The relationship between internalized stigma and coping strategies in bipolar disorder

Bipolar bozuklukta içselleştirilmiş damgalanma ile başa çıkma tutumları arasındaki ilişki

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SUMMARY

Objective: The aim of this study was to evaluate the relationship between internalized stigma and coping attitudes in patients in remission of bipolar disorder. **Method:** The study included 77 patients in remission who were diagnosed with bipolar affective disorder according to DSM-IV by applying the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I). Euthymia was established using the Young Mania Rating Scale and the Hamilton Depression Rating Scale. All patients were evaluated with a Sociodemographic Data Form, the Internalized Stigma in Mental Illness Scale (ISMI) and the Coping Attitudes Rating Scale (COPE). **Results:** The perceived discrimination subscale scores of patients living in towns/villages were found to be significantly higher than those living in urban areas (p=0.038). A positive correlation was found between the total number of episodes (10.0±10.8), the number of depressive episodes (3.7±4.8) and the history of depression with psychotic features and internalized stigma. Patients showing active coping, planning, use of useful social support, positive reinterpretation and development of coping styles were found to have lower internalized stigma scores and higher stigma resistance; moreover, patients using behaviorally disengaged coping styles had higher internalized stigma scores and lower stigma resistance. **Discussion:** According to the results of our study, active coping, planning, use of useful social support, positive reinterpretation and support of developmental coping attitudes, which are among the functional coping attitudes, and attempts to reduce the behavioral disregard of maladaptive coping attitudes can be targeted to reduce internalized stigma.

Key Words: Bipolar Disorder, Stigma, Coping Strategies

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ÖZET

Amaç: Bu çalışma ile bipolar bozukluk remisyon dönemindeki hastalarda içselleştirilmiş damgalanma ile başa çıkma tutumları arasındaki ilişkiyi ortaya koymak amaçlanmıştır.**Yöntem:** Çalışmaya psikiyatri polikliniğine ayaktan başvuran ve tedavisi devam etmekte olan, DSM-IV Eksen I Bozuklukları İçin Yapılandırılmış Klinik Görüşme (SCID-I) uygulanarak DSM-IV'e göre bipolar affektif bozukluk tanısı alan, remisyon dönemindeki 77 hasta dahil edilmiştir. Ötimi ölçütleri Young Mani Derecelendirme Ölçeği ve Hamilton Depresyon Derecelendirme Ölçeği kullanılarak belirlenmiştir. Tüm hastalar Sosyodemografik Veri Formu, Ruhsal Hastalıklarda İçselleştirilmiş Damgalanma Ölçeği (RHİDÖ) ve Başa Çıkma Tutumlarını Değerlendirme Ölçeği (COPE) ile değerlendirilmiştir. **Bulgular:** Kasaba/köyde yaşayan hastaların algılanan ayrımcılık alt ölçek puanları kentte yaşayanlara göre anlamlı düzeyde yüksek bulunmuştur (p=0,038). Toplam dönem sayısı (10.0±10.8), depresyon dönemi sayısı (3.7±4.8) ve psikotik özellikli depresyon öyküsü ile içselleştirilmiş damgalanma arasında pozitif yönde ilişki tespit edilmiştir. Başa çıkma tutumlarından aktif başa çıkma, plan yapma, yararlı sosyal destek kullanımı, pozitif yeniden yorumlama ve gelişme başa çıkma tutumlarını kullanan hastaların içselleştirilmiş damgalanma puanlarının daha az, direncin daha fazla olduğu, davranışsal olarak boş verme başa çıkma tutumunu kullanan hastaların içselleştirilmiş damgalanma puanlarının yüksek, dirençlerinin ise düşük olduğu belirlenmiştir. **Sonuç:** Çalışmamızın sonuçlarına göre işlevsel başa çıkma tutumlarından olan aktif başa çıkma, plan yapma, yararlı sosyal destek kullanımı, pozitif yeniden yorumlama ve gelişme başa çıkma tutumlarının desteklenmesi, uyumsuz başa çıkma tutumlarından davranışsal olarak boş verme tutumunun azaltılmasına yönelik girişimlerde bulunulması içselleştirilmiş damgalanmayı azaltmak için hedeflenebilir.

