Özgün Çalışma / Original Article

Ankara Eğt. Arş. Hast. Derg., 2025 ; 58(2) : 81-84
DOI 10.20492/aeahtd.1493662

Comparison of Internalized Stigma Between Psychiatric Inpatients and Outpatients at a University Psychiatric Clinic

Üniversite Psikiyatri Kliniğinde Yatan ve Ayakta Tedavi Edilen Hastalarda İçselleştirilmiş Damgalanma Kıyaslanması

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ABSTRACT

AIM: Mental illnesses are prevalent globally and often accompanied by significant stigmatization, adversely impacting individuals' lives. This study aimed to investigate the level of internalized stigma among psychiatric inpatients and outpatients and to understand how various factors influence this stigmatization.

MATERIAL AND METHODS: The study included 181 patients (45 inpatients and 136 outpatients) from the Ankara University Faculty of Medicine Hospitals' Department of Psychiatry. Data collection involved a cross-sectional questionnaire study using the Internalized Stigma of Mental Illness (ISMI) scale, the WHO Quality of Life-BREF (WHOQOL-BREF) scale, and the Beck Anxiety and Depression Inventory. Statistical analyses were performed using the Mann-Whitney U test and correlation analysis in SPSS.

RESULTS: The results indicated significantly higher internalized stigma scores among inpatients compared to outpatients ($p = 0.01$). Factors such as sex, occupational status, and income level were significantly related to various dimensions of internalized stigma. Specifically, stereotype endorsement ISMI scores were higher in males ($p=0.02$) and related to income level ($p=0.01$). No significant relationships were found between total ISMI scores and education or marital status. Additionally, anxiety and depression levels were significantly associated with internalized stigma scores ($p<0.05$).

CONCLUSION: Psychiatric inpatients experience higher levels of internalized stigma compared to outpatients. Factors such as male gender, unemployment, and lower-income contribute to higher stigma levels. These findings emphasize the need for targeted interventions to reduce internalized stigma and improve mental health outcomes. Future research should aim for larger sample sizes and include multiple recruitment sites to enhance the generalizability of findings.

Key Words: Stigma, Mental disorders, Inpatient, Outpatient,

ÖZET

AMAÇ: Akıl hastalıkları dünya genelinde yaygın olmakla beraber sıklıkla önemli düzeyde damgalanma ile birlikte görülür ki bu durum da bireylerin yaşamlarını olumsuz yönde etkilemektedir. Bu çalışma psikiyatri kliniğinde ayaktan tedavi gören ve yatan hastaların arasındaki içselleştirilmiş damgalanma seviyesini araştırmayı ve çeşitli faktörlerin damgalanmayı nasıl etkilediğini anlamayı amaçlamaktadır.

GEREÇ VE YÖNTEM: Çalışmaya Ankara Üniversitesi Psikiyatri Anabilim Dalından 181 hasta (45 yatan hasta ve 136 ayaktan hasta) dahil edilmiştir. Veri toplama Ruhsal Hastalıklarda İçselleştirilmiş Damgalanma ölçeği (ISMI), DSÖ Yaşam Kalitesi (WHOQOL-BREF) ölçeği, Beck Anksiyete ve Depresyon Envanterleri kullanılarak gerçekleştirildi. İstatistiksel analizlerde, SPSS'de Mann-Whitney U testi ve korelasyon analizi kullanıldı.

BULGULAR: Bulgular, yatan hastaların ayaktan hastalara göre daha yüksek içselleştirilmiş damgalanma seviyelerine sahip olduğunu gösterdi ($p = 0.01$). Cinsiyet, mesleki statü ve gelir seviyesi, çeşitli içselleştirilmiş damgalanma boyutlarına ilişkin olarak anlamlı olarak ilişkili bulundu. Özellikle, cinsiyet ($p = 0.02$) ve gelir seviyesi ($p = 0.01$) ile 'Kalıp Yargıların Onaylanması' ISMI seviyesi arasında anlamlı bir ilişki bulundu. Eğitim ve medeni hal ile toplam ISMI seviyeleri arasında anlamlı bir ilişki bulunmadı. Ayrıca, anksiyete ve depresyon seviyeleri, içselleştirilmiş damgalanma seviyeleri ile anlamlı olarak ilişkili bulundu ($p < 0.05$).

