Investigation of self-stigmatization and perceptions towards delinguency in inpatient individuals diagnosed with schizophrenia in high-security forensic psychiatry settings in Turkey

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SUMMARY

Objective: Internalized stigmatization indicates the internal acceptance of public stigmatization. Double stigma refers to stigmatization due to more than one personality characteristic. We aimed to investigate the levels of self-stigma and perceptions towards delinquents about both psychiatric disorders and forensic psychiatry hospitalization among male patients hospitalized in the high-security forensic psychiatry service in Turkey.

Method: This cross-sectional study was conducted with 76 male participants. Sociodemographic, clinical, and offense-related variables were defined by interviewing patients and families and examining all records. Perceptions Towards Criminals Scale (PTCS), Self-Stigma Scale (SSS), and Violence Profile of Current Offense Scale were administered to the participants.

Results: The participants' SSS total score was 37.73±16.4, the Internalized Devaluation subdimension score was 17.91±8.19, the Internalized Stereotypes score was 14.77±7.51 and the Social Withdrawal and Concealment Disorder score was 4.77±2.70. The total PTCS score was 32.30±10.38, the Perception of Moral and Personality Traits Subscale score was 21.16±7.23 and the Perceptions of Social Networks subscale score was 11.16±4.03. PTCS social network score was relatively more negative in the patients who received regular antipsychotic treatment before hospitalization compared to those who did not adhere to the treatment (p=0.043).

Discussion: The results of the study are important in terms of examining both internalized stigma and perceptions towards delinquency in male forensic patients diagnosed with schizophrenia. Another result is perceptions of the social networks of delinquency are more negative in the patient group receiving regular treatment. The results of the study do not support high self-stigma levels in the forensic psychiatry population, contrary to the double stigma theory and previous studies conducted in our country. The disparities between the results and the literature could be due to investigating the research with different cultural populations. It will be possible to prevent the effects of stigma on forensic patients and to develop appropriate strategies for the management of self-stigma with stigma studies.

Key Words: Forensic psychiatry, stigmatization, internalized stigmatization, perceptions towards delinquency

INTRODUCTION

The phenomenon of stigmatization has been conceptualized in different ways by various theorists and definitions have varied over the years. However, adults with serious mental disorders experience stigmatization in society for years. People who have impairment in social and cognitive functions in relation to their psychiatric disorders have to cope with social difficulties due to prejudices and stereotypes at the same time like the challenge of making friends, getting married, and not being employed and consequently social defeat in this sense (1,2). Prejudices and negative stereotypes that people with psychiatric patients are dangerous, unpredictable, flawed, or have weak character cause discrimination and alienation from society among mental patients. Furthermore, people may choose not to receive treatment for their psychiatric symptoms to avoid the negative consequences of stigma (2). These attitudes and beliefs may be by the society, patient relatives, patients themselves, or health professionals (3). Internalized stigma is used for the definition of the

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situation of people with mental disorders who are aware of the stigmatization internalize the negative perceptions, and accept their stigmatization as legitimate (4). Internalized stigma is attributed to public stigma. The first stage of self-stigma is the individual's awareness of public stigma (5,6). Internalized stigma is associated with negative outcomes of the disorder. In a review study that evaluated twenty-eight studies was reported that self-stigmatization may related to increased positive symptoms, feelings of discomfort, social anxiety, depression, suicidal thoughts, increased psychiatric hospitalization at follow-up, decreased self-esteem, decreased life satisfaction, non-adaptive coping strategies, low adherence to treatment, and low functionality (7). Moreover, it has been stated that stigma is associated with increased delinquency (8). Since internalized stigma and self-stigma are used as the same concept in the literature, we used both expressions in the continuation of the article.

As a result of the increase in awareness that people who have committed crimes are subject to social stigma and experience various social difficulties due to stigma, stigma-related studies on delinquents have gained importance recently. Studies have reported that public stigmatizing attitudes towards delinquents are often associated with irrational fears of being harmed by these individuals, but paradoxically, social stigma is associated with negative consequences for delinquency (9, 10). In addition, the stigma against delinquents may be more intense in certain groups, such as mentally disordered offenders, and stigma towards mentally disordered offenders is being investigated specifically. In the literature, stigmatizing attitudes towards mentally disordered offenders and offenders without mental disorders were compared, and it was stated that the people with mental disorders encountered more stigmatizing attitudes. This situation is conceptualized as joint stigma/dual stigma (9,11).

The concept of double stigma should not be understood as the stigmatization experienced only by people with mentally disordered offenders. It means that people experience stigmatization in more than one context (being a minority, sexual identity differences, social identity differences, etc.) due to different aspects of their identities generally. In this study, we investigated the double stigma experience in patients with schizophrenia hospitalized in the forensic psychiatry service. Studies indicated mentally disordered offenders may experience double or even triple stigma due to their mental disorders, their offense, forensic service admissions, and/or substance misuse (12-15). Studies have shown that this experience causes difficulties in terms of re-integration into society (13, 16).

There are limited studies on the relationship between stigmatization and receiving treatment in different treatment environments such as general psychiatric units, psychiatric units at different security levels, and forensic psychiatry settings. It is also known that treatment approaches in general psychiatry and forensic psychiatric care must be organized by culture-specific characteristics and even individual differences (17,18). In this context, investigating culture-specific differences in stigma contributes to the specification of treatment goals. In our country, the treatment and protection processes of mentally disordered offenders were managed in mental health hospitals in the past (19). The hospital is the first of the high-secure forensic psychiatry hospitals in our country and opened five years ago. We investigated whether there is a double stigmatization due to their disorders and forensic psychiatry hospitalizations among patients with schizophrenia. In addition, we examined the factors that may be associated with negative perceptions of disorders and delinquency.