Anahtar Sözcükler: Bipolar Bozukluk, Damgalanma, Başetme Stratejileri

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INTRODUCTION

Stigma entails discrediting an individual, being seen as inferior to others and being vilified in a way that distinguishes them from others (1). Among all patients, those diagnosed with mental disorders are generally exposed to the negative consequences of the stigmatization the most. One of the biggest barriers to the diagnosis and treatment of mental disorders is stigmatization, prejudiced thinking/behaviour, stereotypical behaviours and discrimination against people with mental disorders (2). Internalized stigma is the individual's acceptance of negative stereotypes in society for themselves. As a consequence, the individual withdraws themselves from society with negative feelings such as worthlessness and shame (1). Bipolar disorder (BD) is relatively less recognized and stigmatized by society; nonetheless, the patients experience the feeling of stigma intensely, that is, they stigmatize themselves (3). Internalized stigma harms patients by worsening the symptoms of the disease and delaying recovery (4). There is an urgent need to address internalized stigma in the treatment process (2).

In the face of illnesses, an individual develops various coping attitudes to minimize and cope with the negative effects of the illness. Patients suffering from mental illnesses also apply certain coping attitudes to avoid or reduce rejection (5). Coping techniques that are used to alleviate or solve a perceived threat or problem can play an important role in adapting to challenging situations, protecting the individual against environmental, biological and cognitive factors, and maintaining functionality (6,7). However, while some of these coping efforts are likely to be effective, others may have significant adverse consequences. Coping attitudes generally serve to solve a problem and adapt to a situation by reducing mental stress; such attitudes, however, may also cause the stress response to gain a negative quality, making the solution difficult or impossible, thus increasing the mental distress caused by stress (6,8). Knowing the coping attitudes used by an individual may help in understanding the role of psychopathology, determining treatment goals and monitoring therapeutic effectiveness, as well as helping to prevent the occurrence of additional problems (9).

Several studies have been reported in the scientific literature on the relationship between schizophrenia and stigma; only a few studies have drawn attention to stigma in patients with bipolar disorder. The current study aimed to reveal the relationship between coping attitudes and internalized stigma in patients with BD in remission. To our knowledge, the current study is the first to explore the relationship between internalized stigma and coping attitudes in BD patients.

METHOD

Sampling

Participants were selected among patients; who applied to the Karadeniz Tecnichal University Faculty of Medicine Psychiatry Outpatient Clinic between July 2013 and April 2014, were diagnosed with bipolar disorder according to DSM-IV and were still under treatment. Only patients in remission were included in the study. Patients between the ages of 18-65, at least primary school graduates and those who agreed to participate in the study were included. The patients who were followed up with BD in the clinic were evaluated by the researcher for the diagnosis with a clinical examination before being included in the study. The remission status of the patients was evaluated by the clinician with the Hamilton Depression Rating Scale (HAM-D) and the Young Mania Rating Scale (YMRS). The patients with a HAM-D score of seven and a YMRS score of six and below were included in the study. The 8-week time required to use the definition of remission was determined by considering Perlis et al.'s (2007) study "Predictors of recurrence in bipolar disorder: primary results of the Systematic Treatment Development Program for Bipolar Disorder (STEP-BD)" (10). Approval for the research was obtained from the ethics committee of Karadeniz Technical University, Faculty of Medicine (01.10.2013, 2013/71)

Tools

DSM-IV Structured Clinical Interview-Clinical Version (SCID-CV): DSM-IV is a structured clinical interview scale used to diagnose Axis-I disorders. It consists of six modules and investigates 38

disorders in the DSM-IV Axis-I using diagnostic criteria and 10 disorders without the use of diagnostic criteria. Application of the scale takes about 25-60 minutes on average (11). The Turkish adaptation of the scale developed by First et al. (12) and its reliability study were reported by Özkürkçügil et al. (1999) (13).

Sociodemographic Data Collection Form: Data on age, gender, place of residence, marital status, level of education, income, diagnosis, age of onset of illness, family history of psychiatric illnesses, disease duration, the total number of hospitalizations, type of bipolar disorder, type of first and last episode, and the total number of episodes were collected. Information was obtained from patients' file records and through direct interviews with patients.

Hamilton Depression Rating Scale (HAM-D): HAM-D is used to measure the severity of depression. It is not a diagnostic tool; rather, it is used to monitor the course of depression. The original scale reported by Hamilton (1960) has 17 items and predominantly evaluates somatic complaints. A score of 0-4 is given for each item with the highest possible score of 53. Reliability and validity studies for the Turkish version of the scale were carried out by Akdemir et al. (14).

