

Accepted version:

Pascual-Sanchez, A., Jenaro, C., & Montes, J. M. (2020). Understanding social withdrawal in euthymic bipolar patients: The role of stigma. *Psychiatry Research*, 284, 112753.

Link to official URL:

<https://doi.org/10.1016/j.psychres.2020.112753>

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Understanding social withdrawal in euthymic bipolar patients: The role of stigma

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Full reference: Pascual-Sanchez, A., Jenaro, C., & Montes, J. M. (2020). Understanding social withdrawal in euthymic bipolar patients: The role of stigma. *Psychiatry Research*, 284, 112753.
<https://doi.org/10.1016/j.psychres.2020.112753>

Abstract

Social withdrawal acts as a risk factor in mental health, disturbing clinical management and quality of life in euthymic bipolar patients. However, no previous study has analyzed what variables might predict it. We conducted a cross-sectional study in which 49 euthymic bipolar patients were assessed. The analysis showed that taken together, stereotype endorsement, discrimination experience and control over illness as measured by the ISMI, together explained 80.4% of the variability in social withdrawal. In conclusion, an early assessment of selfstigma and perception of control over illness would help euthymic patients to improve their social situation, reducing social withdrawal.

Keywords: Social withdrawal; Self-stigma; Bipolar disorder

1. Introduction

Remitted bipolar patients may experience impairment in daily functioning and low quality of life due to residual symptoms (Henry et al., 2013; Kaya et al., 2007; Martín-Subero et al., 2014; Michalak et al., 2005; Pascual-Sanchez et al., 2019). Social status, together with physical and emotional status, is a relevant domain of quality of life, and is, to a great extent, a subjective experience (Dickerson et al., 2011; Pascual-Sanchez et al., 2019).

Social issues are common among people with mental illness, and these issues are also related to other impairments. For example, social withdrawal has been found as predictor of a higher use of hospitalization resources and outpatient attention in people with mental health problems (Bellido-Zanin et al., 2017). In fact, social withdrawal can act as risk factor of mental health issues, since those who suffer social withdrawal are more likely to transit from a subsyndromal state to a major mental health condition (Cross et al., 2017). Social withdrawal can also have a great impact in bipolar patients, increasing their risk of suicide (Halfon et al., 2013) and making medical prescription more complicated, requiring higher doses of medication (Larsen-Barr et al., 2018). Evidence shows that patients with bipolar disorder

(BD) have poor functioning in terms of social withdrawal (Tigli Filizer et al., 2016).

Social withdrawal can also be understood as a consequence of self-stigma experiences. That is, the way patients integrate their beliefs, prejudices and stigmatizing behaviors, can lead them to suffer a great degree of guilt, shame, social withdrawal and abandonment of personal goals (Richard-Lepouriel, 2015). In fact, a recent study (Grover et al., 2016) showed that social withdrawal, discrimination experience, and alienation help predict are associated with self-stigma. Also, in Europe it is estimated that, approximately 1 in 5 people with BD express a significant degree of self-stigma (Brohan et al., 2011). Subjective experience plays a significant role for those issues in euthymic patients; negative thinking patterns related to how they and others perceive their image can affect the perception of support (Poradowska-Trzos et al., 2008).

With this in mind, it is of interest to know what variables are closely related to social withdrawal in bipolar patients, in order to promote early detection and intervention. Nevertheless, to the best to our knowledge, no previous studies have analyzed how stigma and functioning variables might predict social withdrawal in euthymic bipolar patients. Therefore, the aim of this study is to identify key variables that predict social withdrawal. We expect to find predictors related with self-stigma.