METHOD

Participants

In our country, a protocol regulated by the Turkish Penal Code is followed during patient hospitalization in high-secure forensic psychiatry units. An individual who has committed a crime and is suspected of having a psychiatric disorder is referred to hospitals for the evaluation of the offense and their psychiatric disorders. Patients are evaluated by three specialist psychiatrists. During detailed psychiatric evaluations, it is concluded that whether the individual does or not perceive the legal meaning and consequences of the crime committed due

to their mental disorders and/or whether their ability to manage their behavior about this act has significantly decreased, regarding first and second paragraphs of Article 32 of the Turkish Penal Code (TPC). If the consensus occurs about the patients' judgment abilities are decreased, the forensic process starts. As a result, patients are treated and protected within the scope of Turkish Penal Code Article 57/1 (19,20). During the hospitalization process, patients are encouraged to participate in pharmacotherapy, individual psychotherapy, group psychotherapy, and rehabilitation activities. Patients who are deemed to be able to adapt to society and decrease their criminal tendencies during the follow-up process are evaluated by the consensus consisting of three specialist psychiatrists following Article 57/2 of the TPC and the release process is initiated (20). In our hospital, the target is to reduce the severity of the mental disorder, regenerate psychosocial functionality, reintegrate into society, and reduce the risk of re-offending considering the individual characteristics of the patients. Psychopharmacological interventions, individual and group psychotherapy interventions, and psychosocial rehabilitation interventions are performed to achieve the goals. While supportive individual approaches and mostly pharmacological interventions are applied in the acute phase of the mental disorder, following the symptom severity reduction and the patient's social participation improvement, their participation in group therapies and psychosocial rehabilitation activities is ensured. Despite the lack of structured protocols and policies regarding treatments in forensic psychiatry services and deficiencies such as the lack of qualified personnel, our hospital tries to provide the best possible therapeutic environment.

This research is a cross-sectional study examining the mentally disordered offenders who were hospitalized and treated in the high security forensic psychiatry units of the hospital from December 2020 to December 2022, who were being followed up with a diagnosis of schizophrenia according to DSM-5 criteria. The patients between the ages of 18 and 65 who were undergoing inpatient treatment at the hospital to participate in the present study were invited. The interviews took place as part of the study after the decision to release them was planned, following the TPC article 57/2. No remission criteria were used in our hospital during the discharge process, but clinicians considered whether the patient's criminal tendency was reduced. Patients who had verbalization impairments and could not cooperate with the test due to schizophrenia (n=33), patients who had not conducted a standard psychiatric interview and not collected data because they had some auditory and verbal problems (n=12), and those who had intellectual disability comorbidity according to DSM-5 criteria (n=30) were excluded from the study. As a result, 76 male patients diagnosed with schizophrenia were included in this study. Since there is no inpatient service for female patients in the hospital, they were not included in the study.

Procedure

An extended data form prepared by the researchers, including sociodemographic variables, clinical variables (disease onset age, number of hospitalizations, treatment adherence, etc.), and characteristics of the offense committed (age of the current offense, violence type, the existence of past offense, the gender of the target, relation with the target et.) was applied to all participants in the study. In addition, the patient's medical records and judicial files were examined and the information obtained was checked. The patient’s adaptation to the hospitalization was evaluated according to clinicians and nurse observation notes. The severity of the offense that caused the current hospitalization was evaluated with the Violence Profile of Current Offence Scale. The presence of comorbid antisocial personality disorder (ASPD) was evaluated considering the DSM-5 criteria. The Self-Stigma Scale and the Perception Towards Criminals Scale were administered. Written and verbal informed consent was obtained from the participants and their legal guardians. The study was accepted by the Hospital Clinical Research Ethics Committee with decision number 1098, dated 21.10.2020.

Instruments

The Self-Stigmatization Scale for Patients (SSS); is a 5-point Likert-type scale consisting of 17 items, based on self-report, developed to evaluate the

thoughts, feelings, and attitudes of patients with schizophrenia about self-stigmatization. The developers stated that this scale, which was translated into Turkish, is culturally sensitive and easy to apply and the Cronbach's alpha coefficient of the scale was 0.93, and the reliability coefficient of the subscales was between 0.60 and 0.93 (21). A high score on the scale indicates a high level of self-stigmatization in the individual. Three sub-dimensions were defined for the scale; internalized devaluation, internalized stereotypes, social withdrawal, and concealment of the disorder. The first eight items of the Turkish translation scale were evaluated in the internalized devaluation sub-dimension, items 9-15 in the internalized stereotypes sub-dimension, and the last 2 items in the social withdrawal and concealment the disorder sub-dimension. The score range for the arithmetic mean values of the scale was calculated as 0.80, taking into account previous research since the scale is a Likert-type scale. Accordingly, the range of 1.00-1.80 is interpreted as completely disagree, the range of 1.81-2.60 as disagree, the range of 2.61-3.40 as neither agree nor disagree, the range of 3.41-4.20 as agree, and the range of 4.21-5.00 as completely agree (22).

The Perceptions Towards Criminals Scale (PTCS); was developed to measure participants' perceptions of offenders in the Turkish language (23). It is a 5-point Likert-type scale consisting of 12 items. A high score was associated with negative perceptions. The scale involves a two-factor structure: perceptions of personality traits/moral characteristics and perceptions of delinquents' social networks. The first eight items of the scale are evaluated in the sub-dimension of perceptions about the perception towards personality traits/moral characteristics of delinquents, and the last four items are evaluated in the dimension of perceptions towards the relationship of offenders with social networks. It was stated that the Kaiser-Meyer-Olkin value was 0.859 and the Cronbach alpha value was 0.82. Although it is seen that the scale is mostly applied to professionals or social worker students in studies, the researchers stated that it would be appropriate to apply it to patients as well. Since the scale is a 5-point Likert-type scale, the score ranges for arithmetic mean values are similar to the SSS.