SONUÇ: Psikiyatride yatan hastalar, ayaktan tedavi alan hastalara göre daha yüksek içselleştirilmiş damgalanma seviyelerine sahiptir. Erkek cinsiyet, işsizlik ve düşük gelirin damgalanma seviyelerini arttırdığı görüldü. Bu bulgular, damgalanmayı azaltmak ve ruhsal sağlığı geliştirmek için müdahalelerin gerekli olduğunu vurgulamaktadır. Gelecek araştırmalar, daha büyük örneklem boyutlarına ulaşmayı ve birden fazla kurumdan katılımcı almayı hedeflemelidirler.

Anahtar Kelimeler: Damgalanma, Akıl hastalıkları, Yatan Hasta, Ayaktan Hasta

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Makale geliş tarihi / Submitted: Mayıs / May 2024

Makale kabul tarihi / Accepted: Ağustos / August 2025

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INTRODUCTION

Mental illnesses are common occurrences all around the world as well as in our country and unfortunately, people are highly stigmatized due to that (1,2). Stigma is the disapproval of, or discrimination against, an individual or group based on perceived characteristics that serve to distinguish them from other members of society. Especially, lives of people who have a mental disorder are affected by a community's perspective (3). People who have a mental disorder is already a fragile group yet they are stigmatized by the public, as this condition is like an infectious disease. This stigma can lead to internalized stigma or self-stigma in this group which can cause devastating effects on their lives. Internalized stigma refers to the process in which a person with mental illness cognitively or emotionally absorbs negative messages or stereotypes about mental illness and comes to believe them and apply them to him/herself which is prevalent among psychiatric patients (4). These individuals frequently find themselves at a breaking point in their lives and may feel ashamed or embarrassed about being hospitalized for mental health issues (5). Researching internalized stigma among psychiatric patients, especially hospitalized patients is important for several reasons. It may help us to understand the reasons behind the internalized stigma and try to prevent or cure it. For instance, interventions, to help increase self-esteem and promote self-acceptance to prevail over internalized stigma. Secondly, if the healthcare providers may understand the underlying conditions of internalized stigma, and how to treat them better; psychiatrically hospitalized patients would be more comfortable and feel less guilt. Lastly, researching internalized stigma among psychiatric patients may help them to overcome their mental illness and promote their recovery process more rapidly. Stigma and discrimination against psychiatric patients can have adverse effects on individuals as well as on society. By increasing the awareness of internalized stigma and highlighting the importance of the situation, we may build a more sympathetic and accepting society. Furthermore, the COVID-19 pandemic has also highlighted how important it is to address issues related to mental health, such as stigmatization and prejudice against those who experience them. The pandemic's increased levels of stress, anxiety, and grief can intensify the symptoms of existing mental health problems and open the door to the emergence of new ones (6). Research on internalized stigma among psychiatrically hospitalized patients can help identify the challenges particular to this group during the pandemic, which can then help direct therapy that supports their mental health and well-being. When the previous literature was reviewed, we found that internalized stigma level has been researched mostly on psychiatric outpatients, therefore the main aim of this project is to investigate the level of internalized stigma and its effects among psychiatric inpatients (7). The multiple ways in which stigma can affect individuals has been widely studied within the social and psychological sciences (8). Yet the effects of internalized stigma and level difference between inpatient and outpatient groups are not studied widely.7 Previous studies have yielded mixed findings regarding internalized stigma levels among psychiatric inpatients and outpatients. While two studies reported no significant difference between the groups, one study found that outpatients had higher levels of internalized stigma, whereas another reported higher levels among inpatients (9-12). These conflicting results underscore the need for further investigation and support the rationale for the current study.

MATERIAL AND METHOD

1. Sample

181 patients with psychiatric disorders participated in the study. Surveys conducted in October-November-December 2023. There were 45 inpatients and 136 outpatients in our study. Inpatients were recruited both from open and closed ward services. Recruited patients were between 18-65 years of age who applied to a psychiatry clinic with a psychiatric complaint one or more times or stayed in inward service. Patients who had severe mental retardation or emotional defects that prevented them from following the guidelines, filling out the evaluation form or making decisions were excluded.

