



Original Article

Internalized stigma and the quality of life and self-esteem of individuals with bipolar disorder

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Abstract

Objectives: This study was conducted in order to examine the effect of socio-demographic and clinical characteristics that are thought to have an impact on the internalized stigma, quality of life, and self-esteem of individuals with bipolar disorder and to determine the relationship between these variables.

Methods: This descriptive cross-sectional study was conducted on 105 participants during the remission period in a community mental health center in İzmir City, Türkiye. The participants were interviewed face-to-face, and data were collected in December 2017 and April 2018 using the Socio-Demographic Data Form, Internalized Stigma Scale in Mental Diseases (ISMI), World Health Organization Quality Life Scale-Short Form (WHOQOL-BREF), and the Rosenberg Self-Respect Scale (RSES). The number, percentage, and average were used in descriptive statistics. Comparisons of inter-group socio-demographic and clinical variables are made using Spearman's correlation analysis, while the relationship between internalized stigma, quality of life, and self-esteem, which are conceptual variables, is evaluated using the Mann-Whitney U test and Kruskal-Wallis variance analysis.

Results: The patients' mean ISMI score was 58.56 ± 18 , and the mean WHOQOL-BREF score was 96.48 ± 19.98 . In addition, it was determined that 26% of the patients had low self-esteem. The socio-demographic and descriptive characteristics of the patients included education ($p < 0.05$), income ($p < 0.001$), employment status ($p < 0.01$), a physical illness accompanying their mental illness ($p < 0.05$), and the presence of a suicide attempt ($p < 0.05$). It was determined that there was a significant difference between the groups on all scale scores. There is a strong negative relationship between ISMI and WHOQOL-BREF ($r = -0.782$, $p < 0.001$) and RSES ($r = -0.773$, $p < 0.001$), and a positive relationship between RSES and WHOQOL-BREF ($r = 0.749$, $p < 0.001$).

Conclusion: As internalized stigma increases, the quality of life and self-esteem decrease. For this reason, it is recommended to establish intervention programs to reduce the perceived level of stigma, improve their capacity to cope with and manage stigma, and increase their quality of life and self-esteem.

Keywords: Bipolar disorder; internalized stigma; quality of life; nursing; self-esteem.

Throughout history, individuals diagnosed with mental illness have been exposed to discrimination, marginalization, and stigmatization by the society they live in, especially by their family members and relatives.^[1] A stigma can be defined as a mark, stain, or label that causes the individual to be rejected, despised, excluded, and rejected by the environment he/she lives in. On the other hand, stigma currently refers to

all of the behaviors, attitudes, and beliefs that people do not see or perceive as normal; a person or group who is perceived to be negative, defective, and worthless, causing fear, avoidance, rejection, and alienation toward this person or group.^[2]

Negative connotations, attitudes, and false assumptions associated with mental illness can be as harmful as the illness itself.^[1] In some studies, it has been stated that this process be-

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Submitted Date: January 25, 2022 **Revised Date:** September 19, 2022 **Accepted Date:** September 21, 2022 **Available Online Date:** April 27, 2023

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What is presently known on this subject?

- Internalized stigma, quality of life, and self-esteem are attitudes, thoughts, and judgments that include subjective perceptions of individuals and are considered as concepts that are directly or indirectly related to each other. However, studies investigating this relationship in individuals with bipolar disorder are limited.

What does this article add to the existing knowledge?

- Internalized stigma, quality of life, and self-esteem vary according to the socio-demographic and clinical characteristics of individuals with bipolar disorder. In addition, as the internalized stigma of individuals with bipolar disorder increases, their quality of life and self-esteem decrease.

What are the implications for practice?