Young Mania Rating Scale (YMRS): YMRS is a scale developed by Young et al (15) to measure the severity and change of mania. The reliability and validity study of the Turkish version was performed by Karadağ et al. This scale consists of 11 items and each measures 5-stage symptom severity (16). A clinician obtains the data by marking it on the scale during an interview with the patients. The total score of the scale is obtained by summing the scores obtained from each item. YMRS is not used for diagnosis.

Internalized Stigma Scale in Mental Illnesses (ISMI): ISMI used to determine internalized stigma, was developed by Ritsher et al. (2003). It is a self-report scale consisting of 29 items. The scale evaluates the subjective stigmatization experiences of individuals within the framework of five subscales called “Alienation”, “Confirmation of Stereotypes”, “Perceived Discrimination”, “Social Withdrawal” and “Stigma Resistance ” (11). The items in ISMI are evaluated with a four-point Likert-type scale of “strongly disagree” (1 point), “disagree” (2 points), “agree” (3 points), and “strongly agree” (4 points).

Coping Attitudes Assessment Scale (COPE): COPE was developed by Carver and Scheier in 1989, aiming to evaluate the coping attitudes used by individuals who are faced with difficult or distressing events or problems in their daily lives. The scale was translated into Turkish by Agargün et al.in 2005 and its validity and reliability study has been conducted (7, 17). COPE is a self-report scale with 15 subscales and 60 questions. Each of these subscales gives information about a different coping attitude. As a result, the score obtained from each sub-scales indicates which coping attitude is used more by the individual (17). The sub-dimensions of the coping attitudes scale are as follows (6): Use of instrumental social support, active coping, restraint, suppression of competing activities, planning, positive reinterpretation and growth, religious coping, humour, acceptance, use of emotional social support, focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, substance use. Each of the subscales provides information about a separate coping attitude. The total score of the first five of these subscales gives the "Problem-Focused Coping" score, the sum of the 6–10 subscale scores gives the "Emotional-Focused Coping" score and the total of the last five subscale scores gives the score of "Dysfunctional Coping". The high scores of the subscales allow commenting on which coping attitude is used more by the person (18).

Statistical analyses

In our study, as a result of the post-power analysis of the internalized stigma scale according to the coping strategies of the patients with bipolar disorder in remission; with 95% confidence (1-α), 81% test power (1-β), d=0.381 effect size, the number of samples to be taken was 72. Considering the withdrawal status of the patients, the study was conducted with 76 people. SPSS 13 for Windows was used for statistical analysis of the data obtained from the study. The data obtained by measurement were expressed as mean and standard deviation,

while qualitative data were expressed as numbers and %. Pairwise comparisons according to clinical characteristics were carried out with Student's t-test when the data were parametric and Mann Whitney U test when the data were non-parametric. ANOVA was used for data with normal distribution in comparisons of three or more groups (the Bonferroni test was used as a post hoc test). The Kruskal Wallis test was used for data that did not fit normal distribution (the Mann-Whitney U test was used as a post hoc test). The conformity of the data to a normal distribution was examined with the Kolmogorov-Smirnov test. Relationships between scales were determined by correlation analysis.

RESULTS

Clinical characteristics

Of the 77 BD patients who participated in the study, 29 (37.5%) were male and 48 (62.3%) were female. The age distribution of the patient group was between 18-64 years, and the mean age was determined as 38.8±12.1 years. The sociodemographic data of the patients are presented in Table 1.

Type I BD was diagnosed in 67 (87.0%) patients, while Type II BD was diagnosed in 10 (13.0%) patients participating in the study. The disease duration varied between 0.5 and 37 years, with a mean disease duration of 13.5±9.4 years. Other clinical features of the patients are presented in Table 2.

Assessment of Scales

The mean ISMI score was found to be 52.98±12.76 (min: 32, max: 92). The subscale mean scores are presented in Table 3. COPE, a multidimensional coping inventory, was used to evaluate the ways by which patients responded to stress. According to the COPE results, the total score of problem-focused coping varies between 25 and 72, with an average of 56.62±9.22. Emotionally focused coping total scores range from 27 to 79, with an average of 57.44±9.10. Dysfunctional coping scores range from 22 to 63, with a mean of 41.32±8.34.

