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ARAŞTIRMA/ RESEARCH

'I'm not a Schizophrenic!' Qualitative Research on the Life Stories of Women Diagnosed with Schizophrenia and Bipolar Disorder

"Ben Şizofren Değilim!": Şizofreni ve Bipolar Bozukluk Tanısına Sahip Kadınların Yaşam Öyküleri Üzerine Nitel Araştırma

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Abstract

Objective: Making the life stories of women diagnosed with schizophrenia and bipolar disorder visible with a feminist social work approach.

Material and Methods: In this study, narrative research with qualitative research method was used. In-depth semi-structured interviews were conducted with 12 women who were selected according to the purposive sampling method. The data were analyzed using thematic content analysis method and the MAXQDA 20 program.

Results: In the content analysis of the data, three life focus themes emerged when the life stories of women with schizophrenia and bipolar diagnosis were analyzed according to the feminist social work perspective. These themes are especially the *pre-diagnosis, diagnosis,* and *post-diagnosis* experiences of women regarding their disease. In addiction to these themes, women's *future expectations* and *recommendations* were also analyzed.

Conclusion: When the life stories of women were analyzed, it was seen that they have been systematically exposed to the pressures of the patriarchal system from childhood to present. Gender-based role expectations, which started first in the family, continued increasingly in their married life. After being diagnosed with the disease, they self-stigmatized by isolating themselves from their social circles and had difficulties in participating in public life. The roles that they could not fulfill due to their diseases create pressure on women.

Keywords: Feminist social work, women, psychiatric social work, schizoprenia-bipolar disorder, qualitative research, narrative research.

Öz

Amaç: Şizofreni ve bipolar bozukluk tanısına sahip kadınların yaşam öykülerinin feminist sosyal hizmet yaklaşımı ile görünür kılınmasıdır.

Gereç ve Yöntem: Araştırmada nitel araştırma yöntemi kapsamında anlatı araştırması kullanılmıştır. Amaçsal örnekleme yöntemine göre belirlenen 12 kadın ile yarı yapılandırılmış form aracılığı ile derinlemesine görüşme yapılmıştır. Veri analizi, tematik içerik analizi yöntemi ile MAXQDA20 programı kullanılarak gerçekleştirilmiştir.

Bulgular: Verilerin içerik analizinde feminist sosyal hizmet bakışına göre şizofren ve bipolar tanısına sahip kadınların yaşam öyküleri analiz edildiğinde üç hayat odağı tema olarak karşımıza çıkmıştır. Bu temalar özellikle kadınların hastalıklarına yönelik *tanı öncesi, tanı sırası* ve *tanı sonrası* yaşadıkları deneyimlerdir. Bunlarla birlikte kadınların *gelecekten beklentileri* ve *önerileri* de analiz edilmiştir.

Sonuç: Kadınların yaşam öyküleri analiz edildiğinde çocukluklarından şu anki yaşamlarına kadar sistematik olarak ataerkil sistemin baskısına maruz kaldıkları görülmüştür. Özellikle ilk aile deneyiminde başlayan toplumsal cinsiyete dayalı rol beklentileri evlilik hayatlarında da artarak devam etmiştir. Sahip oldukları hastalıkların tanısı konulduktan sonra da öncelikle kendilerini sosyal çevrelerinden uzaklaştırarak damgalamışlar, kamusal hayata katılımda zorluklar yaşamışlardır. Hastalıkları nedeni ile gerçekleştiremedikleri kadınlık rolleri kadınlar üzerinde baskı unsuru oluşturmuştur.

Anahtar Kelimeler: Feminist sosyal hizmet, kadın, psikiyatrik sosyal hizmet, şizofreni-bipolar bozukluk, nitel araştırma, anlatı araştırması.

1. Introduction

Inequalities between women and men in the world and Turkey are encountered in various ways. When the societies are examined based on gender, it is seen that women and men are attributed to different characteristics and women are associated with the secondary position. Schizophrenia is an illness that affects all cognitive functions of individulas, their emotions, their movements. It can lead to insufficiency in many areas such as working life, interpersonal relationships, self-care, and life skills. It can be predicted that women with mental illness are excluded from social life and are in a secondary position because they are female and have mental illness as well (1).

We can put forward the reason for the need for this study as follows: When the literature is examined, it is seen that the position of women in society is an intensively investigated topic, and the inequalities women experience and the gender discrimination they are exposed to are discussed in many studies (2, 3). However, there is only one study (4) that investigated the experiences of the women diagnosed with schizophrenia and bipolar disorder, the inequalities they experience, and the gender discrimination they are exposed to. For this reason, this study makes the life experiences of women diagnosed with schizophrenia and bipolar disorder visible.