- Determining the negative impact of internalized stigma on individuals with bipolar disorder shows the importance of implementing preventive programs and interventions by psychiatric nurses and other professional groups working in the field of mental health.

gins when patients apply to the psychiatry unit, and after receiving a diagnosis of a mental disorder, they begin to stigmatize themselves without being exposed to triggering stimuli, such as a discriminatory attitude and behavior. At the same time, it has been observed that these patients are ashamed of their situation, have increased feelings of inadequacy and automatic negative thoughts, avoid or stay away from social relations (without being exposed to discriminatory attitudes and behaviors), and have decreased self-worth.^[3,4]

Although bipolar disorder, which is a mental illness characterized by periods of exuberance and depression and mood fluctuations between periods, is less well-known and stigmatized compared with other mental illnesses, it has been stated that the stigma perceived by patients is high, and patients tend to stigmatize themselves before everyone else.^[4] This situation, which is described as “internalized stigma” or “self-stigmatization,” is the process of assimilating, believing, and accepting the assumptions and stereotypes of society and the environment about mental illness, with or without awareness.^[5,6]

The “stigma” attitude toward people with mental illness and the “exclusion” of patients by society as a result of this attitude have negative effects on the quality of life of both patients and their relatives.^[7] These adverse effects are not only limited to the attack periods, but also cause a significant deterioration in the quality of life during the non-attack periods.^[8] It has been reported that the deterioration in the quality of life of individuals diagnosed with bipolar disorder is more common than in those who are healthy in the general population or have a chronic physical disease other than mental illness.^[9] Quality of life, which is considered a multidimensional concept, is defined as meeting the basic needs and social expectations of the individual while at the same time benefiting from the opportunities offered by the society in which one lives.^[10] The World Health Organization (WHO), on the other hand, defines the quality of life as an individual’s perception of their own life in relation to their goals, expectations, standards, and values, within the integrity of the culture and value judgments they live in.^[11]

Bipolar disorder has lifelong negative effects on patients’ mental and physical health, education, occupational functionality,

and interpersonal relationships.^[12] Another subjective dimension that is affected by these negativities in the lives of patients with bipolar disorder is the concept of self-esteem. Self-esteem, which is defined as the state of appreciation that is reached as a result of subjective evaluations and arising from the approval of the current self, expresses an individual’s perception of themselves as valuable, positive, and worthy of being liked and loved by others. The need for self-esteem is closely related to the evaluation and feedback that the individual receives from the individuals in his/her environment.^[5]

Internalized stigma, quality of life, and self-esteem are attitudes, thoughts, and judgments that include subjective perceptions of individuals and are considered as concepts that are directly or indirectly related to each other in individuals with bipolar disorder. According to a study conducted abroad on those with chronic and severe mental illnesses to determine the relationship between the relevant variables, as the level of internalized stigma increases, the quality of life decreases. It has been determined that internalized stigma directly affects self-esteem and negatively affects quality of life indirectly through self-esteem.^[5,12,13] Although the relationship between internalized stigmatization, quality of life, and self-esteem in bipolar disorder has been accepted theoretically, the relevant literature emphasizes the inadequacy of the number of studies demonstrating this relationship.^[9] In our country, no study has been found examining the relationship between “internalized stigma,” “self-esteem,” and “quality of life” in patients diagnosed with bipolar disorder or other mental illnesses. For this reason, this study was carried out to determine the factors affecting the mentioned variables and the relationship between them.

Materials and Method

Type of Research

This descriptive study was conducted on 105 participants who were followed up with the diagnosis of bipolar disorder in a community mental health center operating under a training and research hospital in İzmir, Türkiye. Research data were collected through face-to-face interviews between December 2017 and April 2018.

Universe and Sample

The population of the study consisted of individuals with a diagnosis of bipolar disorder in the remission period (the period when the symptoms of the disease decreased or disappeared) who were followed up by the community mental health center. As a result of the interviews, the number of patients in remission could not be calculated exactly due to the differences in the diagnosis codes in the medical records. Therefore, the sample of the study was Picco et al.^[21] Based on the study conducted by 280 patients by G-Power 3.1.9.2 program, it was calculated as 102 people with 80% confidence interval, $\pm 5\%$ sampling error and 0.5 effect size, and the study was completed with a total of 105 patients.

Inclusion Criteria for Research

- Between the ages of 18 and 65,
- Literate,
- Not in the active phase of the disease (according to the diagnosis and opinion of the outpatient doctor),
- Receiving services from the community mental health center and being diagnosed with bipolar disorder for at least one year.

Exclusion Criteria

- The patient has a visual or hearing defect that may affect the test's performance, or he/she has a sensory defect, and the device (glasses, hearing aid, etc.) to correct this defect is not with him/her during the evaluation.