2. Data Collection Tools and Applications

A cross-sectional questionnaire study was done at the University Faculty of Medicine, Hospitals Department of Psychiatry. Data will be evaluated and analyzed in December 2023.

Data is collected by Informed consent, sociodemographic questionnaire, ISMI scale, WHOQOL-BREF scale, Beck Anxiety, and Beck Depression Inventories.

Data is analysed in MS Excel and SPSS. Mann–Whitney U test, Spearman correlation analysis, and Kruskal-Wallis analysis methods are used for data analysis in SPSS.

3 . Sociodemographic Questionnaire

Sociodemographic data were collected with a questionnaire that included gender, age, marital status, occupation, education level, income level, previous hospital experiences, type of admission, duration of hospitalization, psychiatric history, and familial history. Internalized Stigma of Mental Illness (ISMI) scale for measuring self-stigma among patients with psychiatric disorders. Validity and reliability studies are done for both Turkish and English languages (13,14).

4. The World Health Organization Quality of Life: Brief Version (WHOQOL-BREF) to measure overall quality of life and general health (15). Validity and reliability studies are done for both Turkish and English languages (16,17). The data obtained from measurements are collected in MS Excel.

5. Beck Anxiety Inventory (BAI) for measuring the severity of anxiety (18). Validity and reliability studies are done for both Turkish and English languages (19,20).

6. Beck Depression Inventory (BDI) for measuring the severity of depression (21). Validity and reliability studies are done for both Turkish and English languages (22,23).

7. Statistical Analysis

Statistical analysis was performed with SPSS version 29 for Windows software. The Mann-Whitney U test was used to compare ISMI scores based on sex, occupational state, and patient status (inpatient or outpatient). Additionally, Kruskal-Wallis analysis was employed to assess ISMI scores relative to age, income level, education level, and the number of applications. Furthermore, Spearman correlation analysis was performed to examine the relationship between WHOQOL scores and ISMI scores. A p-value of <0.05 was considered statistically significant for all tests.

RESULTS

There were 45 inpatients and 136 outpatients in our study. The majority of the inpatients were male (75,6%), high school graduates (37,8%), unemployed (55,6%), single (48,9), and had 10+ numbers of admissions (45,2). The majority of the outpatients were female (60,3%), university graduates (39,3%), unemployed (68,7%), married (48,1%), and had 10+ numbers of admissions (51,9%) (Table 1). The Internalized Stigma of Mental Illness (ISMI) scale scores were significantly higher in inpatients when compared to outpatients (p=0,01)(Table 2.2). The relationship between total ISMI scale scores and education, and marital status was not statistically significant (p>0,05 for all). The stereotype endorsement ISMI scores were significantly higher in males (p=0.02), but the total ISMI scores did not significantly differ between sexes (p>0.05).

Table 1. Descriptive Properties of Patients

Descriptives		Inpatient	Outpatient
Sex	Female	11 (24,4%)	82 (60,3%)
	Male	34 (75,6%)	54 (39,7%)
Education	Primary school	7 (15,6%)	18 (13,3%)
	Secondary school	3 (6,7%)	16 (11,9%)
	High school	17 (37,8%)	43 (31,9%)
	University	11 (24,4%)	53 (39,3%)
	PhD	7 (15,6%)	5 (3,7%)
Occupational state	Employed	20 (44,4%)	42 (31,3%)
	Unemployed	25 (55,6%)	92 (68,7%)
Income level	Low	15 (24,1%)	47 (75,8%)
	Lower-middle	7 (14,5%)	41 (85,4%)
	Upper-middle	12 (36,3%)	21 (63,6%)
	High	4 (100%)	0 (0%)
Marital status	Single	22 (48,9%)	54 (40%)
	Married	15 (33,3%)	65 (48,1%)
	Divorced	7 (15,6%)	13 (9,6%)
	Widow	1 (2,2%)	3 (2,2%)
Number of admissions	First time	8 (19%)	9 (6,7%)
	1-5	11 (26,2%)	43 (31,9%)
	5-10	4 (9,5%)	13 (9,6%)
	10+	19 (45,2%)	70 (51,9%)