Violence Profile of Current Offense (VPCO); was developed to determine the crime severity of patients with schizophrenia who committed an offense (24) and a Turkish adaptation study was conducted (25). The scale was used in the current study to evaluate the severity of the current offense within the time of being admitted to a forensic psychiatry hospital. According to the scale, crimes are evaluated at four levels according to their severity. Verbal aggression, carrying a weapon without use, accidental minimal property damage is interpreted as minimal violence, acts causing minor bodily harm, using offensive equipment without causing injury, sexual offense under force, intentional property damage as moderate violence; causing grievous bodily harm, extensive property damage as moderately serious violence; and violence that causes death or life-threatening as serious violence. Although four levels were defined to define offense severity, since the number of participants who committed crimes of serious and moderately serious severity in the present study was quite low, we evaluated two levels, mild and serious, as used in various previous studies. Accordingly, minimal violence was considered mild violence, and moderate and above levels of violence were considered serious violence. While rating the offense severity to ensure inter-reliability, the forensic files were examined in partnership by both researchers.

Statistical analysis

The continuous variables of the research are grouped as follows; current age, age of disease onset, length of hospitalization, age of first offense, and number of offenses. Categorical variables; living environment (village, small town, city) during the development process, marital status at the time of the current offense (single/married), current social life situation (living with family/alone), duration of education (five years or less/more than five years), being under guardianship (yes/no), having a regular job (yes/no), having an occupational profession (yes/no), having a regular income (yes/no), history of drug misuse (yes/no), history of suicide attempt (yes/no), having a history of incarceration in the past (yes/no), whether the family visits regularly during the hospitalization (yes/no), the plan to return to the family home after discharge (yes/no), good adaptation to the service during the hospitalization

In the descriptive statistics of the data, mean, arithmetic mean, standard deviation, lowest and highest values, percentages, and frequency values were calculated. The distribution of variables was evaluated with the Kolmogorov-Smirnov test. Independent Sample t-test and/or Mann-Whitney-U test were used to compare continuous variables, depending on the distribution of the data. Differences between categorical variables were evaluated with the x^2 test. Correlation analyses were evaluated with the Pearson or Spearman Test. All statistical analyses were performed with SPSS (IBM SPSS version 26.0) and the significance level was accepted as $p<0.05$ (two-tailed)

RESULTS

All of the participants were male, their mean age was 40.11±10.13 years, their education period was 3.99±1.14 years, and their disorder duration was 16.80±9.35 years. The average length of stay in the Forensic Psychiatry Unit is 319.42 days. See Table 1 for sociodemographic data and clinical and criminal variables. The percentage value of only one of the binary categorical variables is given in the table.

Tablo1. Descriptive features on sociodemographical- clinical- forensic characteristics of participants

Features	Patient Group (n=76)
Age Mean – STD	40,11–10,13
Living Environment (village/small town /town))	
Village n/(%)	4 (5,3%)
Small Town n/(%)	36 (47,4%)
Town/(%)	36 (47,4%)
Marital status during hospitalization (married/single)	
Married n/(%)	10 (13,2%)
Current social status(Alone/with family)	
Alone	13 (17,1%)
Educational Status (5 years and less/ More than five years)	
5 years and less	30 (40,5 %)
Having an occupational profession (Yes/no)	
Yes* n/(%)	17 (22,4%)
Having a regular job (Yes/no)	
Yes* n/(%)	10 (13,2%)
Disease onset age	23,30–9,51
Duration of hospitalization (day)	319,42 (13-2928)
Substance misuse history (Yes/no)	
Yes* n/(%)	44 (57,9%)
Susbtance misuse during current offense (Yes/no)	
Yes* n/(%)	25 (32,9%)
Existence of ASPD comorbidity (Yes/no)	
Yes* n/(%)	8 (10,5%)
Treatment adherence (Yes/no)	
Yes* n/(%)	11 (14,5%)
Suicide history (Yes/no)	
Yes* n/(%)	6 (7,9%)
History of incarceration (Yes/no)	
Yes* n/(%)	13 (17,1%)
The family visited regularly during hospitalization (Yes/no)	
Yes* n/(%)	13 (17,1%)
Having plan to return to the family home after discharge (Yes/no)	
Yes* n/(%)	50 (65,8%)
Good adaptation to the forensic unit (Yes/no)	
Yes* n/(%)	35 (47,9%)
Number of offense Mean – STD	2,8–2,74
Age of first offense Mean – STD	32,99–9,34
Age of current offense Mean – STD	35,13–9,95

STD: Standard deviation, n: number of participians,
*: percentage of only one of the 2 group categorical variables is given.

Mean scores for SSS were evaluated as follows; the Perceived Devaluation Subscale score was 17.91±8.19, the Internalized Stereotypes subscale score was 14.77±7.51, the Social Withdrawal and Concealment of the Disorder score was 4.77±2.70, SSS total score was 37.73±16,46. The arithmetic mean value for the SSS total score was 2.22, the Perceived Devaluation subscale score was 2.24, the Internalized Stereotypes subscale score was 2.11, Social withdrawal and concealment of illness subscale score was 2.39. This value stated the positive level on a 5-point Likert-type scale. It means that participants disagree with the statement about self-stigma.

Mean scores for PTCS were scored as follows; The Perception towards moral and personality traits of delinquents subscale score was 21.16±7.23, the Perception towards Social Networks of Delinquents subscale score was 11.16±4.03 and the PTCS total score was 32.30±10.38. The arithmetic mean value for the total value of PTCS was 2.69, the Perceptions towards Moral and Personality Traits of Delinquents subscale was 2.65, and The Perceptions towards Social networks of delinquents was 2.70. This value stated the neutral level on a 5-point Likert-type scale. It means that participants neither agree nor disagree with negative perceptions towards delinquents. (Table 2)

Correlation Analysis

According to the results, there is no significant correlation was found between current age, disease onset age, disease duration year, age at the time of offense, age at first offense, number of offenses, severity of offense, length of hospitalization, and SSS total and sub-dimension scores, and PTCS scale and subdimension scores. As expected, there was a significant correlation between PTCS and SSS scale and subscale scores. If it went into