Data Collection Tools

The study data were obtained by using the Introductory Information Form developed in line with the literature review, the Internalized Stigma in Mental Illness Scale (ISMI), the World Health Organization Quality of Life Scale-Short Form (WHOQOL-BREF), and the Rosenberg Self-Esteem Scale (RSES). The relevant forms were filled in by the researcher using the question-answer method or by the participants themselves.

Introductory Information Form: The review of the literature by the researcher generated as a result of the individual's age, gender, marital status, educational level, working status, economic status, age at disease onset, the presence of concomitant physical illness, near the cases of having a mental illness, number of hospitalizations, duration of drug use, medications taken, and outpatient status and maintaining controls in questioning the suicide attempt consists of a total of 14 questions.

ISMI: The Turkish validity and reliability of the scale developed by Ritsher et al.^[14] (2003) to measure perceived stigma in people with mental illness was carried out by Ersoy and Varan (2007). The scale, which has 29 items in total and evaluates perceived stigma, has a total of five sub-scales, which are confirmation of stereotypes, alienation, social withdrawal, perceived discrimination, and resistance to stigma. The items are rated using the four-point Likert scale and are scored between (1 point="I strongly disagree") and (4 points="I strongly agree"). The scores obtained from the scale without a cut-off point according to the total score vary between 29 and 116, and high scores from the scale indicate that the level of internalized stigma is higher in the negative direction. In the Turkish version of the scale, Cronbach's alpha internal consistency coefficient was .93, and in our study, the Cronbach's alpha internal consistency coefficient is .95.

WHOQOL-BREF: The reliability and validity study of the scale developed by WHO for the assessment of individuals' subjectively perceived quality of life was carried out by Fidaner et al.^[15] (1999). The scale, which was created by taking 24 questions from the original scale, WHOQOL-100 consists of a total of 26 questions, with the addition of two questions tackling perceived quality of life and health status. WHOQOL-BREF

evaluates four dimensions: physical well-being, mental well-being, social relations, and environment. The WHOQOL-BREF-TR, which was created by adding a national question to the Turkish validity study, is a 27-item scale. Items on the Likert-type scale were graded as follows: 1=Not at all Satisfied; 5=Very Satisfied. The total scores obtained from the scale ranged from 29 to 116. The Cronbach's alpha internal consistency coefficient obtained for the Turkish version of the scale was .85, and the Cronbach's alpha reliability coefficient for our study is .87.

RSES: The Turkish reliability and validity study of the scale, which was developed by Rosenberg (1963) to evaluate the self-esteem of individuals, was conducted by Çuhadaroğlu (1985).^[16] RSES consists of 11 sub-dimensions, and Rosenberg stated that sub-scales can be used separately in research. The scale is graded as 3=Very true and 0=Very False. The total scores obtained from the scale vary in the range of 0–30; 15–25 points are considered sufficient for self-esteem, while a score of 15 or below is considered low self-esteem. In other words, as the score obtained from the scale increases, self-esteem increases. In the Turkish version of the scale, the Cronbach's alpha internal consistency coefficient was .76. In our study, the Cronbach's alpha internal consistency coefficient is .89.

Variables of the Study

In the study, the dependent variables of ISMI, WHOQOL-BREF, and RSES and sub-scale mean scores. The descriptive features are the independent variables.

Data Collection Process

The study was carried out by directing the patients in the remission period to the researcher after their medical examination with the physicians of the polyclinic and community mental health center. Verbal information was given to the participants by the researcher, and their written consents were obtained. The data were obtained by meeting face-to-face with individuals who agreed to participate in the study during working hours, in the polyclinic environment, and in the community mental health center using the data collection forms, which took approximately 30–35 minutes.

Statistical Analysis

Research data were evaluated with the SPSS 22.0 package program. For continuous data, descriptive information about the mean, standard deviation, median, minimum, and maximum values, and the number and percentage distributions for categorical data, are given. Whether the variables conformed to normal distribution was tested using visual (histogram and probability) and analytical (Kolmogorov-Smirnov test) methods. Since the distribution did not show normality in the study ($p < 0.05$) and the visual histogram was far from the symmetrical distribution, the nonparametric Mann-Whitney U test (for two group comparisons) and Kruskal-Wallis analysis of variance (for more than two group comparisons) were used. While examining the correlation between the variables, Pearson correlation analysis was used for those with a normal distribution

and Spearman's correlation analysis for those without a normal distribution.