1.1. The Situation in Turkey

People diagnosed with schizophrenia and bipolar disorder in Turkey can receive services from the Community Mental Health Centers (CMHC) affiliated to Turkish Ministry of Health. As of February 2020, there were 177 CMHC (5) in Turkey. Official statistics on the people with a general diagnosis of schizophrenia and bipolar disorder are not available. Some non-governmental organizations provide information about the number of people diagnosed with schizophrenia and bipolar disorder. According to one NGO, there are more than 500 thousand individuals with schizophrenia and bipolar disorder in Turkey (6). The total number of women diagnosed with schizophrenia and bipolar disorder has also been unknown, as the official statistics have not been released.

1.2. Schizophrenia and Feminist Social Work

There is a need to examine the status of being a schizophrenic and bipolar woman from a feminist social work perspective. The main goal of social work is to increase the well-being of its clients in every sense via the applied practices (7).

Due to patriarchy, women are pushed out of the public sphere and women's lives are limited to home and family (8). In this context, empowerment is one of the main themes of feminist social work (9). Therefore, the issue of what kind of changes, pressures, fears, and anxieties created by both being a woman and having schizophrenia and bipolar disorder needs to be investigated in depth from a feminist approach.

The aim of this narrative research is to examine in-depth the life stories of women diagnosed with schizophrenia and bipolar disorder who receive service from CMHCs from the feminist social work perspective. To this end, we ask the following questions: What were the life experiences of women with schizophrenia and bipolar disorder before the diagnosis? What did they experience during the diagnosis and treatment? What are their post-diagnosis experiences? What do they expect from the future?

2. Material and Methods

This study was planned with a qualitative research design as it aimed to examine in depth the life stories of women with schizophrenia and bipolar disorder from a feminist social work perspective. The qualititaive research approach allowed the women to reveal their experiences in an appopriate way (1).

In this context, narrative research is defined as the process of narrating 'an illness' chronologically, according to the milestones (10) or life histories (11,12). Narrative research is used for in-depth understanding and description of human life experiences (13). In this study, the purpose of using the narrative approach was to narrate the individual experiences of women diagnosed with schizophrenia and bipolar disorder and to make them visible according to the chronological milestones.

Approval for the study was obtained from Non-interventional Research Ethics Board, and then from the CMHC where the study was conducted. In addition, the principles of Declaration of Helsinki and the rules of National Association of Social Workers Code of Ethics were respected while conducting the research. Each participant was informed about the research and their consent was obtained. The names of all participants were anonymized.

2.1. Identiying the Participants

Participants in this study were identified according to the purposeful sampling method. Maximum diversity sampling, which is a purposeful sampling technique, was used. When the general profile of the patients who receive service from CMHCs in Turkey during this application process has been examined, it is observed that people from different socio-economic and educational backgrounds, ages, professions, and experiences receive service from these centers. In this context, the diversity in age, educational status and marital status were taken into consideration in the study. The existence of a heterogeneous structure among clients is an extremely important opportunity for research. For this reason, 12 women who received service from CMHC and volunteered to take part in the study participated in the research. The demographic information of these women can be found in Table 1.

Table 1. Demographic Information of Participants

Interviewees	Diagnosis	Age	Education	Marital Status	Children	Length of interview (minutes)	Date of interview
1	B	60	PS	M	3	95	6.11.2019
2	S	38	PS	D	1	30	7.11.2019
3	B	46	PS	M	1	80	8.11.2019
4	S	30	HS	D	1	62	11.11.2019
5	B	60	HS	M	2	55	12.11.2019
6	S	29	AD	S	0	60	13.11.2019
7	S	30	AD	S	0	95	14.11.2019
8	S	32	BD	S	0	50	15.11.2019
9	B	40	HS	M	0	60	18.11.2019
10	B	47	PS	M	3	100	11.11.2019
11	B	49	HS	D	0	70	19.11.2019
12	S	46	PS	S	0	85	20.11.2019

Diagnosis B: Bipolar, S: Schizophrenia; Education PS: Primary School, HS: High School, AD: Associate degree, BD: Bachelor's degree; Marital Status M: Married, D: Divorced, S: Single.

2.2. Creating Data

Everything that the women said and that was observed during the interview formed the data sources of this research. The interview form is prepared with the aim of obtaining the same type of information from different people by addressing similar issues (14). This interview approach includes the list of information and questions to be obtained during the interview and gives the researcher the freedom to ask additional questions (15). The data obtained from the semi-structured in-depth interviews consist of evaluation reports to be kept after the interviews, voice recordings used during the interview, and participant's observation.