Table 2. Total scores and subscale scores of the self-stigma scale and the perceptions towards criminals scale

	x	Mean	STD	Min	Max
Self-Stigma Scale (SSS)					
Internalized devaluation	2,24	17,91	8,19	8	39
Internalized stereotypes	2,11	14,77	7,5	7	34
Social withdrw. Concealm. of Disord.	2,39	4,77	2,70	2	10
SSS-Total	2,22	37,73	16,46	17	76
Perceptions Towards Criminals Scale (PTCS)					
Moral and Personality traits	2,65	21,16	7,23	8	40
Social Network	2,79	11,16	4,03	4	20
PTCS-Total	2,69	32,30	10,38	12	60

PTCS: Perceptions Towards Delinquents Scale, SSS:Self Stigma Scale, x: Aritmethic Mean, STD: Standard Deviation, Min: Minimum value, Max:Maximum value

details; a significant correlation was found between the PTCS total score and SSS Total score (r:0.355, p<0.003), the perceptions of the PTCS personality/morality sub-dimension and SSS Total score (r:0.287, p:0.019), and the PTCS social networks sub-dimension and SSS Total score (r:0.249, p:0.039). Similarly, there were found significant correlations between the internalized devaluation sub-dimension of the SSS and the PTCS Total score (p:0.000, r:0.411); the SSS internalized stereotype score and the total PTCS score (p:0.015, r:0.289); PTCS personality aspects subdimension score and SSS internalized devaluation (p:0.003, r:0.351), PTCS social network score and SSS internalized devaluation (p:0.008, r:0.306), PTCS total score and SSS internalized devaluation subscale (p:0.000, r: 0.411) and PTCS Total score and SSS internalized stereotype (p:0.015, r:0.289) (Table 3.)

Difference Analysis

In the present study, the relationships between sociodemographic, clinic, and offense-related variables, and the scale and subscale scores of SSS and PTCS were evaluated by difference analysis. A significant relationship was found only between receiving regular treatment before hospitalization and the social network sub-dimension of PTCS (U=217.50, Z=-2.026, p=0.043).

There was no significant relationship between the total scores and subscale scores of the scales and other sociodemographic, clinical, and offense-related variables (Table 3).

DISCUSSION

Studies have shown that individuals with mental disorders are subject to stigmatization, and as a result, this situation is associated with social withdrawal, negative outcomes of disorders, decreased treatment adherence, and lower social skills (26, 27). In studies on stigma in schizophrenia, it is stated that internalized stigma levels are generally high in both outpatients and inpatients, and it is recommended that it should not be overlooked in the management of schizophrenia (28, 29). In a study which is performed in Turkey that enrolled 63 outpatients diagnosed with schizophrenia, it was stated that internalized stigma was associated with low treatment adherence (30). In a study investigating the levels of self-stigma, measured by SSS, in patients with schizophrenia treated in a Community Mental Health Center (CMHC) and psychiatry outpatient clinic, higher scores were obtained compared to the scores measured in this study (31). In another study, all three sub-dimensions of the SSS score were evaluated in members of the Schizophrenia Friends Association and all three sub-dimensions of the SSS score were calculated higher than in this study (32). In this study, self-stigma levels were evaluated with the SSS in 76

Table 3. Examining the relation between sociodemographic, clinical, and offense-related variables with the self-stigma scale and the perceptions towards criminals scale with Spearman Correlation Analysis

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1.Age	CC	1.000	.600**	.926**	.771**	.141	.015	.002	.529**	-.028	-.066	.063	.051	-.007	-.110	-.021
2.Disease onset age	CC	.600**	1.000	.643**	.632**	.078	-.031	-.104	-.232*	-.057	-.078	.016	-.084	-.093	-.097	-.109
3.Age at current offense	CC	.926**	.643**	1.000	.868**	.044	-.011	-.067	.406**	-.050	-.090	.072	.041	.010	-.063	-.004
4.age at first offense	CC	.771**	.632**	.868**	1.000	-.207	.054	-.092	.270*	-.014	-.030	.068	.001	-.026	-.152	-.051
5.Number of offense	CC	.141	.078	.044	-.207	1.000	.119	.194	.070	.036	.035	.090	.077	.010	.236*	.070
6.Duration of hospitalization	CC	.015	-.031	-.011	.054	.119	1.000	.302**	.006	.178	.218	.091	.161	.028	.172	.048
7.Offense severity	CC	.002	-.104	-.067	-.092	.194	.302**	1.000	.106	.060	.116	-.056	.056	-.051	.062	-.071
8.Duration of ilness	CC	.529**	-.232*	.406**	.270*	.070	.006	.106	1.000	-.020	-.045	.041	.069	.001	-.134	-.011
9.PTCS.Tot.	CC	-.028	-.057	-.050	-.014	.036	.178	.060	-.020	1.000	.942**	.826**	.411**	.289*	.219	.355**
10.PTSC-pers-moral.	CC	-.066	-.078	-.090	-.030	.035	.218	.116	-.045	.942**	1.000	.621**	.351**	.234	.177	.287*
11.PTCS-Soc.netw.	CC	.063	.016	.072	.068	.090	.091	-.056	.041	.826**	.621**	1.000	.306**	.206	.155	.249*
12.SSS-int.dev.	CC	.051	-.084	.041	.001	.077	.161	.056	.069	.411**	.351**	.306**	1.000	.712**	.611**	.906**
13.SSS-int. Stere.	CC	-.007	-.093	.010	-.026	.010	.028	-.051	.001	.289*	.234	.206	.712**	1.000	.569**	.905**
14. SSS. Soc. Withd. Conc. dis	CC	-.110	-.097	-.063	-.152	.236*	.172	.062	-.134	.219	.177	.155	.611**	.569**	1.000	.724**
15.SSSTot.	CC	-.021	-.109	-.004	-.051	.070	.048	-.071	-.011	.355**	.287*	.249*	.906**	.905**	.724**	1.000

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).
CC: Spearman Correlation Coefficient, p: Significance (2 tailed), PTCS: Perceptions Towards Criminals Scale, PTCS Soc netw.:PTCS-Social Network Subscale,, PTCS Pers. Moral: PTCS, Personality traits and Moral subscale, PTCS Tot.: PTCS Total Score, SSS: Self Stigma Scale, SSS nt. Dev.: SSS Internalize Devaluation Subscale, SSS int. stereo: SSS Internalized Stereotypes Subscale, SSS Soc. Withd. Cons. Dis: SSS Social Withdrawal and Concealment the Disorder Subscale, SSS Tot: SSS Total Score

patients receiving inpatient treatment in a high-security forensic psychiatry service, and lower self-stigma levels were shown compared to those two studies conducted in Turkey.

