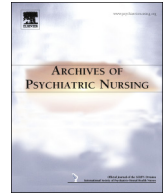




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Effectiveness of Psychoeducation in Reducing Internalized Stigmatization in Patients With Bipolar Disorder

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A B S T R A C T

This research was conducted as an experiment–control experimental study which aimed to determine the effectiveness of a psychoeducation program prepared to reduce internalized stigmatization. The study included 47 patients (24 experimental, 23 control) who had been diagnosed with bipolar disorder. At the end of the psychoeducation program, a significant decrease was observed in the total ISSMI mean scores, as well as in the ISSMI subscale mean scores for subscales such as alienation, approval of stereotypes, perceived discrimination and social withdrawal ($p < 0.05$). The results demonstrated that a psychoeducation program designed for internalized stigmatization may have positive effects on the internalized stigmatization levels of patients with bipolar disorder.

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Individuals with marked mental disorder usually display their difference from the rest of the society through words and gestures; and this difference causes discrimination in society towards these individuals. In every epoch of history, other people have failed to make sense of these individuals' words, thoughts and gestures, and therefore considered them to be dangerous and harmful for their environment (Bahar, 2007).

It is observed that once individuals are referred to a psychiatrist and are diagnosed with a mental disorder, they feel stigmatized although they are not exposed to explicit discrimination. These patients experience embarrassment, a sense of insufficiency, an increase in negative automatic thoughts, withdrawal from social relationships, and a decrease in their self-esteem (Taşkın, 2007a).

It has been reported that a negative outcome depends on the internalization of stigmatic beliefs and the meaning that patients attach to their illness. While some patients believe that they no longer have the ability to achieve valued social roles, others disagree, remain hopeful and engage in active coping. The post-diagnostic identity of patients with mental illness has two dimensions; one of them is the amount of identification with a community of people with severe mental illness, and the other is the amount of stigma that is internalized in the self narrative. Patients with high identification but low internalized stigma are assumed to be socially active and to not experience diminished self-esteem (Staring, Van de Gaag, Van den Berge, Duivenvoorden, & Mulder, 2009).

Internalized stigmatization is a condition experienced extensively by one in three people with severe mental illness. Internalized stigmatization or self-stigmatization refers to a process in which the individual with a mental illness adopts and internalizes the stigmatizing opinions of the society, such as dangerousness and insufficiency; and it includes low self-esteem and poor social relationships (Werner, Aviv, & Barak, 2007).

The objective behaviors of stigmatization are discrimination and exclusion. With stigmatization it is emphasized that individuals or groups who are stigmatized are different from us, and due to this difference, a lot of negative features are attributed to these people. Perceived stigmatization is the feeling of stigmatization and social exclusion which emerges as a result of individuals' diagnosis of mental illness and is independent from objective experiences such as stigmatizing and excluding. As a result of internalized stigmatization, the sick person begins to think that it is the society that stigmatizes and excludes him/her. This in turn causes the patient to experience a feeling of stigmatization. The individual begins to make some negative judgments about his/her own condition without any concrete evidence, and thinks that the society devalues him/her and stigmatizes and excludes him/her because of his/her illness. The behavior of others is perceived as discrimination and exclusion, either when intended or unintended. Nevertheless, the main determinant of the feeling of stigmatization is one's internalized tendency of stigmatization (Taşkın, 2007b).

Bipolar disorder is known and stigmatized by society relatively less than other disorders, yet patients report experiencing an intense feeling of stigmatization (Aydemir, 2004).

It has been reported given in the literature that bipolar patients present lower rates of autonomy and fewer interpersonal relationships than individuals without bipolar disorder, and such difficulties

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may lead to embarrassment and discrimination among bipolar patients which in turn contributes to high levels of perceived stigma. Stigma-related impairment in functioning could result from the avoidant coping strategies such as withdrawal and behavioral avoidance that bipolar disorder patients may use as a strategy to avoid people from outside their family. Bipolar patients with concerns about stigmatization may adapt their social behavior to avoid exposure to rejection or discrimination (Cerit, Filizer, Tural, & Tufan, 2012; Vazquez et al., 2011).

Developing awareness is the essential focus of a successful psychoeducation program for this illness and reducing stigmatization. Many patients have negative myths in their minds about this illness. This causes them to experience additional difficulties in coping with their diagnosis and complying with the treatment (Colom & Vieta, 2004). Internalized stigmatization may decrease once individuals acquire research-based information on how to resist this feeling. Educating individuals with internalized stigmatization on mental illnesses has been shown to help them cope with negative beliefs (Watson & Corrigan, 2010).

Psychoeducational interventions generally emphasize the presentation of factual information about mental illness and treatment in order to address misperceptions, and these interventions generally provide optimistic messages about the treatability of mental health problems. For individuals already in treatment, stigma-focused psychoeducation can decrease perceived stigmatization (Alvidrez, Snowden, Rao, & Boccelari, 2009).