2. Methods

2.1. Participants

A sample of 49 bipolar outpatients was recruited at the Ramón y Cajal Hospital, Spain. The sample was drawn from patients who came to a regularly scheduled visit and were willing to give informed consent. Outpatients aged 27 to 72 years (mean= 50.02 ± 11.84); 67.3% were female. Average years with BD was 23.01 (sd=11.33, range: 3 to 52). The average age of onset was 26.94 years (sd=10.18; range: 12 to 56). The time since the last relapse averaged 2.87 years (sd=4.91; range: 0.10 to 20). Other sociodemographic data are given in Table 1. For inclusion in the study, participants had to score ≤7 on both the Young Mania Rating Scale (YMRS) (Colom et al., 2002) and the Hamilton Depression Scale (HAM-D) (Lobo et al., 2002) to ensure euthymic state, and they should have been

euthymic for at least one month. Patients with co-morbid diagnoses of personality disorder and substance abuse, as well as those with concomitant chronic physical pathologies were excluded from the current study.

2.2. Design and procedure

This is a cross-sectional study with an ex-post facto design. After receiving the approval of the Ramon y Cajal Hospital Ethics Committee, a socio-demographic questionnaire, the YMRS (Colom et al., 2002) and HAM-D (Lobo et al., 2002) scales were applied to verify euthymia. Next, four other scales were applied: the FAST (Rosa et al., 2007) scale to assess functioning, the ISMI (Boyd Ritsher et al., 2003) to assess factors associated with self-stigma (including social withdrawal), the PBIQ (Birchwood et al., 2012) to assess negative beliefs concerning BD and the DISBIP-S (Short Distress Scale for Bipolar Disorder) (Pascual-Sánchez et al., 2019). Previously, informed consent was required and confidentiality was guaranteed to the participants.

2.3. Instruments

2.3.1. Sociodemographic data

A questionnaire was used to collect these data.

2.3.2. Mood symptoms

To assess euthymia, the Spanish version of the Young Mania Rating Scale (YMRS) (Colom et al., 2002), and the Hamilton Depression Scale (HAM-D) (Lobo et al., 2002) were used. Both of them have shown high construct validity and reliability (YMRS Cronbach's $\alpha=0.88$; YMRS Cronbach's $\alpha=0.89$).

2.3.3. Functioning

Functioning at different levels was assessed with the Functioning Assessment Short Scale (FAST) (Rosa et al., 2007), which is a brief instrument designed to assess the main functioning problems experienced by bipolar patients; it has good construct validity and reliability (Cronbach's $\alpha=0.91$). It comprises 24 items that assess impairment or disability in six specific areas of functioning: (1) Autonomy, (2) Occupational functioning, (3) Cognitive functioning, (4) Financial issues, (5) Interpersonal relationships, and (5) Leisure time. The higher the scores, the worse the functioning.

2.3.4. Stigma

Stigma was measured by the Internalized Stigma of Mental Illness (ISMI) (Boyd Ritsher et al., 2003) composed of five subscales measuring: (1) Alienation (2) Stereotype endorsement (3) Discrimination Experience (4) Social withdrawal, and (5) Stigma resistance. The ISMI has shown high construct validity and reliability (Cronbach's alpha=0.90).

2.3.5. Personal beliefs

Personal beliefs were measured by the Personal Beliefs about Illness Questionnaire (PBIQ) (Birchwood et al., 2012), which has five scales: (1) Self as illness (2) Control over illness, that assesses the extent to which patients believe that they can take the control of it; (3) Stigma (4) Social containment (5) Expectations. The PBIQ has shown high construct validity and reliability (Cronbach's alpha=0.72-0.81).

2.3.6. Distress

To assess perceived distress by BD patients, the DISBIP-S (Short Distress Scale for Bipolar Disorder) (Pascual-Sánchez et al., 2019) was used. It evaluates: (1) Cognitive distress (2) Interpersonal distress (3) Management of the disease. DISBIP-S has shown good content and construct validity, as well as good reliability (Cronbach's alpha=0.90).

2.4. Statistical analysis

IBM@ SPSS@ v.23 was utilized for the analysis. T-tests were conducted to explore differences by gender. Correlation test were used before regression test, to decide which variables should be included. Stepwise multiple linear regression analysis was used.