Ethical Considerations

Written consent was obtained from the responsible authors who developed the scales for ISMI, WHOQOL-BREF, and RSES, which were used as data collection tools in the study. The approval of the Scientific Research and Publication Ethics Committees of a university (01.11.2017 Decision No: 24), followed by the institution's approval from the relevant provincial health directorate and the unit where the study will be carried out. Verbal information about the research was given to the participants, and then data were collected through the relevant forms.

Results

When the descriptive characteristics of the individuals participating in the study were examined, it was determined that 62

December 9% were women, 30.5% were between the ages of 35 and 44, 50.5% were married, 43.8% had a primary education level, 70.5% did not work in any job, and 51.4% perceived themselves to be in the middle income group (Table 1).

The effect of the descriptive characteristics of the participants based on the ISMI, WHOQOL-BREF, and RSES scores is shown in Table 1. Accordingly, it was determined that the ISMI, WHOQOL-BREF, and RSES scores of the patients were not different according to age, gender, and marital status ($p>0.05$). Education, working in any job, and perceived income status of the patients had no significant difference between the groups ($p>0.05$). Patients with a job and a high perceived income status had higher ISMI scores, and lower WHOQOL-BREF and RSES scores. In terms of education, patient groups who were literate and had a primary education level were found to have higher ISMI scores and lower RSES and WHOQOL-BREF scores compared with groups with a high school or university education level (Table 1).

Table 1. Comparison of ISMI, WHOQOL-BREF and RSES mean scores according to descriptive characteristics of individuals (n=105)

Demographic Characteristics			ISMI		WHOQOL-BREF		RSES	
	n	%	Ort.±SS	Test	Ort.±SS	Test	Ort.±SS	Test
Gender								
Male	66	62.9	58.28±18.62	U:-0.83	97.57±19.68	U:0.547	21.65±7.8	U:-1.10
Female	39	37.1	59.02±17.55	p>0.05	94.64±20.58	p>0.05	21±7.47	p>0.05
Age								
24≥	5	4.8	64 ±11.95		84.2± 8.55	KW: 3.3	17.8±8.04	KW:1.71
25-34	31	29.5	57.61±18.22	KW:2.08	99.8±17.25	p>0.05	22±7.26	p>0.05
35-44	32	30.5	61.81±18.42	p>0.05	94.34±22.45		20.3±8.22	
45-5	23	21.9	57.39±20.3		98.82±21.18		22.04±7.68	
55≤	14	13.3	53.21±15.67		94.57±20.3		22.71±7.4	
Marital status								
Married	53	50.5	55.84±17.85	96.26±21.29	KW: 0.05	21.9±7.76	U: -1.10	
Single	36	34.3	61.61±18.56	96.83±18.36	p>0.05	21.3±7.18	p>0.05	
Divorce	16	15.2	60.68±17.95	96.43±20.21		20±8.56		
Education level								
Just literate	11	10.5	75.2±15.76 ^a	KW:17.2	78.7±13.8 ^{ac}	KW:27.1	16.54±7.8 ^{ab}	KW:10.6
Primary	46	43.8	60.08±16.5 ^{ab}	p<0.01 ^{**}	90.9± 18.8 ^{bd}	p<0.001 ^{***}	20.6±7.96 ^c	p<0.01 ^{**}
High School	29	27.6	57.3±19.45 ^a		101.9±18.2 ^{ab}		22.31±7.1 ^a	
University or ↑	19	18.1	47.1±3.28 ^{ab}		111.8±14.9 ^{cd}		24.78±6.13 ^{bc}	
Employment status								
Working	31	29.5	49.48±15.40	U:-3.06	108.96±16.7	U:4.3	24.45±6.04	U:-2.9
Not Working	74	70.5	62.36±17.95	p>0.05 [†]	91.25±18.9	p<0.001 ^{***}	20.13±7.92	p<0.01 ^{**}
Perceived Income								
Low	40	38.1	70.97±15.41	KW:35.6	80.25±12.8	KW:45.6	16.45±7.76 ^{ab}	KW:29.5
Middle	54	51.4	53.07±15.90	p<0.001 ^{***}	104.12±17.3	p<0.001 [*]	23.87±6.11 ^a	p<0.001 ^{***}
High	11	10.5	40.36±4.17		118±5.96		27.36±2.29 ^b	