The relationship between occupational state and the alienation ISMI scores was statistically significant (p=0.04), whereas the relationship between occupational state and total ISMI scores was not statistically significant. (p=0.23)

Table 2.1. Comparison of Average ISMI Total Scores with some Descriptive Properties of Patients

Descriptives		Total ISMI Scale Scores			
		n	mean	SD	p
Sex	Female	93	2,019	0,54215	0,323
	Male	88	2,0991	0,56266	
Education	Primary school	25	2,12	0,489	0,126
	Secondary school	19	2,17	0,599	
	High school	60	2,15	0,587	
	University	64	1,92	0,536	
	PhD	12	2,01	0,445	

Table 2.2. Comparison of Average ISMI Total Scores with some Descriptive Properties of Patients

Descriptives		Total ISMI Scale Scores			
		n	mean	SD	p
Occupational state	Employed	62	1,98	0,497	0,232
	Unemployed	117	2,1	0,582	
Income level	Low	62	2,19	0,073	0,72
	Lower-middle	48	1,97	0,081	
	Upper-middle	33	1,94	0,833	
	High	4	1,78	0,156	
MMaritalstatus	Single	76	2,02	0,521	0,833
	Married	80	2,08	0,583	
	Divorced	20	2,14	0,589	
	Widow	4	2	0,503	
Administration type	Inpatient	45	2,31	0,579	0,01
	Outpatient	136	1,98	0,519	
Anxiety	Minimal	40	1,85	0,461	0,04
	Mild	40	1,91	0,586	
	Moderate	23	2,22	0,572	
	Severe	59	2,19	0,567	
Depression	Minimal	35	1,68	0,466	0,00
	Mild	38	1,84	0,412	
	Moderate	46	2,06	0,446	
	Severe	42	2,5	0,586	

Table 3. Comparison of Total ISMI Scores with WHOQOL-BREF Domain Scores

Total ISMI score with	r value	p-value
Physical Health	-0.444	<0.001
Psychological Health	-0.526	<0.001
Social Relations	-0.439	<0.001
Environment	-0.401	<0.001

As exhibited in Table 3, negative correlations were found in total ISMI scores and all domains of quality of life with statistical significance

(p<0.001, for all).

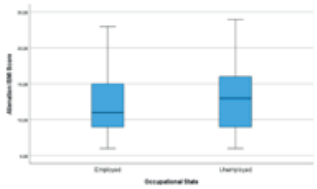

Fig. 1. The relationship between occupational state and the alienation ISMI scores (Z=-1,99, p=0,046)

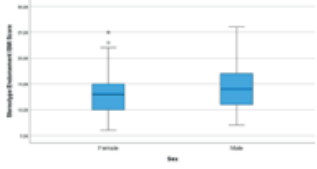

Fig. 2. The relationship between sex and the stereotype endorsement ISMI scores (Z=-2,27, p=0,023)

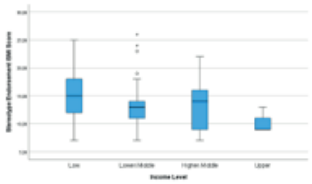

Fig. 3. The relationship between income level and the stereotype endorsement ISMI scores (x^2=10,45, p=0,015)

DISCUSSION

To our knowledge, this study is one of the few that directly examines the association between admission type (inpatient vs. outpatient) and internalized stigma levels among psychiatric patients. In line with our hypothesis, receiving inpatient treatment, being unemployed, and male gender were found to be strong predictors of higher internalized stigma (7,24). Historically, inpatients have been considered more vulnerable to internalized stigma due to longer treatment durations, often related to psychotic disorders, and associated lower quality of life (25). Previous literature also suggests that frequent hospital admissions are linked to increased stigma, which may culminate in inpatient status. As expected, our results indicate that internalized stigma is significantly associated with being an inpatient, as well as with parameters such as low income and the severity of mood disorders (26). In our data, most participants (n=64) had a university degree without a PhD. However, patients with lower levels of education (secondary or high school) showed higher internalized stigma levels, regardless of the number of patients in those categories. This suggests a potential protective effect of higher education against internalized stigma. A previous study indicated that married patients tend to experience higher stigma than single or divorced individuals (12). However, our findings revealed no statistically significant association between marital status and ISMI scores. This discrepancy might be due to sociocultural differences or variations in support systems. In collectivist cultures like Türkiye, where marriage may be associated with social acceptance and support, the expected protective effect might not uniformly translate into lower internalized stigma. Lower quality of life had a strong effect on ISMI scores regardless of admission status, reinforcing the role of low income and unemployment in exacerbating stigma levels (Figs 1 and 3).