Each woman was interviewed in the CMHC's rooms where confidentiality was protected and they felt safe, and the participants were informed that the interviews would be kept confidential. Interviews lasted about two hours. Each interview was recorded with the consent of the participants.

The women had difficulty expressing their feelings due to their illness and long silences ensued. In addition, while answering the questions, they change the subject. Therefore, when researchers conduct research with women, their trust should be gained first. Otherwise, the participants would not meet with the researchers they meet for the first time and do not know. Thus, the researchers spent 4 months at CMHC prior to this study. They communicated with the women at the institution and participated in different events. Consequently, they established trusting relationships with the women.

Social worker (author 6) conducted interviews with women. Psychiatrist (author 5) of the center was present as an observer to make the patients feel safe and to intervene in the crises that may develop during the interview.

2.3. Analysis of Data

Thematic content analysis method was used in the analysis of the data. The main purpose of content analysis is to reach concepts and relationships that can explain the data (16). As noted in the literature, narrative stories focus on participants' life experiences and can be analyzed in a variety of ways, including thematic, structural, dialogic, and visual. Additionally, the narratives are narrated in a chronological order (13, 17). This study is first to examine the experiences of women with schizophrenia-bipolar disorder with narrative research.

MAXQDA20, a computer software program that helps the researcher to systematically evaluate and interpret qualitative texts, was used in the analysis of the data (18). After the voice recordings of life stories of the women were transcribed, they were coded by the authors (1, 2, 3) by reading them line by line, and the subcodes were created. After the subcodes, themes were identified. The themes were also structured based on women's life stories. They were analyzed specifically from the feminist social work perspective. Therefore, female experiences of gender, patriarchy, and power/powerlessness constituted the key concepts used in examining the women's lives. All sub- and main themes identified in this process can be seen in Table 2.

2.4. Validity, Reliability and Ethical Issues of the Research

The study was approved by the Non-Interventional Clinical Research Ethics Committee of İzmir Katip Celebi University with the date of 27.03.2019 and decision number 150. In addition, the principles of the Declaration of Helsinki and the Ethics Rules of the National Society of Social Workers were followed while conducting the research. All participants were informed about the study and informed consents were obtained. The names of the participants were anonymized and abbreviated as *"Participant 6-S-29-S-B"*. While forming the interview questions, the opinion of the psychiatrist (author 5) working in the CMHC (Community Mental Healty Center) was taken into consideration. In addition, validity and reliability of the research, a computer-assisted qualitative data analysis program was used in the research process to provide transparency regarding the analysis. The research report was written by considering the Standards for Reporting Qualitative Research (SPQR) criteria (19).

For the validity and reliability of the study, the researchers performed long-term participation and observation at CMHC. Interview questions was examined by a psychiatrist; all members analyzed the data with blinding method. Transparency was achieved using the computer-supported qualitative data analysis program.

2.5. Role of the Researcher

The first researcher works as an academician at x university and has recearh and application experience on disability and women. The second and third authors worked as practice students at hospital x and communicated with the participants and developed a trusting relationship. The fourth author is a social worker working at Izmir Katip Celebi University Atatürk Training and Research Hospital. The fifth author is a psychiatrist working at Izmir Katip Celebi University Atatürk Training and Research Hospital. After the second and third authors collected the data, the first, second and third authors transcribed the data electronically and made the first coding. Afterwards, analysis, synthesis and writing phases were carried out. Also researchers play narrating roles and became the writers of the participants' stories.

Table 2. Main Theme and Sub-Themes of the Analysis

Main Themes	Sub Themes
Theme I; Pre-Diagnosis Experiences	1. Childhood experiences 2. Adolescent experiences 3. Marriage experiences 4. Participation in economic life
Theme II; Experiences During Diagnosis	5. Signs of illness 6. Genetic presence of the illness
Theme III; Post-Diagnosis Experiences	7. The patient herself after diagnosis 8. Relationships with post-diagnosis support systems
Theme IV; Expectations	9. Their recommendations 10. Their future expectations

3. Results

When the life stories of women diagnosed with schizophrenia and bipolar disorder were examined, three life focuses emerged as themes. They are pre-diagnosis experiences, diagnosis experiences, and post-diagnosis experiences. In addition, the women's expectations from the future and their recommendations were also analyzed. All main themes can be viewed in Figure 1.

3.1. Theme I: Pre-Diagnosis Experiences: 'Childhood, Adolescence, Marriage, Participation in Economic Life'

When the pre-diagnosis experiences of women were examined, their experiences of childhood, adolescence, marriage, participation in economic life came to the fore.

