Public Stigma Towards Bipolar Disorder

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Introduction

- **Bipolar disorder (BD)** is a lifelong, complex affective disorder either characterized by **manic, hypomanic, or depressive episodes** [1].
- BD is the fifth leading cause of disease burden in the world [4]; it affects about **2.8% of the U.S. population** [5].
- **BD** is often **misdiagnosed with major depressive disorder** and though individuals with BD-I diagnosis do not need to meet DSM-V criteria for a depressive episode, more than 90% of individuals report experiencing at least one depressive episode [1, 6].
- **Stigma** has consistently been found to be a limiting factor for people with serious mental illness, **leading to negative consequences** like worsening of symptoms and discrimination [7,8].
- The **public health toll** of BD-I is similar to schizophrenia, a severe mental disorder, yet there is little research about public stigma towards BD compared to schizophrenia [9].
- Having **contact or familiarity** with individuals that are subject to prejudice has been found to **reduce levels of discrimination** [10].
- There are **differences in attitudes (public stigma) toward different disorders,** thus the purpose of this study is to examine the impact of public stigma towards bipolar disorder if familiarity with someone with a mental illness impacts attitudes [11].

Hypotheses

H1: Exposure to a vignette of an individual labeled with **BD** experiencing a **manic episode** will result in a **higher score on the measure of stigma** than exposure to a vignette of the character with **BD** experiencing **a depressive episode**.

H2: **Familiarity with a person diagnosed with BD will affect perceptions** towards the vignette of the character with BD in a **manic episode differently from** the vignette of the character with BD in a **depressive episode**.

H3: **Contact with** a person diagnosed with **any mental disorder** will result in a **lower score on the measure of stigma for all three conditions** than those that report not knowing someone with a diagnosed mental disorder.

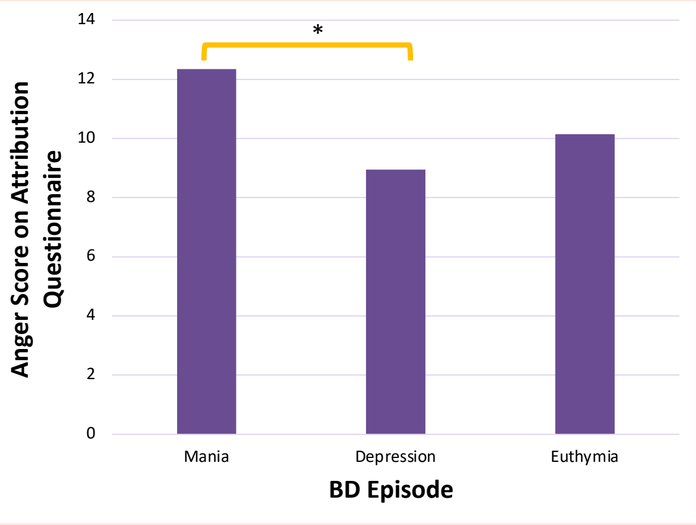
Methods and Materials

- Participants (**N=246**) on **MTurk** completed an **online survey** [12]
  - Mean age: 0.41 (*SD = 10.87*)
  - Demographic information is provided in **Table 1**
- **3 vignettes** using a gender-neutral individual with bipolar disorder: 1) a manic episode, 2) major depressive episode, and 3) euthymia.
- **Attribution Questionnaire (AQ-27**) measured public stigma and includes 9 dimensions: Blame, Anger, Pity, Help, Dangerousness, Fear, Avoidance, Segregation, Coercions [13]
- **Familiarity and Contact Questions** developed by the researcher
- **Marlowe Crowne Social Desirability Scale** measured socially desirable response tendencies [14]
- The 3-way ANOVA tested for differences between public stigma toward the 3 conditions

Table 1. Demographic Information

	Mania (n=82)	Depression (n=82)	Control (Euthymia; n=83)
Gender (M/F)	55/27	44/28	46/37
Race/ethnicity	White: 65 Biracial/Multiracial: 5	White: 59 East Asian: 5 Black: 5	White: 60 Biracial/Multiracial: 4
Education	4-year degree: 43 Graduate degree: 13	4-year degree: 37 Graduate degree: 14	4-year degree: 46 Some college or vocational training: 11

Results



No significant differences in the familiarity ratings and stigma scores were found ($p > .05$).

Figure 1. A three-way ANOVA indicated participants expressed more anger towards people with bipolar disorder experiencing a manic episode than those with bipolar disorder experiencing a depressive episode ($F(2, 247) = 4.155$, $p = .017$, partial $\eta^2 = 0.034$).
* *p<0.05*

Discussion

- The results from this study were similar to the only other stigma study that assessed a domain similar to anger, which revealed an increase in irritation towards people experiencing mania, compared to someone experiencing depression [15].
- Unlike prior studies, the other stigma domains did not differ across conditions, suggesting a need to replicate the research study questions.
- Prior studies have had mixed results on the impact of familiarity on stigma and the results of this study found no association between contact or familiarity ratings and stigma scores.
- This study utilized Mturk users, which represent a limited portion of the general U.S. population and this sample was predominantly White participants with a college degree and might not fully generalize.
- All measures were self-report and although the study had no impact of socially desirable response tendencies on dependent measures, explicit attitude measures may not capture deeply held biases.

Future Directions

- It is important to replicate this research as there is almost no research on public stigma towards BD using a U.S. population.
- Future research would benefit from involving a racially diverse sample.
- Findings suggest the importance of carefully addressing mania symptoms in destigmatization campaigns.

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