3. Results

To identify the variables that best predict social withdrawal, we performed a multiple regression analysis with the score on social withdrawal (ISMI dimension) as the dependent or predicted variable and with time since last relapse, predominant polarity, and the scores of some dimensions of FAST, ISMI, PBIQ and DISBIP-S as independent or potentially predictor variables. The F-ratio in the ANOVA tests was significant [$R^2=80.4$, $F(3, 26) = 35.479$, $p < 0.001$]. Table 2 depicts the Model summary.

As can be noted, taken together the predictors stereotype endorsement, discrimination experience and control over illness together explain 80.4% of the variability in social withdrawal, as measured by the ISMI. The variable

with the highest explanatory power was stereotype endorsement (62.9% of the variability), followed by discrimination experience and Control over illness. In sum, self-stigma variables together with the perception of control over illness help explain a significant amount of social withdrawal.

No differences ($p > .05$) were found regarding gender in any of the variables tested as predictors.

4. Discussion

The main goal of this study was to identify variables that help explain social withdrawal commonly found in patients with bipolar disorder, even when they are euthymic. As mentioned earlier, such social withdrawal may be at the root of perceived low quality of life and of additional issues such as low adherence to treatment, higher use of hospitalization resources, etc. This research helps overcome a gap in the existing literature regarding predictors of social withdrawal in BD patients even when euthymic.

As in previous studies with mental health patients, social withdrawal and self-stigma are strongly related, ~~as well as discrimination experience~~ (Grover et al., 2016). In that study, 28.6% of patients with social withdrawal showed moderate or high levels of self-stigma, and high correlations were found between social withdrawal and stigma related variables such as stereotype endorsement ($r=0.772$) or discrimination experience ($r=0.882$), as in our study, but regression analyses were not conducted. Moreover, a recent study with patients with depression (Bharat et al., 2019) has found a negative association between subjective social status and stigma, which is congruent with our findings. Brohan et al. (2011), explained that alienation, stereotype endorsement, social withdrawal and discrimination experience explained most of the overall self-stigma scores in patients with mood disorders, suggesting that a 'feeling of separateness' might be a common factor to consider in self-stigma. However, we did not find alienation as a predictor of social withdrawal in particular, but stereotype endorsement and discrimination experience explained around 75% of the social withdrawal variance, which would support this hypothesis.

Furthermore, previous studies suggest that perceived control over the illness was positively associated to different areas of quality of life, including social issues (Kravetz et al., 2000), which is congruent with the explanatory role of

the perception of control over illness in social withdrawal found in our study. In line with this, a significant decrease of self-efficacy has been found in patients who internalize stigma and this may interfere with the course of their illness and social participation (Corrigan et al., 2013). In fact, since some studies considered that self-stigma may hinder social inclusion, it was suggested that stigma-oriented interpersonal approaches be recommended for euthymic patients (Tigli Filizer et al., 2016). Moreover, promoting empowerment as a way to improve control over illness is receiving more attention in self-management interventions in mental health patients (Fortuna et al., 2018).

This study has several practical implications. First, an early assessment of self-stigma and perception of control over illness would help euthymic patients to improve their social situation, reducing social withdrawal. Second, due to its association with clinical outcomes (such as quality of life, adherence to treatment, required doses of medication, number of hospitalizations or risk of suicide), the improvement on these variables could lead to better clinical management, helping to design and promote specific interventions for BD patients.

Several limitations should be noted. First, participants were euthymic, so conclusions cannot be generalized to those patients who are not stabilized. Second, the sample size was limited, so future studies should include larger samples to verify current findings.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

- Bharat, V., Habarth, J., Keledjian, N., Leykin, Y., 2019. Association between subjective social status and facets of depression self-stigma. *J Community Psychol* 26.
- Bellido-Zanin, G., Vazquez-Morejon, A.J., Martin-Rodriguez, A., Perez-San-Gregorio, M.A., 2017. Predictors in use of mental health resources: The role of behaviour problems in patients with severe mental illness. *Int J Soc Psychiatry* 63 (6), 532-538.

