective episode. This was found to be the case when controlling for marital status and severity of symptoms. However, the research also showed that early stigma did not predict family functioning or overall functioning, this indicates that the stigma experienced by these individuals impacts specifically the functioning of the social and leisure domains rather than a universal negative influence on every aspect of the functioning of a bipolar person.

Hayward et al (2002) studied the relationship between self-stigma, self-esteem and social functioning and found supporting results. Just as Perlick et al (2001) had found the previous year stigma was significantly inversely correlated with social functioning. the study also showed that there was a significant inversely correlated relationship between stigma and self-esteem.

Aydemir and Akkaya (2011) showed similar results in their research studying 150 euthymic individuals with BD. The researchers used confirmatory path analysis to show that feeling stigmatized correlated with a lower level of self-esteem. They also found that those who felt more stigmatized were significantly more likely to have a higher level of social anxiety.

This research seems to indicate that stigma has a significant impact on an individual’s ability to function, while also having what seems to be an increased negative effect on social functioning.



Qualitative effects of Bipolar Disorder stigma

Michalak et al (2006) Qualitative research showing that people with BD, their families and healthcare workers felt that the stigma surrounding BD affected them in work and in healthcare settings. The participants of the study reported that in their experience physical illnesses were not stigmatised in the same way that BD was. Participants also reported concealing their diagnosis. Overall the study showed that stigma is a factor of living with BD which negatively impacts an individual’s quality of life.

Supporting this Sajatovic et al (2008) showed similar results. Again, participants felt that physical illnesses were not stigmatised in the same way BD was and that they selectively concealed their BD diagnosis. The participants also reported that disclosing their diagnosis had a positive effect when the person they tell was supportive, a benefit lost if they felt they must conceal their diagnosis because of stigma.

Corrigan et al (2004) Herek (2007) Livingston and Boyd (2010) When the policies and practices of institutions that are in power restrict the opportunities and rights of individuals with mental illness then it is considered structural stigma.

Suto et al (2012) specifically questioned individuals with BD and their family members on the subject of stigma and its effects on their lives. The study showed that in participants eyes structural stigma created zones of exclusion which devalued in school, in work and in healthcare settings as well as limited their opportunities in those same settings. The participants also mentioned the impact of the media on their experience of stigma, which in their eyes fostered social stigma. This stigma them lead to a reduction in quality of life and impeded their relationships.

Stigma among Caregivers of individuals with bipolar disorder

Gonzales et al (2007) divided their sample of a thousand participants (500 individuals with BD and 500 family members of someone with BD) into two groups family members of individuals who had been symptomatic in the past year and the family members of those who had been mostly well in the past year. For the families of symptomatic BD patients high levels of stigma could be predicted by a BD-1 diagnosis (as opposed to a BD-2 diagnosis), lower perceived social support and lower levels of social interaction.

Perlick et al (2007) studied the relationship between stigma and depressive symptoms in primary caregivers of patients with BD. The research showed that stigma uniquely predicted the depressive symptoms of the caregiver. The impact of the stigma seemed to be mitigated by an avoidant coping style and social support, which suggests that those caregivers who cope with high levels of stigma by withdrawing from social situations would be particularly at risk of developing depressive symptoms.

Perlick et al (2008) using the same sample then tried to determine if there was a relationship between stigma and a negative health effect. The analysis clustered the caregivers into three groups burdened, effective and stigmatized. Those found in the stigmatized cluster reported higher levels of stigma, less control over the events in their lives and higher burden than the individuals in the effective cluster. The stigmatised cluster also demonstrated poorer health practices. These profiles seem to be reasonably stable over time as almost two thirds of carers remained in the same profile a year later.



Poster References

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