According to the mean scores of the SSS, it was observed that the patients included in the present study had lower levels of perceptions of devaluation, internalization of stereotypes, social withdrawal and a tendency to concealment the disease and the total level of self-stigma. In the evaluations made for patients receiving inpatient treatment in forensic psychiatry services in our country, it has been stated that the level of internalized stigma was at a neutral level (33, 34). We thought that the low self-stigma tendency in this study might be related to the difference in the research populations. Because the research population is not homogeneous in terms of psychiatric diagnoses in the beforementioned studies, the scales were performed on patients without diagnostic discrimination, and patients diagnosed with schizophrenia constitute a small portion of the sample. The population of the current study, as a more homogeneous group, consists of people diagnosed with schizophrenia and hospitalized in high-secure forensic psychiatric services. In this sense, results may be valuable. The findings are descriptive in terms of double stigma in the group of forensic patients diagnosed with schizophrenia receiving inpatient treatment, that is, due to both their mental disorder and their offensive behavior.

The participants neither agreed nor disagreed with the negative perceptions in the Perceptions Towards Criminals Scale, in all sub-dimensions and the whole scale, considering the arithmetic mean score of the scale total score and subdimension score in the study. There is no other study in the literature investigating the perceptions of the patient group toward making offense. Generally, studies conducted on professionals are available. For example, the average of the total scale scores of the participants in social work students is 3, 2.73 for the personality traits sub-dimension, and 3.5 for the social networks sub-dimension (35). The averages for social work students are similar to the present study but relatively low. When the arithmetic mean of both scales in the current study was evaluated, it was determined that self-stigma was low and perceptions towards criminals were neither positive nor negative in the study population. Our results did not coincide with the double stigma theory. According to double stigma theory, it is expected that experiences of being hospitalized in a forensic psychiatry service, or committing an offense will increase self-stigmatizing tendencies. Contrary to expectations, the tendencies of patients with schizophrenia receiving inpatient treatment in the forensic psychiatry service of our hospital regarding self-stigma are generally positive. In addition, similar to the SSS, it was observed that forensic psychiatry patients did not have negative perceptions about delinquents but they were rather neutral. Although studies in the literature generally support the double stigma theory, there are also studies showing similar results to the current study. The findings are consistent with Wall et al.'s (2017) study results in which the mental disorder perception for schizophrenia was compared in patients hospitalized in the forensic service and the general adult psychiatric service. In this study, it was stated

Table 4. Examination of clinical, sociodemographic and crime-related binary categorical variables in terms of self-stigma and perceptions towards criminals -difference analysis

	PTCS-Pers.	PTCS-Social	PTCS-Tot.	SSS- D	SSS- S	SSS-SW-CD.	SSS Total
Marital Status	.356	.505	.308	.099	.149	.104	.068
Living Enviroment (town/village-small town)	.173	.435	.161	.053	.193	.102	.061
Educational Status (5 years and less/ More than five years)	.486	.978	.631	.208	.782	.921	.467
Having a regular job	.968	.724	.974	.714	.820	.344	.840
Substance Misuse History	.439	.996	.497	.279	.137	.636	.201
Existence of ASPD comorbidity	.916	.736	.993	.803	.908	.162	.985
Treatment adherence	.932	**.043**	.297	.426	.230	.367	.401
Offence severity-(minimal/serious)	.282	.870	.453	.331	.870	.269	.955
Suicide history	.520	.731	.786	.639	.420	.401	.793
History of incarcerations	.371	.368	.308	.449	.473	.969	.503
Having plan to live with family after discharge	.054	.709	.132	.444	.912	.640	.468
Regular meeting with family during hospitalization	.880	.540	.885	.994	.696	.689	.904

Note, PTCS: Perceptions Towards Criminals Scale, PTCS Soc..:PTCS-Social Network Subscale,, PTCS Pers.: PTCS, Personality traits and Moral subscale, PTCS Tot.: PTCS Total Score, SSS: Self Stigma Scale, SSS .D..: SSS Internalized Devaluation Subscale, SSS ID: SSS Internalized Stereotypes Subscale, SSS SW-CD: SSS Social Withdrawal and Concealment the Disorder Subscale, SSS Tot: SSS Total Scorep: Mann Whitney U significance

that the perceptions of patients hospitalized in the forensic service towards schizophrenia were less negative (36). In another study, forensic psychiatry patients and non-forensic patients with schizophrenia were compared. It was found that the levels of shame experienced by the patients regarding their illness were similar (36). In those studies, researchers explained that the lower or similar levels of stigmatization in forensic psychiatry patients compared to the non-forensic group was the longer duration of hospitalization in forensic psychiatry services, and the positive effects of the interventions made during the hospitalization. The participants were enrolled in the study after the clinicians reached the consensus to release the patient and their average length of hospitalization was 319 days. During the hospitalization process, interactive group therapies, individual psychotherapies (psychoeducational interventions and supportive approaches), and psychosocial rehabilitation interventions are applied to the patients. Interventions aimed at management of the stigmatization are implemented through both group and individualized therapeutic modalities within the hospital. These interventions, however, are not explicitly integrated into a structured program. Therefore, although it is very assertive to say that the stigma levels in patients may be lower due to the interventions with the results of the study as highlighted in the literature, it brought this interpretation to mind. Studies evaluating the effectiveness of treatment in forensic psychiatry settings will contribute to clarification of the relationship between stigma and therapeutic interventions.