Table 1: Sociodemographic Characteristics of the Patients

		n	%
Gender	Female	48	62.3
	Male	29	37,5
Marital status	Single	26	33,7
	Married	44	57,1
	Widowed/Divorced	7	9,0
Education level	Primary education	29	37,7
	High school	21	27,3
	High school over	27	35,1
Occupation	Unemployed	14	18,2
	Housewife	20	26,0
	Working	27	35,1
	Retired	8	10,4
	Student	8	10,4
Income level	Low	25	32,5
	Medium	45	58,4
	High	7	9,1
Co-habitants	Elementary family	67	87,0
	Extended family	10	13,0
Place of Residence	Urban	62	80,5
	Suburban/Country	15	19,5
Smoking	No	39	50,6
	Yes	38	49,4

According to the COPE results, it was found that the patients used problem-focused coping methods and emotionally-focused coping methods other than joking more, and they used dysfunctional coping styles such as denial, behavioral disengagement and substance use less.

Evaluation of the ISMI scale according to sociodemographic data such as age, gender, marital status, education level, job, financial situation, family, place of residence, smoking history, suicide history and the presence of another known medical disease indicated the presence of a significant relationship between the ISMI total score and the education level (p=0.013). ISMI total scores of patients with

Table 2: Clinical Characteristics of the Patients

	Mean– Standard Deviation	Min-Max Values
Disease duration (years)	13.5–9,4	0.5-37
Age of onset	25.0–9.9	12-60
Untreated time (years)	25.0–9.9	0-12
Number of hospitalizations	2.3–2.5	0-13
Duration after last hospitalization (years)	3.5–4.9	0-29
Time after last episode (years)	1.8–1.8	0.25-10.0
Total number of episodes	10.0–10.8	1.0-60.0
Number of manic episodes	3.3–4.2	0-26
Number of depressive episodes	3.7–4.8	0-30
Number of mixed episodes	0.16–0.44	0-2
Number of hypomanic episodes	2.5–7.2	0-50

Table 3: Distribution of ISMI Scale Scores

	Mean– Standard Deviation	Min-Max Values
Alienation	10.16–3.46	6-24
Confirmation of stereotypes	11.93–3.59	7-24
Perceived discrimination	8.97–3.26	5-20
Social withdrawal	10.57–3.30	6-19
Resistance to stigma	13.66–3.30	6-20
ISMI total	52.98–12.76	32-92

ISMI: Internalized Stigma Scale in Mental Illnesses

primary school education were found to be significantly higher than patients with a higher education level (p=0.042, Table-5).

Considering the relationship between disease characteristics and ISMI total score and subscale scores; A positive correlation was found between the age of onset of the disease and the confirmation of stereotypes. An inverse correlation was found between the time elapsed after the last period and the confirmation of stereotypes. A positive relationship was found between the total number of episodes and alienation, confirmation of stereotypes and total ISMI scores, a positive relationship was found between the number of depressive episodes and alienation and the total score, while a negative relationship was found between the number of mixed episodes and the scale scores of resistance to stigma. It was determined that the alienation and confirmation of stereotypes subscale scores of the patients were significantly different

Table 4: The Relationship Between Sociodemographic Data and ISMI Scale Scores

			ISMI	
		N	Mean– Standard deviation	p value
Age	18-38	39	50.7–12.2	p=0.119
	39-64	38	55.2–12.9	
Gender	Female	48	52.7–11.9	p=0.864
	Male	29	53.3–14.2	
Marital status	Single	26	52.5–12.0	p=0.216
	Married	44	55.4–12.0	
	Widowed / divorced	7	47.4–11.2	
Education level	Primary schol	28	58.3–11.5	**p=0.013**
	High school	21	53.2–9.0	
	Higher education	27	48.9–13.1	
Employment status	Active working	27	52.9–12.4	p=0.676
	Not working	50	54.1–11.9	
Financial status	Low	25	55.9–9.7	p=0.303
	Medium	45	53.1–13.3	
	High	7	48.1–10.2	
Co-habitants	Elementary family	67	52.7–12.3	p=0.710
	Extended family	10	54.4–15.7	
Smoking	No	39	54.8–12.7	p=0.185
	Yes	38	51.0–12.5	