According to the results of a systematic literature review of the psychotherapeutic and psychosocial approaches to bipolar disorder (Cakir & Özerdem, 2010), psychoeducation, family-focused therapies and CBT have benefits in terms of the prevention of manic or depressive episodes, medication compliance, the number and duration of hospitalizations and the time to recurrence. Eker and Harkin (2012) used psychoeducation for 6 weeks, 2 hours/week to evaluate the adherence to treatment in bipolar disorder patients, and they found that adherence in the intervention group increased significantly.

Several studies discuss reducing internalized stigmatization in patients with mental illness. Macinnes and Lewis (2008) used a structured program using cognitive therapy with psychoeducational input of 6 sessions with schizophrenia patients and found a significant reduction in stigma. Alvidrez et al. (2009) used psychoeducation for 3 months (plus or minus 14 days) and determined that stigma reduced. Yanos, Roe, and Lysaker (2011) used a combination of psychoeducation (3 weeks), cognitive restructuring (8 weeks) and narrative enhancement (8 weeks) with mental illness patients and reported that internalized stigma reduced. Parikh et al. (2012) used cognitive behavioral therapy and psychoeducation (20 sessions of CBT, 6 sessions of psychoeducation) and found that psychoeducation showed greater clinical benefit compared to cognitive behavioral therapy.

The aim of this study was to determine the effectiveness of a psychoeducation program designed to reduce internalized stigmatization in patients diagnosed with bipolar disorder.

MATERIAL AND METHODS

Design

This research was conducted as a controlled experimental study to determine the effectiveness of a psychoeducation program prepared to reduce internalized stigmatization.

Sample

The sample of the study was 63 outpatients who consented to participate to this study. Patients were assigned to groups as 32 for the

intervention group and 31 for the control group. However, 8 patients from the intervention group and 8 patients from the control group discontinued the psychoeducation sessions due to various reasons. Therefore, the final study group consisted of 47 outpatients: 24 intervention, 23 control. Having performed a pilot study, power analysis was based on the results of the study. The power calculations suggested that 24 intervention patients and 23 control patients would be sufficient based on a power calculation of 94% and a significance level of 5%.

In order to ensure homogeneity between the intervention and control groups in terms of characteristics that may affect the result of the study, matching and randomization methods were used together in this study. For this, first a pretest was done with all patients who had agreed to participate in this study. Using the pretest results, we separated the patients according to their characteristics (gender, age, education level, etc.), and patients with matching characteristics were randomly assigned to groups. Each patient was numbered and assigned to a group using a random table of numbers. The inclusion criteria for the study were; having a bipolar disorder diagnosis, being 18–65 years old, being in remission, receiving outpatient treatment, and having no problems with communication. Exclusion criteria were; having psychiatric diseases except bipolar disorder, having communication problems, receiving in-patient treatment and being in an episode (mania, hypomania, mixed or depressive).

Ethical Considerations

Approval to conduct the research was received from the Scientific Ethics Committee of Ege University Nursing School. Administrative approval was received from two hospitals in Turkey. Patients gave informed consent after receiving information and having their questions answered.

Measurements

Individual Identification Form

The form, which was developed by the researcher, included 17 questions about the sociodemographic characteristics of the patients and their illness.

Internalized Stigmatization Scale of Mental Illnesses (ISSMI)

The Internalized Stigma of Mental Illness Scale (ISSMI) developed by Boyd-Ritsher, Otilingam & Grajales (2003) was designed to measure the subjective experience of stigma. The items are rated on a 4-point Likert-type scale, ranging from strongly disagree to strongly agree. High scores in the ISSMI indicate that internalized stigmatization is more severe in the individual. The reliability and validity study of the Turkish version of the ISSMI was conducted by Ersoy and Varan (2007). The scale has five subscales which are alienation, approval of stereotypes, perceived discrimination, social withdrawal and resistance against stigmatization. The Cronbach alpha value of the scale was found to be .90 for the English form, .93 for the Turkish form, and .83 for this study (Boyd-Ritsher and Phelan, 2003, Ersoy & Varan, 2007).

Bipolar Disorder Functioning Questionnaire (BDFQ)

The Bipolar Disorder Functioning Scale (BDFQ) was developed by Aydemir et al. (2007), and it was designed to measure the subjective experience of functionality of patients with bipolar disorder. The validity and reliability study of the scale was conducted by Aydemir et al. The items are rated on a 3-point Likert-type scale. High scores in the BDFQ indicate higher functionality. The scale consists of subscales of emotional functioning, mental functioning, sexual functioning, feeling of stigmatization, introversion, domestic relationships, relationships with friends, participation in social activities, daily activities and hobbies, taking initiative and using one's potential,

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