- Birchwood, M., Jackson, C., Brunet, K., Holden, J., Barton, K., 2012. Personal beliefs about illness questionnaire-revised (PBIQ-R): reliability and validation in a first episode sample. *Br J Clin Psychol* 51 (4), 448-458.
- Boyd Ritsher, J., Otilingam, P.G., Grajales, M., 2003. Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research* 121 (1), 31-49.
- Brohan, E., Gauci, D., Sartorius, N., Thornicroft, G., Group, G.A.-E.S., 2011. Self-stigma, empowerment and perceived discrimination among people with bipolar disorder or depression in 13 European countries: the GAMIAN-Europe study. *J Affect Disord* 129 (1-3), 56-63.
- Colom, F., Vieta, E., Martinez-Aran, A., Garcia-Garcia, M., Reinares, M., Torrent, C., Goikolea, J.M., Banus, S., Salamero, M., 2002. [Spanish version of a scale for the assessment of mania: validity and reliability of the Young Mania Rating Scale]. *Med Clin (Barc)* 119 (10), 366-371.
- Corrigan, P.W., Kosyluk, K.A., Rusch, N., 2013. Reducing self-stigma by coming out proud. *Am J Public Health* 103 (5), 794-800.
- Cross, S.P.M., Scott, J., Hickie, I.B., 2017. Predicting early transition from sub-syndromal presentations to major mental disorders. *BJPsych Open* 3 (5), 223-227.
- Dickerson, F., Wohlheiter, K., Medoff, D., Fang, L., Kreyenbuhl, J., Goldberg, R., Brown, C., Dixon, L., 2011. Predictors of quality of life in type 2 diabetes patients with schizophrenia, major mood disorder, and without mental illness. *Qual Life Res* 20 (9), 1419-1425.
- Fortuna, K.L., DiMilia, P.R., Lohman, M.C., Bruce, M.L., Zubritsky, C.D., Halaby, M.R., Walker, R.M., Brooks, J.M., Bartels, S.J., 2018. Feasibility, Acceptability, and Preliminary Effectiveness of a Peer-Delivered and Technology Supported Self-Management Intervention for Older Adults with Serious Mental Illness. *Psychiatr Q* 89 (2), 293-305.
- Grover, S., Hazari, N., Aneja, J., Chakrabarti, S., Avasthi, A., 2016. Stigma and its correlates among patients with bipolar disorder: A study from a tertiary care hospital of North India. *Psychiatry Res* 244, 109-116.
- Halfon, N., Labelle, R., Cohen, D., Guile, J.M., Breton, J.J., 2013. Juvenile bipolar disorder and suicidality: a review of the last 10 years of literature. *Eur Child Adolesc Psychiatry* 22 (3), 139-151.
- Henry, B.L., Minassian, A., Perry, W., 2013. Everyday functional ability across different phases of bipolar disorder. *Psychiatry Research* 210 (3), 850-856.