ISMI: Internalized Stigma Scale in Mental Illnesses

Table 5: The Relationship Between Disease Characteristics and ISMI Scale Scores

	Alienation	Confirmation of stereotypes	Perceived discrimination	Social withdrawal	Resistance to stigma	ISMI total
Age onset	r=0.064 p=0.583	r=0.238 **p=0.037**	r=0.172 p=0.135	r=0.172 p=0.135	r=0.104 p=0.368	r=0.200 p=0.081
Time after last hospitalization	r=0.081 p=0.481	r=0.125 p=0.281	r=0.017 p=0.881	r=0.169 p=0.143	r=0.047 p=0.686	r=0.123 p=0.286
Time after last episodes	r=0.095 p=0.409	r=0.269 **p=0.018**	r=0.091 p=0.432	r=0.143 p=0.214	r=0.181 p=0.116	r=0.188 p=0.102
Total number of manic episodes	r=0.272 **p=0.017**	r=0.309 **p=0.006**	r=0.165 p=0.152	r=0.162 p=0.159	r=0.183 p=0.111	r=0.287 **p=0.011**
Total number of episodes	r=0.027 p=0.813	r=0.015 p=0.898	r=0.140 p=0.226	r=0.123 p=0.286	r=0.011 p=0.922	r=0.006 p=0.957
Number of depressive episodes	r=0.235 **p=0.040**	r=0.221 p=0.053	r=0.120 p=0.300	r=0.135 p=0.240	r=0.196 p=0.088	r=0.253 **p=0.027**
Number of mixed episodes	r=0.165 p=0.152	r=0.217 p=0.059	r=0.092 p=0.426	r=0.182 p=0.112	r=0.233 **p=0.042**	r=0.213 p=0.063

ISMI: Internalized Stigma Scale in Mental Illnesses

according to the type of the last period, and in the posthoc analyses, a significant difference was found between only the alienation subscale scores and those with depression or hypomania in the last stage. A positive correlation was found between a

Table 6: The Relationship Between ISMI and COPE Scale Scores

	Alienation	Confirmation of stereotypes	Perceived discrimination	Social withdrawal	Resistance to stigma	ISMI total
Problem-Focused Coping	0.134	0.056	0.597	0.075	**0.016**	**0.030**
Useful social support	0.078	**0.002**	0.181	**0.005**	0.104	**0.004**
Active coping	0.062	0.139	0.572	0.360	**0.006**	**0.044**
Restraint	0.482	0.315	0.498	0.478	0.759	0.362
Suppressing competing preoccupations	0.560	0.936	0.597	0.840	0.539	0.797
Planning	0.199	**0.021**	0.406	**0.016**	**0.002**	**0.008**
Emotionally focused coping	0.314	0.387	0.515	0.312	**0.041**	0.255
Positive reinterpretation and improvement	**0.001**	**<0.001**	0.524	**0.008**	**0.013**	**0.001**
Religious coping	0.298	0.201	**0.048**	0.206	0.868	0.082
Humor	0.892	0.838	0.726	0.540	0.205	0.763
Use of emotional social support	0.522	0.253	0.874	0.232	0.316	0.269
Acceptance	0.443	0.950	0.680	0.937	0.157	0.638
Dysfunctional Coping	0.480	**0.026**	0.358	0.084	0.068	**0.048**
Mentally disregard	0.684	0.102	0.197	0.304	0.465	0.330
Focusing on the problem and revealing	0.828	0.336	0.428	0.877	0.472	0.813
Denial	0.344	0.623	0.504	0.558	0.380	0.557
Behavioral disengagement	**0.027**	**0.021**	0.406	**0.028**	**0.009**	**0.004**
Substance abuse	0.551	0.077	0.599	0.149	0.258	0.074

ISMI: Internalized Stigma Scale in Mental Illnesses,COPE: : Coping Attitudes Assessment Scale

history of depression with psychotic features and confirmation of stereotypes, social withdrawal, and total ISMI scores. A positive correlation was found between the history of rapid cycling and the confirmation of stereotypes. Perceived discrimination scores were found to be significantly higher in patients with postpartum onset compared to those without.

Comparison of the subscale scores of alienation, approval of stereotypes, perceived discrimination, social withdrawal and stigma resistance with the same sociodemographic data indicated the presence of a statistically significant relationship between the perceived discrimination subscale score and the place of residence (city or town/village). The perceived discrimination subscale scores of patients living in towns/villages were found to be significantly higher than those living in urban areas ($p=0.038$, Table 5). No significant correlation was found between the other sociodemographic data and ISMI total and subscale scores.