Disparities in attitudes towards individuals with mental disorders have been documented within the literature across different countries (38). Although there are limited studies on this topic, various cultural factors associated with public stigma have been identified (39). To investigate stigma-related sociocultural factors in order to develop culture-specific interventions for stigma would be beneficial. In our literature review, The study investigating the relationship between the establishment time of forensic psychiatry hospitals and social stigma was not discerned. Nevertheless, it is important to note that investigations observed more negative attitudes towards psychiatric patients who have committed offenses were conducted in countries where the forensic psychiatric care system is well-established (10,15). As an interpretation of this situation, although these countries specialize in the management of forensic psychiatric care, the insufficiency of interventions to prevent public stigmatization may have caused high levels of stigmatization. On this interpretation, we would like to emphasize to the multifactorial structure of public stigmatization rather than the inadequacy of institutions. This study does not constitute a cross-cultural comparison. Despite the heightened stigmatized attitudes towards forensic psychiatry patients reported in the existing literature, our study suggests that such findings may not be applicable to our country. In our country, High-Security Forensic Psychiatry Hospitals have been in the process of institutionalization in our country for five years. For this reason, public stigmatizing attitudes toward the relationship between hospitalizations in forensic psychiatry hospitals and delinquency may be inchoate in our country. As a result, the public stigmatizing effect of delinquency and hospitalizations in forensic psychiatry hospitals may be relatively lower. According to the results of our research, the internalized stigmatization level of patients hospitalized in forensic psychiatry settings is not at a very high level in our country. It should be considered as an opportunity to prevent the internalized stigma of patients and public stigma towards forensic psychiatric patients at an early stage in Turkey.

Although large samples and comparative studies are needed to test the legitimacy of the double stigma hypothesis in forensic psychiatry patients in our country, our results showed that the double stigma hypotheses associated with forensic hospitalizations may not be accurate in our country. We did not compare the forensic schizophrenia patients with non-forensic schizophrenia patients in the study. Nevertheless, the findings of our research are descriptive in terms of double stigma in the group of forensic patients diagnosed with schizophrenia receiving inpatient treatment, that is, due to as well as their stigma experiences about their mental disorder and delinquency. Moreover, considering the knowledge from the literature, while higher stigma was expected, our results that it was scored at lower levels in forensic patients thought that there may be a difference for our

country in terms of the forensic psychiatry population. Our research has previousness for future comparative studies with large samples involving the forensic psychiatry population in our country. The results of the study may be thought that it will contribute to the development of treatment and rehabilitation programs by planning preventive medical approaches and preventing stigmatization specific to the diagnosis group.

Another important result of the study is that it has been shown that perceptions towards delinquents' social networks are more negative in the forensic patient group receiving regular treatment. In other words, the perception that delinquents have poor social relations is higher in the forensic patient group receiving regular treatment. Conversely, current age, age at the time of the offense, age at first offense, duration of disorder, length of status, employment status, marital status, educational status, whether or not living with the family before hospitalization, having a plan to stay with the family or alone after hospitalization, substance misuse history, suicide attempt history, having a history of incarceration in the past, existence of comorbid ASPD, and moderate or serious offense severity did not cause a significant difference in terms of self-stigma and perceptions towards delinquents. In the literature, there are various results in studies investigating stigma-related factors in mental disorders. In a study conducted in a Chinese population, female gender, young age, presence of insight into disorders, and long duration of untreated psychosis were associated with high internalized stigma (40, 41). In a meta-analysis study conducted last year, living outside of urban areas, having a low-income level, being single, unemployment, high-dose antipsychotic use, and low functionality were associated with different dimensions of stigma (42). In this meta-analysis, similar to the current study, sociodemographic variables such as the age of onset of the disease, duration of the disease, age, and education level were not associated with self-stigmatization. The presence of different findings despite extensive studies may be related to the characteristics of the study samples. Since those studies were conducted in different countries participants had different cultural characteristics, the results may affected. In addition, although severe mental disorders are chronic, whether the participants are in the early or late stages of the disease process may affect the results. It has been reported in our country that factors such as being single, occupational status, educational status, marital status, disease onset age, and duration of disorder do not reveal a significant difference in terms of internalized stigma in patients diagnosed with schizophrenia and schizoaffective disorder (21). Similar to this research conducted in our country, no difference was found in terms of sociodemographic variables. We also found that clinical variables such as antisocial personality disorder, suicide attempt history, drug history, and offense-related factors such as age at first offense and offense severity were not associated with self-stigma. It is noteworthy that, receiving regular treatment was associated with more positive perceptions towards criminals. The findings of the study highlight the relationship between stigma and treatment adherence in the literature (2,7,30). However, it cannot be said whether good treatment adherence has a positive effect on stigma with these results. Because these results can also be interpreted as low self-stigma is associated with high treatment compliance. Clarification of this is only possible with comprehensive prospective studies.

The need to investigate stigmatization, especially in specific groups, has been reported in many studies (42). The present study is valuable in that it shows the factors associated with stigmatization in a more specific group of patients with schizophrenia receiving inpatient treatment in forensic psychiatry. Considering the results of the study and literature, it was thought that possible differences may be obvious in studies with large samples and various variables in this study. In this sense, with the findings obtained from comprehensive studies in which the effects of possible variables' effects in preventing self-stigma are investigated in detail, treatment targets can be made more specific, thus stigma can be prevented.

The distinctive value of the study is that there is no other study examining perceptions of delinquents in a group of forensic psychiatry patients diagnosed with schizophrenia receiving inpatient treatment, and that self-stigma towards co-occurring mental disorder has been examined. The fact that the scale assessing the perception towards delinquents scale

was developed in Turkey and that culturally sensitive, easy-to-use inventories developed for patients with schizophrenia in Turkey were used in the study contribute to the sensitivity of the research.