- Kaya, E., Aydemir, O., Selcuki, D., 2007. Residual symptoms in bipolar disorder: the effect of the last episode after remission. *Prog Neuropsychopharmacol Biol Psychiatry* 31 (7), 1387-1392.
- Kravetz, S., Faust, M., David, M., 2000. Accepting the mental illness label, perceived control over the illness, and quality of life. *Psychiatric Rehabilitation Journal* 23 (4), 323-332.
- Larsen-Barr, M., Seymour, F., Read, J., Gibson, K., 2018. Attempting to stop antipsychotic medication: success, supports, and efforts to cope. *Soc Psychiatry Psychiatr Epidemiol* 53 (7), 745-756.
- Lobo, A., Chamorro, L., Luque, A., Dal-Ré, R., Badia, X., Baró, E., 2002. Validation of the Spanish versions of the Montgomery-Asberg Depression Rating Scale and the Hamilton Anxiety Rating Scale for the assessment of depression and anxiety. *Medicina Clínica* 118 (13), 493-499.
- Martín-Subero, M., Berk, L., Dodd, S., Kamalesh, V., Maes, M., Kulkarni, J., De Castella, A., Fitzgerald, P.B., Berk, M., 2014. Quality of life in bipolar and schizoaffective disorder--a naturalistic approach. *Comprehensive Psychiatry* 55 (7), 1540-1545.
- Michalak, E.E., Yatham, L.N., Lam, R.W., 2005. Quality of life in bipolar disorder: a review of the literature. *Health Qual Life Outcomes* 3, 72.
- Pascual-Sanchez, A., Jenaro, C., Montes-Rodriguez, J.M., 2019. Quality of life in euthymic bipolar patients: A systematic review and meta-analysis. *J Affect Disord* 255, 105-115.
- Pascual-Sánchez, A., Montes-Rodríguez, J.M., Jenaro-Río, C., Saiz-Ruiz, J., 2019. Validation of a brief scale for the assessment of distress associated to bipolar disorder. *The European Journal of Psychiatry* 33 (1), 32-37.
- Poradowska-Trzos, M., Dudek, D., Rogoz, M., Zieba, A., 2008. [Perception of social support in the aspect of a cognitive style of patients with affective disorders]. *Psychiatr Pol* 42 (2), 271-282.
- Richard-Lepouriel, H., 2015. [Bipolar disorders and self-stigma]. *Rev Med Suisse* 11 (486), 1696, 1698-1701.
- Rosa, A.R., Sanchez-Moreno, J., Martinez-Aran, A., Salamero, M., Torrent, C., Reinares, M., Comes, M., Colom, F., Van Riel, W., Ayuso-Mateos, J.L., Kapczinski, F., Vieta, E., 2007. Validity and reliability of the Functioning Assessment Short Test (FAST) in bipolar disorder. *Clin Pract Epidemiol Ment Health* 3 (5).

Tigli Filizer, A., Cerit, C., Tuzun, B., Aker, A.T., 2016. Social Aspect of Functioning Deteriorates More Than Individual Aspect in Patients with Remitted Bipolar Disorder. *Noro Psikiyatr Ars* 53 (2), 158-162.

Table 1. Sociodemographic and clinical data.

Variables	Category	N	%
<i>Sociodemographic data</i>			
Sex	Male	16	32.7
	Female	33	67.3
Cohabitation	Alone	13	26.5
	With family of origin	10	20.4
	With own family	25	51.0
	Other	1	2.0
Marital status	Single	15	30.6
	Married	19	38.8
	Divorced	14	28.6
	Widow	1	2.0
Academic level	Elementary School or less	6	12.2
	Middle School	19	38.8
	University	24	49
Employment status	Employed	21	42.9
	Unemployed	9	18.4
	Pensioner	19	38.8
<i>Clinical variables</i>			
Diagnosis	BD I	31	66.3
	BD II	18	36.7
Predominant polarity	Manic	18	36.7
	Depressive	31	63.3
Admissions in Psychiatry	None	16	32.7
	1-2	14	28.6
	3-5	13	26.5
	6-9	2	4.1
	≥10	4	8.2

Table 2. Model summary^a

Model	Predictors	R	R ²	Adj R ²	SE of the estimate	R ² change	F change
1	Stereotype endorsement	0.793	0.629	0.616	0.42	0.629	47.52**
2	Stereotype endorsement and discrimination experience	0.869	0.754	0.736	0.35	0.125	13.76**
3	Stereotype endorsement, discrimination experience and control over illness	0.896	0.804	0.781	0.32	0.049	6.53*

~~a. Predictors: (Constant), stereotype endorsement; b. Predictors: (Constant), stereotype endorsement and discrimination experience; c. Predictors: (Constant), stereotype endorsement, discrimination experience and control over illness~~

^a Dependent variable: Social withdrawal

*p<0.05; **p<0.01