A significant relationship was identified between the active coping scores under the problem-focused coping sub-dimension of the COPE scale and the total ISMI score ($p=0.044$). Additionally, a significant relationship was found between the stigma resistance score and active coping ($p=0.006$).

A significant relationship was also identified between the 'making a plan' scores and confirmation of stereotypes ($p=0.021$), social withdrawal ($p=0.016$), and total ISMI scores ($p=0.008$). A significant relationship was identified between the scores of stigma resistance and 'making a plan' ($p=0.02$). A significant negative correlation was found between the use of beneficial social support and the approval of stereotypes ($p=0.002$), social withdrawal ($p=0.005$) and total ISMI scores ($p=0.004$). The total score of the problem-focused coping sub-dimension of the COPE scale and the total score of ISMI ($p=0.030$) were negatively correlated while a significant positive correlation was identified between the stigma resistance score and problem-focused coping score ($p=0.016$).

A negative correlation was found between positive reinterpretation and development scores under the emotionally focused coping sub-dimension of the COPE scale and the total scores of alienation ($p=0.001$), confirmation of stereotypes ($p<0.001$), social withdrawal ($p=0.008$) and ISMI ($p=0.001$). Additionally, a positive correlation was identified between the scores of stigma resistance and the scores of positive reinterpretation and improvement ($p=0.013$).

A significant positive correlation was found between the scores of religious coping and the scores of perceived discrimination ($p=0.048$). A significant positive correlation between the total score of the emotionally focused coping sub-dimension of the COPE scale and the stigma resistance score ($p=0.041$) was found. A positive correlation was found between behavioural disengagement scores in the dysfunctional coping sub-dimension of the COPE scale and the total scores of alienation ($p=0.027$), confirmation of stereotypes ($p=0.021$), social withdrawal ($p=0.028$) and ISMI ($p=0.004$) while a negative correlation was identified between the behavioural disengagement and stigma resistance scores ($p=0.009$). A significant positive correlation was determined between the total score of the dysfunctional coping sub-dimension of the COPE scale and the total score of ISMI ($p=0.048$) and confirmation of stereotypes ($p=0.026$, Table 6).

DISCUSSION

Relationship Between Sociodemographic Data and Internalized Stigma

The ISMI total scores of patients with primary school education were found to be significantly higher than patients with a higher level of education. Various studies have shown that stigma in general psychiatric patients was associated with a lower level of education, being unmarried or living alone, and being unemployed (19, 20, 21). Thus, the higher the education level, the lesser personal, social and biological reasons contribute towards the aetiology of the disease, providing greater optimism for recovery. In addition, since the increase in the level of education is likely to positively affect self-esteem, it can play a supportive role in reducing the level of internalized stigma (21,22). A sig-

nificant difference in the perceived discrimination subscale score was found between patients living in rural areas versus those living in a city in the current study. It has previously been reported that living in rural areas was associated with a greater perception of stigma, and individuals living in rural areas had greater stigma anxiety (22). No significant relationship was found between other sociodemographic characteristics such as age, gender, marital status, job, income level and internalized stigma.

Relationship Between Clinical Characteristics and Internalized Stigma

No significant relationship was identified between the age of onset of the disease and internalized stigma in the current study. However, a positive correlation was found between the subscale scores of confirming stereotypes and the age of onset of the disease. Patients whose disease was manifested at an early age approved the stereotypes less; as the age of onset of the disease increased, the stereotypes were approved more. We found an inverse correlation between the time elapsed after the last period and the confirmation of stereotypes. Previously, the absence of a significant relationship between internalized stigma and the last remission period has been reported (24). The most striking impression that emerges in patients at the end of a mood episode is that they have failed themselves and are unreliable because they have disappointed everyone. On the other hand, since BD patients mostly do not show any symptoms during the remission periods, their perception of stigma may also vary (22,24). An important finding of recent studies is that with the prolongation of the duration since an acute attack, psychosocial adjustment is improved and the general level of functioning is positively affected (25).