3.1.1. Childhood Experiences: Happiness Versus Pressure

When the women remembered their childhood period, the concept of happiness comes to the fore within their definitions. They brought up that they were experiencing pressure along with happiness. 'I9' mentioned:

> Tense and irritable. My father was an alcoholic and a gambler. He wouldn't come home at night. When he came, he would fight with my mother. He commited violence against my mother. When we cried, he was violent towards us too. But I was successful in my school life.

The relationships between the mothers and fathers of the women with schizophrenia and bipolar disorder during their childhood were generally *not good*. However, the women consider conflict and violence as good, and they normalize violence like I6: 'They were good. … my father was yelling and cursing at us. He was also yelling at my mother'.

Women generally *have domestic responsibilities (in home)* in their childhood. In this context, women *did housework, ironed, dusted, and helped their mothers* when they were girls. What is important here is that *in case the women had older sisters when they were children,* they stated that *their older sisters would do these duties.* In this case, we see that gender role expectations for girls are reproduced: 'It was helping housework, tidying up, dusting, cleaning, helping my mother (I6)'

Women were exposed to role sharing within the scope of gender-based division of labor in their childhood as well. While girls are restricted to private sphere of helping their mothers, boys are given professional roles specific to the public sphere.

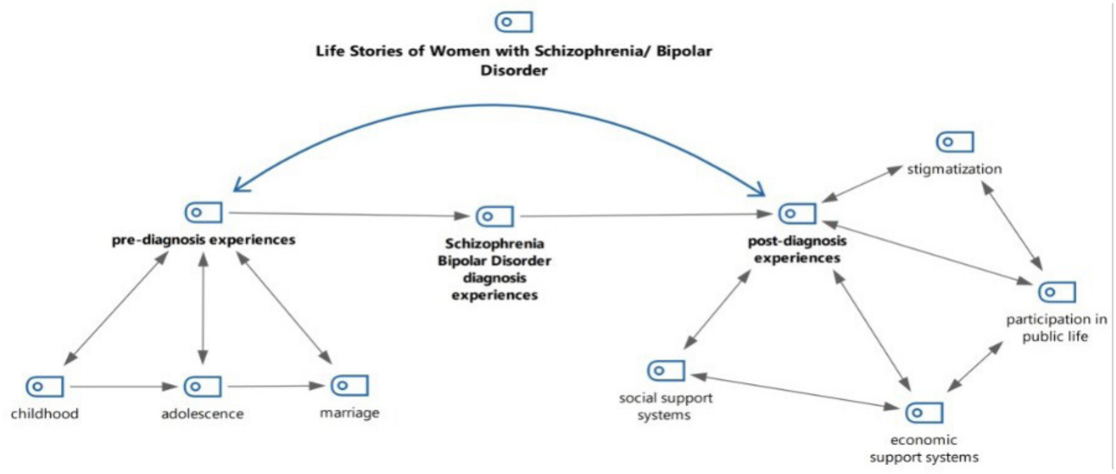
> It was a violent incident again. My father came home drunk again. My mother was fighting with him because he was drinking and coming home late. I remember my dad grabbing my mom by the hair and bumping her against the wall and my mom's head bleeding. I was 7 years old (I9).

Women have been subjected to oppression and violence during their childhood. Although they got along with their siblings, their role expectations based on social gender affected their lives.

3.1.2. Adolescent Experiences: 'All the Burden was on My Shoulders!'

Considering their experiences during adolescence, women focused on the difficulties of being a woman in adolescence, such as educational opportunities, family, friendship relations etc. Examining the adolescence period of the women in the pre-diagnosis period, the women *experienced more difficulty* than childhood. *They are more in conflict with the family.* There is even a woman who stated that she married without ever experiencing her adolescence. In addition, *they sought love in other men,* as they could not meet the need for knowledge of adolescence from their families, and *relationships with their fathers and mothers could not be established.* They also had *mania and depression* as diagnostic signs. In this case, it is difficult for the women to communicate with people in their environment and this period is a period of *failure* for the women:

> It was not taught to me; I had a little difficulty. I asked for help from my mother. … My father has an authoritarian nature at home. My father is someone who shouts at everyone and cannot control his anger. I could not tell my father about everything. … I could share my thoughts only to my mother; that's why I had a very hard time going through puberty (I6).



Figüre 1. Life Experiences of Women diagnosed with Schizophrenia and Bipolar Disorder MAXQDA20 Code-Subcode Model

Women could communicate with their friends and state that they had a good relationship with them, but there are also some women who state that they could not establish a relationship with their friends because *they married or worked at an early age.* The reason for this is that the women see their families *as oppressive* during adolescence: 'They wouldn't really let me go anywhere with my friends. Think of an oppressive mom and dad' (I11).