Limitations

The scales we used in this study were marked by the patients themselves. This could have resulted in measurement bias in psychiatric disorders such as schizophrenia which observed verbal function impairment. However, in our study, scales adapted to Turkish were used to prevent other possible limitations related to verbal impairment. This provided for linguistically and culturally sensitive measurement.

As we mentioned before, an important limitation of the study is that there was no control group with which we could compare the study populations. Comparative studies with large samples are needed to clarify the double stigma in forensic psychiatry patients.

Another limitation of the study is that female patients were not included. Considering the studies showing that self-stigma levels are higher in women (40), it is an important limitation that the sample consists of only male patients. However, our hospital has forensic settings only for male patients. So, results can only be generalized to male patients. Additionally, since this study was conducted with a specific group that is patients with schizophrenia hospitalized in forensic settings, the number of people we could reach in the study is small. These situations may have caused existing relationships not to be shown.

In addition, symptom severity was not evaluated. This is a limitation, considering that there is a relationship between symptom severity and internalized stigma (7, 43, 44). However, considering the patients are in the discharge process, which means their symptom severity was reduced enough for the discharging decision, we thought that all of them were in, so it would not make a significant difference in the results.

The research is valuable in terms of both investigating self-stigma and perceptions towards delinquents in patients with schizophrenia receiving inpatient treatment in a high-secure forensic psychiatry service in Turkey. The research differs in that it specifically focused on assessing individuals diagnosed specifically with schizophrenia. Contrary to expectations in the literature, low levels of stigmatization were observed in forensic psychiatry patients. This may be related to the positive effects of the pharmacotherapy and psychotherapy interventions during the hospitalization period and perhaps the experience of observing other forensic psychiatry patients. Another reason may be that forensic psychiatry services have not become widespread in our country yet. Early prevention of public stigma regarding hospitalizations in forensic psychiatry services in our country will be beneficial. In this sense, providing lectures about psychiatric disorders to the general public and monitoring the news in the media may help to prevent the occurrence of public stigma.

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REFERENCES

1. Corrigan PW. The impact of stigma on severe mental illness. Cognitive and Behavioral Practice 1998; 5(2): 201-222.

2. Corrigan PW. Challenging the Stigma of Mental Illness: Different Agendas, Different Goals. Psychiatr Serv 2015; 66(12): 1347-1349.

3. de Jacq K, Norful AA, Larson E. The Variability of Nursing Attitudes Toward Mental Illness: An Integrative Review. Arch Psychiatr Nurs 2016; 30(6): 788-796.

4. Quinn DM, Williams MK, Weisz BM. From discrimination to internalized mental illness stigma: The mediating roles of anticipated discrimination and anticipated stigma. Psychiatr Rehabil J 2015 Jun; 38(2): 103-108.

5. Link BG. Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. American sociological review 1987: 96-112.

6. Corrigan PW, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can J Psychiatry 2012 Aug; 57(8): 464-469.

7. Dubreucq J, Plasse J, Franck N. Self-stigma in Serious Mental Illness: A Systematic Review of Frequency, Correlates, and Consequences. Schizophr Bull 2021 Aug; 47(5): 1261-1287.

8. Campanelli PC, Cleek EN, Gold PB, Lieberman HJ, Nakagawa A, Skoraszewski M. Screening offenders with histories of mental illness and violence for supportive housing. J Psychiatr Pract 2005 Sep; 11(5): 279-288.

9. Rade CB, Desmarais SL, Mitchell RE. A Meta-Analysis of Public Attitudes Toward Ex-Offenders. Criminal Justice and Behavior 2016; 43(9): 1260-1280.

10. Tremlin RC, Beazley P. A systematic review of offender mental health stigma: commonality, psychometric measures and differential diagnosis. Psychology, Crime & Law 2022:1-25. DOI: 10.1080/1068316X.2022.2072842

11. Feingold ZR. The stigma of incarceration experience: A systematic review. Psychology, Public Policy, and Law 2021; 27(4): 550.

12. Livingston JD, Rossiter KR, Verdun-Jones SN. 'Forensic' labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. Psychiatry Research 2011; 188(1): 115-122.

13. Hartwell S. Triple Stigma: Persons with Mental Illness and Substance Abuse Problems in the Criminal Justice System. Criminal Justice Policy Review 2004; 15(1): 84-99.

14. West ML, Yanos PT, Mulay AL. Triple Stigma of Forensic Psychiatric Patients: Mental Illness, Race, and Criminal History. International Journal of Forensic Mental Health 2014; 13(1): 75-90.

15. Healey LV. The psychometric properties of the Forensic Stigma Scale (FSS). International Journal of Law and Psychiatry 2022; 83:101804.

16. Margetić B, Aukst-Margetic B, Ivanec D, Filipcić I. Perception of stigmatization in forensic patients with schizophrenia. Int J Soc Psychiatry 2008 Nov; 54(6): 502-513.

17. Beis P, Graf M, Hachtel H. Impact of legal traditions on forensic mental health treatment worldwide. Frontiers in Psychiatry 2022; 13: 876619.

18. Upfold C, Jentz C, Heilmann P, Nathanielsen N, Chaimowitz G, Sørensen LU. Forensic psychiatry patients, services, and legislation in Nunavut and Greenland. International journal of law and psychiatry 2023; 91: 101921.

19. Balcioglu YH, Oncu F, Kennedy HG. Forensic psychiatry in Turkey. International Review of Psychiatry 2023: 1-17.

20. 5237 sayılı Türk Ceza Kanunu. Availlable from; https://www.mevzuat.gov.tr/mevzuatmetin/1.5.5237.pdf (erişim tarihi 01.10.2023)

21. Yıldız M, Kiras F, İncedere A, Abut FB. Development of self-stigma inventory for patients with schizophrenia (SSI-P): reliability and validity study. Psychiatry and Clinical Psychopharmacology 2019; 29(4): 640-649.