Mean: Mean; SS: Standard deviation; U: Mann Whitney U Test; KW: Kruskal Wallis-H Test; ^{a, b, c, d}: According to the Bonferroni test, there is a statistically significant difference between them; [†]p<0.05; ^{**}p<0.01; ^{***}p<0.001.

The effect of the clinical conditions of the participants based on the ISMI, WHOQOL-BREF, and RSES scores is shown in Table 2. Accordingly, the age of onset of the disease, duration of drug use, and compliance with hospital controls did not make a statistically significant difference between the groups for the ISMI, WHOQOL-BREF, and RSES scores ($p>0.05$). On the other hand, the presence of mental illness in the family, the presence of physical illness, the number of hospitalizations, adherence to drug treatment, and suicide attempts did not make a significant difference between the groups for the ISMI

score ($p>0.05$). It was determined that the patients with a family history of mental illness, physical illness, suicide attempt, not taking medication regularly, or partially continuing had higher ISMI scores ($p<0.05$). For the WHOQOL-BREF total score, it was observed that the presence of physical disease, adherence to drug treatment, and suicide attempt had a significant difference ($p<0.05$). It was determined that the WHOQOL-BREF scores of the patients who had a physical disease, suicide attempt, and did not or partially complied with drug treatment were significantly lower ($p<0.05$). When the total RSES score

Table 2. Comparison of ISMI, WHOQOL-BREF and RSES and mean scores according to clinical characteristics of individuals (n=105)

Clinical Features	n	%	ISMI		WHOQOL-BREF		RSES	
			Ort.±SS	Test	Ort.±SS	Test	Ort.±SS	Test
Mental Illness in Family								
Yes	37	35.2	64±17.3	U:-2.27	95.5±17.86	U:-1.624	9.75±8.34	U: -1.36
No	68	64.8	55.6±18.04	$p<0.05^*$	99.7±20.89	$p>0.05$	22.3±7.15	$p>0.05$
Physical Illness								
Yes	15	14.3	73.2±15.95	U:-3.18	80.4±12.54	U:-3.197	17.33±7.92	U: -2.45
No	90	85.7	56.12±17.4	$p<0.05^*$	99.1±19.77	$p<0.01^{**}$	22.08±7.43	$p<0.05^*$
Disease Onset Age								
18≥	9	8.6	54.44±15.86	KW:4.1	102.55±17.1	KW:6.13	23.55±6.71	KW:4.84
19-28	49	46.7	55.61±17.73	$p>0.05$	99.73±19.3	$p>0.05$	22.1±7.69	$p>0.05$
29-38	22	21	61.63±19.62		96.27±22.7		20.27±8.4	
39-48	17	16.2	64.47±19.49		89±17.5		20.76±7.47	
49≤	8	7.6	60.25±15.17		86.25±19.6		19.25±7.28	
Hospitalization status								
No hospitalization	55	52.4	54.01±16.99	KW:11	100.38±19.0	KW:6.88	22.72±6.94	KW:6.55
1-2 times	26	24.8	58.73±18.46	$p<0.05^*$	96.1±21.01	$p>0.05$	21.23±8.32	$p>0.05$
3-4 times	12	11.4	68.58±16.45		90.08±20.5		17.08±8.94	
>5 times	12	11.4	69±17.93		85.75±17.7		20.08±6.96	
Duration of drug use								
Beginner	4	3.8	41.75±3.59	KW:4.8	113.5±14.38	KW:4.42	28±1.63	KW:5.47
1-3 years	14	13.3	55.85±14.29	$p>0.05$	97.5±20.45	$p>0.05$	20.64±7.77	$p>0.05$
4-6 years	24	22.9	57.62±18.14		97.5±20.87		19.45±8.55	
7-9 years	21	20	59.19±18.96		97.8±20.73		21.33±7.75	
10 years	42	40	61.28±19.28		93.2±19.2		22.19±71.7	
Compliance with drug therapy								
Regular	71	67.6	54.56±16.95	KW:12	101.76±18.4	KW:17.7	23.12±6.9	KW:4.85
Irregular	13	12.4	72.61±15.95	$p<0.05^*$	79±11.9	$p:0.001^{***}$	18.76±7.31	$p>0.05$
Party regular	21	20	63.38±18.59		89.47±21.3		18.47±8.3	
Outpatient clinic control								
Regular	95	90.4	57.43±17.95	KW:3.8	97.72±20.08	KW:4.26	21.83±7.6	KW:3.46
Irregular	5	4.8	71±17.42	$p>0.05$	84.6±13.81	$p>0.05$	16.2±9.06	$p>0.05$
Party regular	5	4.8	67.6±19.08		84.8±18.01		18.6±5.72	
Suicide Attempt								
Yes	29	26.7	67.68±16.73	U:3.27	89.27±19.79	U: -2.25	18.31±8.23	U: -2.26
No	76	73.3	55.07±17.54	$p<0.01^{**}$	99.23±19.47	$p<0.05^*$	22.59±7.12	$p<0.05^*$