These findings highlight the need for psychosocial interventions that target socioeconomic vulnerabilities. For instance, job training programs and financial assistance services may help reduce stigma by enhancing self-efficacy and autonomy among patients. Although sex and income level were not associated with the total ISMI score, both showed significant correlations with specific subdomains—namely, stereotype endorsement (Figs 2 and 3). This implies that while overall stigma may not differ drastically by demographic characteristics, the internalization of negative beliefs is more prevalent among certain subgroups. This result may be partially explained by prevailing gender roles and societal expectations. Males, particularly with traditional male role norms, may feel more threatened by psychiatric diagnoses, leading to stronger internalization of stereotypes (27). Similarly, individuals with lower income may perceive their illness as more socially discrediting, reinforcing negative self-perceptions. A common understanding among the public is that patients with severe psychiatric disorders are more stigmatized due to prolonged disease duration and hospitalization (26). Our results align with this perspective, showing that psychiatric diagnosis remains the most potent determinant of internalized stigma, surpassing other variables such as education, marital status, and occupation. Given that the differences in ISMI scores among diagnostic groups were more pronounced than among sociodemographic factors, future research should prioritize diagnosis-specific interventions. Tailored psychoeducation and anti-stigma campaigns for conditions like schizophrenia or bipolar disorder may be more effective than generalized approaches. This study has several limitations. First, we did not reach our targeted sample size. Originally, we aimed to include 218 inpatients and 218 outpatients (n=436), but were only able to recruit 181

participants due to logistical barriers. In contrast, studies like Kamışlı et al. (2016) had larger outpatient samples, allowing more robust statistical analyses and potentially more generalizable findings. Second, the study duration was limited to two months, which hindered patient recruitment. Lastly, since recruitment was restricted to a single hospital, with many long-term inpatients, the circulation of new inpatient participants was limited. Moreover, our cross-sectional design restricts the ability to assess how stigma levels evolve over time. Longitudinal studies tracking ISMI scores before, during, and after hospitalization could provide valuable insights into the temporal dynamics of stigma. Cultural factors may also influence our findings. In collectivist societies such as Türkiye, societal perceptions of mental illness can significantly affect patients' self-concepts.3 Future cross-cultural comparisons could shed light on how cultural norms mediate internalized stigma. Despite these limitations, our study provides valuable insights into how internalized stigma varies with admission type and sociodemographic factors. It also emphasizes the need for more targeted, individualized interventions. We recommend implementing community-based mental health models, which prioritize integration over institutionalization. These models may reduce stigma by normalizing psychiatric treatment and fostering inclusion. Additionally, incorporating structured anti-stigma interventions such as cognitive-behavioral therapy, peer support, and vocational rehabilitation into standard care could mitigate the impact of stigma. Future research should focus on larger, multi-center samples, extend the follow-up period, and examine how ISMI subscales shift over time with treatment and psychosocial interventions.

CONCLUSION

In conclusion, we found that inpatients tended to exhibit remarkably higher internalized stigma scores compared to their outpatient counterparts. Furthermore, we uncovered a significant negative correlation between the internalized stigma level of the patient and the WHO quality of life domain scores. This emphasizes the far-reaching implications of internalized stigma on a patient's overall well-being. The implications of these findings are substantial, highlighting the need for targeted interventions and support systems, especially for inpatients grappling with heightened internalized stigma. Further studies are needed to address the effects of anxiety and depression on internalized stigma.

Yazar Katkıları

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