The current study showed a positive correlation between the total number of episodes and alienation, confirmation of stereotypes subscale scores, and total ISMI scores. It is well known that with each new episode, the risk associated with subsequent periods increases and the prognosis worsens (26). Similar to our study, Kamaradova et al. found a positive correlation between self-stigmatization and the number of hospitalizations, disease severity and depression episodes in a study they conducted with 332 patients with mental disorders (27). We observed a positive correlation between the number of depressive episodes, alienation and total ISMI score. A positive correlation was also found between a history of depression with psychotic features and confirmation of stereotypes, social withdrawal and total ISMI scores. Patients with end-stage depression were found to report more alienation than those with hypomania.

Patients with a history of rapid cycling recruited to the current study were found to be more likely to approve of stereotypes about the disease. A previous study has shown that internalized stigma was more common among patients with rapid cycling; moreover, the latter was predictive of internalized stigma (28). The fact that a process that is independent of life events or compelling can be observed clearly in rapid cycling takes the disease away from a reactive nature. Rapid cycling may enable the perception of the disease as a more structural or personal trait (22). Stigmatization was suggested to be aggravated due to the difficulty in distinguishing the disease from personality (33).

The Relationship Between Internalized Stigma and Coping Attitudes

In the face of illness, which is an important source of stress, the individual develops various coping attitudes to minimize and deal with various negativities caused by the illness. Such coping attitudes are considered to avoid or reduce rejection. However, while some of these coping efforts are likely to be effective, others may have significant adverse consequences. Knowing the coping attitudes used by patients may help in understanding the role of such attitudes in the psychopathology of the disease, determining treatment goals, monitoring therapeutic effectiveness and preventing the occurrence of other complications (7, 11). In a study investigating internalized stigma in patients with BD or depression, both groups of patients were determined to experience high levels of stigma; however, patients with BD felt more stigmatized than patients with depression. This difference between the experience of stigmatization and the

effects of stigmatization may be due to different coping attitudes in the two diseases. Thus, there is an urgent need for studies examining the coping attitudes used by patients with BD for stigma (30) since none of the studies in the published literature has examined internalized stigma and coping styles in BD patients. Such studies are important to increase functionality, identify coping attitudes that can be effective in preventing internalized stigma and support such patients.

Patients who used problem-focused coping styles were found to display less internalized stigma and more stigma resistance in the current study. Problem-focused coping attitudes play an important role in regulating stress, producing alternative solutions and including direct interventions that can change the relationship between the person and their environment (31). We found that patients who used problem-focused coping attitudes such as active coping, planning, and use of helpful social support were more resistant to stigma and therefore experienced less internalized stigma. We also observed that patients who used emotionally focused coping styles were more resistant to stigmatization. Emotionally focused coping styles are generally used together with problem-focused coping attitudes. Thus, it can facilitate the use of problem-focused attitudes by reducing stress in intensely challenging situations. However, emotionally focused coping can also restrict the individual and prevent problem-focused actions (32).

Patients in the current study who used positive reinterpretation and growth attitude, which is one of the emotionally focused coping styles, had less internalized stigma and more stigma resistance. Such a coping style has been shown to reduce anxiety, hopelessness, and suicidal thoughts (33). Coping here plays a role in reducing stress rather than dealing with the problem. It may help to reconstruct a challenging life event such as having a mental illness with positive terms and perspective, increase stigma resistance and reduce internalized stigma (34).

We observed a positive correlation between the use of dysfunctional coping attitudes and internalized stigma and a negative correlation between dysfunctional coping attitudes and stigma resistance. Patients who use dysfunctional coping styles of behavioral disengagement were found to feel more internalized stigma and have lower stigma resistance (7). Behavioural disengagement is a non-adaptive attitude that is based on giving up any struggles with the source of stress and also prevents adaptive coping. Behavioural disengagement has been reported to be associated with hopelessness and suicidal thoughts (35).

The current study has some limitations. Statistical analysis of some of the differences in scores of subscales did not reach significance most likely due to the number of patients included in the study. Additionally, a cause-effect relationship could not be established because of the cross-sectional design of the study. Studies with larger samples are needed to support and re-evaluate the data obtained from the current study.

CONCLUSION

Overall, the current study showed that active coping, planning, use of beneficial social support, positive reinterpretation and developmental coping strategies, as well as attempts to reduce behavioral disengagement can reduce internalized stigma and increase stigma resistance. The use of cognitive behavioral interventions may lead to a reduction in internalized stigma and increase psychosocial functionality (36, 37, 38, 39).

Conflicts of interest: The authors declare that they have no conflict of interest.

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