Ort.: Ortalama; SS: Standart sapma; U: Mann Whitney U Test; KW: Kruskal Wallis-H Test; * $p<0.05$; ** $p<0.01$; *** $p<0.001$.

Table 3. ISMI, WHOQOL-BREF, and RSES score ranges and patient scores (n=105)

ISMI/WHOQOL-BREF /RSES Subscales and Total Scores	Range of Points Available	Range of Points Received	Mean±SD
ISMI 1 Alienation	6-24	7-23	13.94±4.66
ISMI 2 Stigma resistance	5-20	6-20	12.17±4.30
ISMI 3 Stereotype endorsement	7-28	7-21	11.49±3.47
ISMI 4 Social with- drawal	6-24	6-18	11.06±3.37
ISMI 5 Discrimination experience	5-20	5-19	9.89±4.31
ISMI Total	29-116	35-92	58.56±18.15
WHOQOL-BREF TR 1 Physical Health	7-35	9-34	26.25±6.03
WHOQOL-BREF TR 2 Psychological Health	6-30	8-30	19.82±5.2
WHOQOL-BREF TR 3 Social Relationships	3-15	4-15	8.94±3.05
WHOQOL-BREF TR Environment	9-45	16-34	26.56±5.14
WHOQOL-BREF TR Total	27-135	56-125	96.48±19.98
RSES Total	0-30	9-27	21.40±7.65

was examined, it was determined that the scale scores of the group with a physical illness were significantly lower than those of the group with no signs of suicide attempt, and the group with a suicide attempt had significantly lower scale scores ($p<0.05$) (Table 2).

The participants' total ISMI score was 58.56 ± 18.15 , and it was seen that they got the highest "Alienation Sub-scale" (13.94 ± 4.66) and the lowest "Perceived Discrimination Sub-

scale" (9.89 ± 4.31) mean scores. The WHOQOL-BREF total score of the patients was 96.48 ± 19.98 , and they had the highest "Environmental Dimension TR Sub-scale" (26.56 ± 5.14) and the lowest "Social Well-being Sub-scale" (8.94 ± 3.05) mean scores. The patients' total RSES score was 21.40 ± 7.65 .

As shown in Table 4, there is a negative correlation between ISMI and WHOQOL-BREF ($r=-.782, p<0.001$) and ISMI and RSES ($r=-.773, p<0.001$), and there is a positive correlation between

Table 4. The relationship between the participants' ISMI, WHOQOL-BREF, and RSES mean scores (n=105)