22. Kaplanoğlu E. Mesleki Stresin Temel Nedenleri Ve Muhtemel Sonuçları: Manisa Ilindeki SMMM'ler Üzerine Bir Araştırma. Muhasebe ve Finansman Dergisi 2014;(64): 131-150.

23. Gonultas MB, Ozturk M, Rios EYZ, Kanak M, Demir E. Perceptions toward Criminals Scale: the reliability and validity analyses/Suclulara Yonelik Algilar Olcegi: Gecerlilik ve guvenilirlik calismasi. Anadolu Psikiyatri Dergisi 2019; 20(1): 41

24. Taylor PJ. Motives for offending among violent and psychotic men. Br J Psychiatry 1985 Nov; 147: 491-498.

25. Balcioglu YH, Oncu F. Adaptation of the Turkish version of the Violence Profile for Current Offense to evaluate the violence severity of index offense. Dusunen Adam 2021; 34(3): 315-317.

26. Abiri S, Oakley LD, Hitchcock ME, Hall A. Stigma-related avoidance in people living with severe mental illness (SMI): Findings of an integrative review. Community mental health journal 2016; 52: 251-261.

27. Javed A, Lee C, Zakaria H, et al. Reducing the stigma of mental health disorders with a focus on low-and middle-income countries. Asian journal of psychiatry 2021;58:102601.

28. Fadipe B, Adebowale TO, Ogunwale A, Fadipe YO, Ojeyinka A-HA, Olagunju AT. Internalized stigma in schizophrenia: a cross-sectional study of prevalence and predictors. International Journal of Culture and Mental Health 2018; 11(4): 583-594.

29. Dhungana S, Tulachan P, Chapagai M, Pant SB, Lama PY, Upadhyaya S. Internalized stigma in patients with schizophrenia: A hospital-based cross-sectional study from Nepal. Plos one 2022; 17(3): e0264466.

30. Yılmaz E, Okanlı A. The Effect of Internalized Stigma on the Adherence to Treatment in Patients With Schizophrenia. Archives of Psychiatric Nursing 2015 2015; 29(5): 297-301.

31. Kurt A, Erşan EE, Savaş İ. Comparison of self-stigma and subjective recovery status of patients receiving Community Mental Health Service and outpatient psychiatry policlinic. Journal of Psychiatric Nursing 2021; 12(2): 103-112.

32. Duran S, Öz YC. The Impact of Family Environment on Self-Stigmatization and Social Functionality Among Schizophrenic Patients. Ethiopian Journal of Health

Development 2022; 36(1).

33. Arabaci LB, Basogul C, Büyükbayram A. Adli psikiyatri hastalarinin içsellestirilmis damgalanma ve sosyal islevsellik düzeyleri/Social functionality and internalized stigmatization levels of forensic psychiatry patients. Anadolu Psikiyatri Dergisi 2015; 16(2): 113.

34. Kılıçaslan AK, Yıldız S, Emir BS, Osman K. Internalızed Stigma, Perceived Social Support, And Life Quality In Patients Admitted to a Forensic Psychiatry Unit. Journal of Istanbul Faculty of Medicine 2022; 85(3): 378-387.

35. Gönültaş BM, Öztürk M. Sosyal hizmet öğrencilerinin suçlulara yönelik algılarının değerlendirilmesi. Toplum ve Sosyal Hizmet 2020; 31(2): 477-499.

36. Wall ELE, Mirfin D, White S, Mezey GC. Patient perceptions of schizophrenia in forensic and general adult psychiatry. The Journal of Forensic Psychiatry & Psychology 2017; 28(3): 357-367.

37. Lateef R, Moloney F, Ali A, Jones RM. Shame among Forensic and Non-Forensic Patients and the Impact of the Social Determinants of Health: A Pilot Study. Journal of Forensic Psychology Research and Practice 2023; 23(1): 92-111.

38. Krendl AC, Pescosolido BA. Countries and cultural differences in the stigma of mental illness: the east–west divide. Journal of Cross-Cultural Psychology 2020; 51(2): 149-167.

39. Ran MS, Hall BJ, Su TT, Prawira B, Breth-Petersen M, Li XH, Zhang TM. Stigma of mental illness and cultural factors in Pacific Rim region: a systematic review. BMC Psychiatry 2021: 21; 1-16.

40. Chu RST, Ng CM, Chu SC, Lui TT, Lau FC, Chan SKW, Lee EHM, Hui CLM, Chen EYH, Lui SSY, Chang WC. Rate and correlates of self-stigma in adult patients with early psychosis. Front Psychiatry. 2023 Jul 13;14:1200568. doi: 10.3389/fpsyt.2023.1200568. PMID: 37520240; PMCID: PMC10374014.

41. Ho RWH, Chang WC, Kwong VWY, Lau ESK, Chan GHK, Jim OTT, Hui CLM, Chan SKW, Lee EHM, Chen EYH. Prediction of self-stigma in early psychosis: 3-Year follow-up of the randomized-controlled trial on extended early intervention. Schizophr Res. 2018 May;195:463-468. doi: 10.1016/j.schres.2017.09.004. Epub 2017 Sep 7. PMID: 28888358.

42. Fond G, Vidal M, Joseph M, Etchecopar-Etchart D, Solmi M, Yon DK, Correll CU, Boyer L. Self-stigma in schizophrenia: a systematic review and meta-analysis of 37 studies from 25 high- and low-to-middle income countries. Mol Psychiatry. 2023 May;28(5):1920-1931. doi: 10.1038/s41380-023-02003-4. Epub 2023 Mar 8. PMID: 36890299.

43. Livingston JD, Boyd JE. Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. Social Science & Medicine 2010; 71(12): 2150-2161.

44. Tomar N, Brinkley-Rubinstein L, Ghezzi MA, Van Deinse TB, Burgin S, Cuddeback GS. Internalized stigma and its correlates among justice-involved individuals with mental illness. International Journal of Mental Health 2020; 49(2): 201-211.