Some women stated that they *did not experience difficulties*, while some had difficulties because of *menstrual period*, *excessive responsibilities,* and the *restriction of* the society they lived in *due to the patriarchal nature of their society*. In general, the difficulties they experienced in adolescence started with changes such as the *onset of menstruation biologically,* while *the domestic roles* of girls also put pressure on women during adolescence. *They felt the entire burden on them.* As I3 said:

> When I was a young girl, I was looking after my two younger siblings and cleaning the house. There was too much responsibility, and it was difficult. My older brother got married and we lived together in the same house. The entire burden was on my shoulders.

They experienced some changes in their adolescence due to both the symptoms of their disease and the general characteristics of their adolescence period, and they had difficulty keeping up with these changes. In addition, they experienced the pressure created by the patriarchal family system and experienced violence. The most important thing here is that some of the women got married during their adolescence. There are also women who entered to this period of life before they were diagnosed. For this reason, their marital experiences were examined in the pre-diagnosis category.

3.1.3. Marriage Experiences: 'Fear and Anxiety'

Seven of the women stated that they had an arranged marriage by the decision of their families (without getting to their spouses): 'Well, it happened after they wanted to. We had no right to speak. Whatever my father says is what happens' (I8), and only one of them stated that she had a love marriage.

Women experienced *fear, anxiety*, and *happiness* in the early stages of their marriage. As I8 mentioned 'There was fear, of course. Now girls learn everything from the internet. In our time, they would lock you up in a room with a stranger.'

According to the women, the role of women in marriage is the *altruistic, division of labor* between men and women, and the *woman standing on her own feet.* In this case, it is seen that women internalize gender role patterns.

> Well, a woman should get education. … Woman should stand on her own feet so that she should not be a slave to anyone. Material or spiritual. What a woman should do today is that she should not be dependent on her husband (I8).

In this context, when the expectations of the social environment from the marriage *to maintain their marriage, have children, and respect their families.* Throughout marriage, women are exposed to *violence, especially physical, psychological, and sexual violence.* Also, events occurring through *'proving virginity'* on the wedding night, which reflects the patriarchal structure, have affected the women the most.

> I was subjected to a lot of violence, and brutally. I remember that my feet, for example, were completely bruised. I was beaten with a belt ... Due to an incident at home. As I said, I was subjected to a lot of violence for 10 years. I got sick. (I8).

Economic life is important for women before the diagnosis. Because working means 'freedom.' Most of the women *worked before* but are *currently not working.* Only one woman is currently working. Some women have never worked. The women worked in *hairdressing, retail, insurance, textiles, kindergarten,* and *agriculture.* In this context, the women participated in public life.

The women have stated that when they work, they *feel free, they feel self-confident, and that work provides discipline in their lives.* Women give their money *to their families; make an investment and spent it.* The women cannot work in the same job for a long time or get bored quickly due to the effects of their illnesses: 'It has contributed a lot. You get the chance to express yourself' (I10).

Conlusion for this theme: When the pre-diagnosis experiences, the women had gender-based role responsibilities in childhood, adolescence, and marriage periods. Societies with a patriarchal structure, and they were subjected to pressure and violence from their families. In this case, the women's participation in economic life strengthened them and made them feel free.

3.2. Theme II: Experiences During Diagnosis: 'I'm Not a Schizophrenic!'

Women did not remember the diagnosis process and could not explain their feelings about the moment of diagnosis. At this stage they conveyed their experiences during the diagnosis process mostly based on how the diagnostic process started.

They showed many symptoms throughout the diagnosis period. They experienced symptoms *such as visual and auditory delusions, excitement, withdrawal, doubting, self-talk, and constant crying:* 'Hearing voices. Seeing images. Talking to myself in an abnormal way. (I4). They confused reality and imaginary: 'I was told that I was schizophrenic at the hospital. I said I was not schizophrenic. I have just accepted it' (I7). Also, 'It started when my father passed away. I had introversion. I wanted to die so much. I put my husband's gun to my head and didn't want to see anyone' (I11).

To conclude this theme: While women were talking about their diagnostic processes, they could not go much deep. They remained silent, both because of their existing diagnosis and because they did not want to talk much. However, it is seen that the process of diagnosing started after important life events and psychological pressure, and progressed with the symptoms mentioned in the literature.