ISMI/RSES	WHOQOL Total	WHOQOLI Physical Health	WHO-QOL2 Psychological Health	WHO-QOL3 Relationships Social	WHO-QOL4 Environment	RSES
ISMI 1 Alienation	r	-.610	-.740	-.645	-.686	-.752
	p	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*
ISMI 2 Stereotype Onaylanması	r	-.565	-.706	-.612	-.657	-.701
	p	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*
ISMI 3 Discrimination Experience	r	-.552	-.682	-.630	-.642	-.628
	p	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*
ISMI 4 Social with-drawal	r	-.627	-.664	-.625	-.682	-.703
	p	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*
ISMI 5 Stigma resistance	r	-.516	-.676	-.612	-.681	-.660
	p	<0.001*	<0.001*	<0.001*	<0.001*	<0.001*
ISMI Total	r	-.782				-.773
	p	<0.001*				<0.001*
RSES	r	.749	.709	.604	.597	
	p	<0.001*	<0.001*	<0.001*	<0.001*	

* $p<0.001$

RSES and WHOQOL-BREF ($r=0.749$, $p<0.001$) and a strong correlation was determined ($p<0.001$).

The relationship between the sub-scales of ISMI, WHOQOL-BREF, and RSES is also shown in Table 4. Accordingly, there is a negative correlation between all sub-scales of ISMI, WHOQOL-BREF, and RSES, and a positive correlation between all sub-scales of WHOQOL-BREF and RSES ($p<0.001$).

Discussion

It was determined that there was no significant difference between the ISMI, WHOQOL-BREF, and RSES scores in terms of age, gender, and marital status of patients. When the relevant literature is examined, it is reported that age, gender, and marital status have no effect on ISMI,^[17-21] quality of life,^[22,23] and self-esteem.^[24,25] On the other hand, in some studies, being a woman is considered one of the indicators of a low quality of life, whether in the general population or in those diagnosed with bipolar disorder.^[26,27] It is thought that the different results between the gender factor and the quality of life are due to the fact that the studies are conducted in different regions, age groups, and socio-economic environments.

Education, working in any job, and perceived income status of the patients had a significant difference between the groups. The increase in the education level of the patients, in addition to the increase in knowledge about the disease, may lead to a more scientific and humane attitude and more compliance with medical treatment recommendations. This allows patients to integrate with the society, take more active roles, participate in working life, and thus increase their financial income. Similar to the findings of the relevant literature, our study found that there is a negative relationship between the increase in education level, active employment, and high perceived income status and ISMI^[28,29] and a positive relationship between quality of life^[27,30] and self-esteem.^[19] In this respect, the results of our study are compatible with that of the literature.

Those with a family history of mental illness had higher ISMI scores than the group without. However, there are conflicting results on the subject in the literature. While Beyazyüz et al.'s^[17] study with outpatient psychiatric patients drew attention to the existence of a negative relationship between a family history of mental illness and internalized stigmatization, Tel and Ertekin's study, also conducted with outpatient psychiatric patients, found this to be a risk factor. They stated that it did not constitute a factor.^[18] It is thought that these results, which are inconsistent with the findings of our study, include patients who have diagnoses other than bipolar disorder in other studies and that the pre-existing stereotypes of the participants in our study against mental illnesses interact with the diagnosis of bipolar disorder and cause them to stigmatize themselves more.

While the age of onset of the disease did not make a difference between the groups for the total ISMI scores, the scale scores

of the group that had never been hospitalized were lower than those of the group that had been hospitalized 3–4 times or more. As the number of inpatient hospitalizations and duration of the mental illness increase, the negative reaction of the environment and the level of stigma increase. These results are compatible with those in the literature.^[19,22,31,32]

In our study, the ISMI total scores of the patient group with chronic physical illness were found to be higher than those of the group without physical illness. Sahoo et al.'s^[33] study with 107 participants diagnosed with depressive disorder determined that internalized stigmatization is higher in people with a chronic physical illness as well as mental illness, which is similar to the results of our study. On the other hand, in their study conducted in patients with severe mental illness, İsmanur was stated that there was no significant relationship between the presence of an additional physical illness and ISMI scores.^[25] It is thought that this difference is due to the periodic difference between physical diseases and physical diseases in the patients included in the study.