3.3. Theme III: Post-Diagnosis Experiences: 'Stigmazation Versus Social Support'

Relationships with social support systems and economic support systems, participation in public life and stigmatization are at the forefront of post-diagnosis experiences. Social support systems of women and the support of spouse, family and friends were examined within the scope of gender-based division of labor. While most women received support from their spouses after the diagnosis, very few did not because their husbands *could not cope with the diagnosis of the women*. Two of the women were diagnosed after their marriage. The diagnosis was learned by the spouses after marriage, and some of the women told their diagnosis to their spouses before marriage. The women expressed their relations with their spouses as *'my husband was supportive'* and *'he could not endure'* like 'I3': 'My husband was always upset; he seemed to be angry he seemed to reproach. He said, you did it yourself, you obsessed with your family, you made yourself sick, but he always stayed with me.'

Two of the women were divorced, and one of them stated that their marriage ended with death. After the divorce, the women's lives *got worse because their families gave them a hard time*. In addition, the women *continued to receive support from their families* after their divorce. It can be seen here that families have a great impact on maintaining systematic pressure on the women's lives or on the women's liberty: 'My life got worse. My family gave me a hard time. They put a lot of pressure on me. Did you come after you surrendered yourself, my father said' (I9).

Regardless of whether they are married or not, when the support systems are examined, the women get the *most support from their families, -mother, father, and siblings*. For those who are married, the first thing that comes to minds of the women is their families, while the spouse is in the second place.

The women often expressed their relationships with their families as *'good' or 'very good'.* Women isolate themselves from social life with their own will. While their relationships with their friends, *did not change* for some women or *improved* for some women, for others they were negative. Because of their diagnosis, they are afraid of people and have some delusions. They do not want to meet with their friends because they do not prefer to participate in the society: 'My friendships and social life have been negatively affected. Most of my friends don't know about my illness. I don't have many friends; there are a few people. I don't tell them everything. Because people look at it negatively' (I4).

The women get their income from their *pensions, house rents, spouses,* and *parents*. They stated that *they were not affected economically after the diagnosis, behaved cautiously, or were affected.* Since the women with bipolar disorder tend to spend money excessively during the manic period, the social workers in the CMHC control the women's spending especially in this period of their illness.

Psychological support systems also appear as tools that support the women's participation in public life. Women generally receive psychological support from the *Community Mental Health Center.* CMHC provide a good opportunity for patients to socialize. Only one woman has a therapist and she stated that she *received psychological support from her therapist:* 'I get psychological support from CMHC' (I1)

In this sense, the women leave their homes to go to CMHC; they use the public transportation and leave their homes on their own. Therefore, getting psychological support strengthens the women's participation in public life (20). In addition, the realization of public affairs by themselves is the process that empowers the women: 'I was a member of the public house before. I was trying to participate in all events. Right now, I am getting reaction that I came a long way' (I12). Only I5 doesn't want to be a member of NGO: 'I do everything by myself. I have never cooperated with an NGO. I didn't want to be a member' (I5).

3.4. Theme IV: After Diagnosis: 'Stigmatized Myself!'

When the opinions of the women about themselves are examined, the women both stigmatize themselves and experience the concern that they will be stigmatized by society: 'I don't want to be hospitalized; they will call me crazy in the village, I said. I was very angry. They directly stigmatize those using psychiatric drugs' (I12).

At the beginning of this stigma, most of the women *could not accept* the disease at first or *stigmatized themselves* because of the illness: 'Naturally, you cannot accept the illness at first. …. I saw it differently from normal people and society. I stigmatized myself' (I4). They could not associate themselves with the illness that coexisted with depression.

3.5. Theme V: Expectations: 'Don't Give Up on Yourself!'

Women mostly expect to *have a job* in the future. Married women have expectations about *their children and grandchildren*: 'I want my children to marry. Having their children. Getting rid of my illness' (I8). Married, happy, even with children' (I5). Unmarried women, on the other hand, aim and expect to *get married*, and women who do not have children *to have children*.

The women mostly focus on vital routine issues and have expectations about their life. This situation shows that the women focus more on the events they experience in their life course and their illnesses are not always on their minds.

Women recommend that attention should be paid to *treatment and drug* use, and *sleep patterns* should be considered. In addition, they stated that the i*llness should be accepted* and that the women *should socialize:* 'They should stop listening to themselves for a while. They should accept their illnesses. They should say that "This is me", "I exist".' (I10). Also, they recommend not giving up:

> Don't give up on yourself. Embrace life tightly. Think positively. Do not give up on your dreams and goals. Do not despair and do not be pessimistic. Everything will be alright (I6).

Being female and having a psychiatric diagnosis make women's lives difficult. In conlusion, women's expectations for the future are affected by social role expectations, on their children. And they want to believe in themselves.

4. Discussion

When the life stories of women diagnosed with schizophrenia and bipolar disorder are examined, we encounter with a three-dimensional process. For this reason, the pre-diagnosis, diagnosis, and post-diagnosis experiences of women are important. In their pre-diagnosis experiences, the women feel the pressure of gender-based role patterns due to the patriarchal family structure. They experience domestic pressure and violence.

Most of women got diagnosed when they were married and in their 20s. In accordance with the literature, the average age of diagnosis in women was 20 (21, 22). Similar to the literature, the diagnosis of women in the study was made during their marriages (23).

At this point, the acceptance of the diagnosis and the implementation of the treatment process are seen as important factors. It is observed that the treatment process of women who accept their diagnosis and adapt to the treatment is shorter (24). In connection with this, the support of their family and spouses appears as the systems that help women to overcome isolation and stigmatization.

When women got supported and accepted by their social environment, they accept their diagnoses and then accept themselves. In this context, the women's recommendations were related to accepting their illness.

It is stated that the social adjustment is influenced by sociocultural context, social role expectations, baseline personality, type of culture, and family situation (4, 25). The cultural norms of women living in a patriarchal family structure will determine their social adjustment because the diagnoses were made as a result of domestic violence, or their level of coping with their diagnoses changed by the support of family and spouse.

Many studies have been conducted on the importance of the family in terms of schizophrenia (26, 27). According to these studies, it has been observed that the support of the family is effective in both the patient's acceptance of the illness and the progression of treatment process, and this support also reduces the care burden of the family.

Problems related to mental health are common both in Turkey and in the World and can lead to social problems such as exclusion, discrimination, and stigmatization by the society. The variables of psychiatric illnesses differ for women and men; women are exposed to more pressure and discrimination. In the study, it is seen that women diagnosed with schizophrenia and bipolar disorder are excluded from social life, stigmatized, and isolated from the society because both they were females, and they had a mental illness. In this context, women diagnosed with schizophrenia and bipolar disorder constitute one of the client groups of the social work profession. In particular, CMHC in Turkey, is one of the most important units to bring the social workers with women diagnosed with schizophrenia and bipolar disorder together.

5. Conclusions

In conclusion, when the life stories of women diagnosed with schizophrenia and bipolar disorder are analyzed, three focus of the life stories have been found. These themes appeared with the pre-diagnosis, diagnosis, and post-diagnosis experiences. Pre-diagnosis experiences of women, they live with pathriarcal system in childhood, adolescence, and marriage periods. Also they lived with psychological pressure and remained silent during diagnosis. Post-diagnosis experiences of women especially live with stigmazation. Their expectation from the other women is don't give up on theirselves.

It is revealed that they are systematically subjected to the pressure of patriarchal system from their childhood to today. Particularly, gender-based role expectations that start first in the family have continued increasingly in their marital life. After the diagnosis, these women move away from their social environment and stigmatize themselves. The roles of women that they cannot fulfill due to their illnesses put pressure on them. In this context, the narrative research strengthens the relationship of researchers with the women.

Especially in developing countries such as Turkey, there is a need for micro, mezzo, and macro feminist social work practices to eliminate the patriarchal oppression on women.

6. Contributions

In this research article, pre-diagnosis, diagnosis, and post-diagnosis life experiences of women with schizophrenia and bipolar disorder were examined. It will contribute to the planning of new research topics for researchers who conduct research on the life experiences of individuals with mental illness.

Ethical Considerations

The study was approved by Non-Interventional Clinical Research Ethics Committee of İzmir Katip Celebi University with the date of 27.03.2019 and decision number 150. Informed consent was obtained from the study participants.

Conflict of Interest

This article did not receive any financial fund. There is no conflict of interest regarding any person and/or institution.

Authorship Contribution

Concept: MT, ŞÖÖ, GNU; **Design:** MT, ŞÖÖ, GNU; **Supervision:** MT, ŞÖÖ, GNU; **Funding:** None; **Materials:** AB, EÜK; **Data Collection/Processing:** MT, ŞÖÖ, GNU; **Analysis / Interpretation:** MT, ŞÖÖ, GNU; **Literature Review:** ŞÖÖ, GNU; **Manuscript Writing:** MT, ŞÖÖ, GNU; **Critical Review:** MT, ŞÖÖ, GNU.

References

1. Scheyett AM, McCarthy E. Women and men with mental illnesses: Voicing different service needs. Affilia. 2006; 21(4): 407-418.

2. Başar F, Demirci N. Toplumsal cinsiyet eşitsizliği ve şiddet. Kadın Sağlığı Hemşireliği Dergisi. 2015; 2(1): 41-52.

3. Yavuz RA. Toplumsal cinsiyet eşitsizliği ekseninde kadın istihdamı ve ekonomik şiddet. Journal of Life Economics. 2016; 3(3): 77-100.

4. Nassar EH, Walders N, Jankins JH. The experience of schizophrenia: What's gender got to do with it? A critical review of the current status of research on schizophrenia. Schizophrenia Bulletin, 2002; 28(2): 351-362.

5. Toplum Ruh Sağlığı Merkez Listeleri. Sağlık Bakanlığı. Avaible from: https://khgmsaglikhizmetleridb.saglik.gov.tr/TR,43118/toplum-ruh-sagligi-merkezleri-trsm-listesi.html. date of access: 17.09.2020

6. Şizofreni Dernekleri Federasyonu (ŞDF). Avaible from: http://sizofrenifederasyonu.org/ date of access: 17.09.2020

7. International Federation of Social Workers (2014). Sosyal Hizmetin Tanımı. Avaible from: https://www.ifsw.org/what-is-social-work/global-definition-ofsocial-work/ date of acces: 30.04.2021

8. Günindi-Ersöz A. Özel alan/kamusal alan dikotomisi: Kadınlığın "doğası" ve kamusal alandan dışlanmışlığı. Sosyoloji Araştırmaları Dergisi. 2015; 18(1): 80-102.

9. Attepe Özden S, Tuncay T. The experiences of Turkish families caring for individuals with Schizophrenia: A qualitative inquiry. International Journal of Social Psychiatry. 2018; 64(5): 497–505.

10. Denzin NK. Interpretive Biography. Sage: Newbury Park, CA. 1989.

11. Chase SE. Narrative inquiry. Multiple lenses, approaches, voices. (Denzin NK, Lincoln YS. Eds. The sage handbook of qualitative research). Sage: Thousand Oaks, CA. 2005.

12. Pinnegar S, Daynes JG. Locating narrative inquiry historically: Thematics in the turn to narrative. Handbook of narrative inquiry mapping a methodologies. Sage: Thousand Oaks; CA. 2007.

13. Uğuz Arsu Ş, Tekindal M. Nitel araştırmalarda anlatı araştırmasının tanımı, kapsamı ve süreci. Ufkun Ötesi Bilim Dergisi. 2021; 21(1): 85-124.

14. Patton, MQ. How to use qualitative methods in evaluation. Sage: Newbury Park, CA. 1987.

15. Kvale, S. Interviews- An introduction to Qualitative Research Interviewing. Sage: Thousand Oaks, CA. 1996.

16. Downe-Wamboldt, B. Content analysis: Method, applications, and issues. Healthcare for Women International. 1992; 13, 313–321. doi:10.1080/07399339209516006

17. Reissman CK. Narrative methods for the human sciences. Sage: Thousand Oaks, CA. 2008.

18. Tekindal M. (Ed.). Nitel araştırmalarda yazılım kullanımı adım adım. (Silver C. Lewins A. Eds. Nitel araştırmada yazılım kullanımı adım adım kılavuz. SAGE Yayınları. 2014). Ankara: Nika Yayınevi; 2018.

19. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: A synthesis of recommendations. Academic Medicine. 2014; 89(9): 1245-1251.

20. Karoff MQ, Norton CL, Tucker AR, Gass MA, Foerster E. A Qualitative gender analysis of women field guides' experiences in outdoor behavioral healthcare: A feminist social work perspective. Afillia: Journal of Women and Social Work. 2019; 34(1): 48-64.

21. Güz, H. Şizofreni ve cinsiyet: Başlangıç yaşı ve sosyodemografik özellikler. Klinik Psikiyatri. 2000; 3: 27-33.

22. Harvey PD, Strassnig MT, Silberstein J. Prediction of disability in schizophrenia: symptoms, cognition and self assessment. Journal of Experimental Psychopathology. 2019; 1-20.

23. Gove WR, Tudor J. Adult sex roles and mental illness. American Journal of Sociology. 1973; 78: 812-835.

24. Kamens S. De-othering "schizophrenia". Theory & Psychology. 2019; 29(2): 200–218.

25. Shirakawa I, Mari JJ, Chaves AC, Hisatsugo M. Family expectation, social adjustment and gender differences in a sample of schizophrenic patients. Revista de Saude Publica. 1996; 30: 205-212.

26. Arslantaş H, Adana F. Şizofreninin bakım verenlere yükü [The burden of schizophrenia on caregivers]. Current Approaches in Psychiatry. 2011; 3: 251-277.

27. Karaçar Y, Bademli K. Relationship between perceived social support and self stigma in caregivers of patients with schizophrenia. International Journal of Social Psychiatry. 2021; 1-11.