In our study, regular attendance to hospital appointments and duration of drug use did not differ between the groups in terms of ISMI scores, while the scale scores of patients who adhered to drug treatment were found to be lower. In parallel with these results, it is stated in the literature that internalized stigma decreases inversely with increasing compliance with drug therapy.^[31,34,35]

The group of patients who had attempted suicide in the past had higher ISMI scores compared with the group that did not. There are different studies in the literature on the effect of a suicide attempt on internalized stigma. Despite the results of studies that determined the level of internalized stigmatization of patients who had attempted suicide in the past,^[25,37] there are also those stating that a suicide attempt has no effect on internalized stigmatization.^[36,37] The difference in our study is due to the cultural and diagnostic groups of the study group thought to be due to variation.

In our study, the presence of a family history of mental illness did not make a significant difference on the WHOQOL-BREF scores, while the scores of the participants with a physical illness accompanying the mental illness were found to be lower. This result, which is an expected situation, is compatible with those in the literature.^[38,39] While the deterioration of mental well-being, which is one of the most important indicators affecting the quality of life of individuals, is a risk factor in itself for a decrease in the quality of life, the presence of a physical disease accompanying this condition appears as a factor that increases the existing risk level.

In our study, while the age of onset of the disease, hospitalization status, and total pharmacotherapy duration applied to the patients did not make a difference on the WHOQOL-BREF scores, in line with the literature,^[40,41] the WHOQOL-BREF scores of the patients who were compliant with drug treatment were found to be higher. When the literature is reviewed, despite the results of studies stating that non-adherence to drug ther-

apy constitutes a risk factor for low quality of life,^[42,43] there are also studies reporting that adherence to drug therapy has no effect on patients' quality of life.^[41,44] To evaluate the quality of life in studies. It is thought that due to the use of different scales for the study and the fact that the sampled patients are in different episodes of bipolar disorder, the perceived quality of life indicators differ between societies.

While the regular visits of the patients to the hospital controls did not make a difference in the WHOQOL-BREF scores, it was observed that there was a statistically significant difference between the groups when the effect of suicide attempts on the quality of life scores of the patients was examined ($p < 0.05$). A suicide attempt is a common complication of mood disorders. It has been reported that the risk of suicide in people with bipolar disorder increases 30–60 times compared with the general population. Approximately 25%–50% of patients attempt suicide once in their lives, and approximately 15% of them die as a result.^[46] However, the relationship between suicidal behavior and quality of life in patients with bipolar disorder has not been adequately clarified. As a result of the literature review, no study on this subject was found in our country. The results of the limited number of studies conducted abroad on the subject contradict each other.^[42,46] Therefore, more research results are needed to reveal the relationship between related variables.

While the presence of a mental illness in the families of the patients did not make a difference in their self-esteem scores, the RSES total scores of the participants with a physical illness accompanying the mental illness were calculated to be higher. These results are compatible with those in the literature.^[2] While bipolar disorder alone is a risk factor for low self-esteem, adding physical illness to the picture causes self-esteem to be affected more negatively.

In our study, the age of onset of the disease, the number and frequency of inpatient hospitalizations, the duration of drug use, and compliance with medication and controls did not make a difference in the self-esteem scores of the patients, but it was determined that the patients who attempted suicide at least once in the past had lower RSES scores. In addition, this study found that 26% of the patients had low self-esteem according to the RSES total score (15 or below). These results for self-esteem are similar to those in the literature.^[25,47]

It was observed that the mean ISMI total score of the patients was 58.56 ± 18.15 . In the study conducted by Kök and Demir on patients with schizophrenia and bipolar disorder, the mean ISMI score of patients with bipolar disorder was 76.12 ± 17.15 .^[19] In the study conducted in Eskişehir, it is noteworthy that ISMI scores were higher. The difference is due to the socio-cultural and regional differences in our country, which can affect the perceived level of stigma.

The mean WHOQOL-BREF score of the patients was 96.48 ± 19.98 . On the other hand, in another study conducted in our country on individuals with bipolar disorder and their caregivers, the mean WHOQOL-BREF score was found to be

74.2 ± 11 for the patient group.^[48] The difference is thought to be due to the fact that the sample of our study consisted only of patients in remission. Gutiérrez-Rojas et al.^[42] reported that the quality of life of patients with a bipolar disorder, with or without remission, was comparable to that of individuals in the general population. In a study comparing patients in remission and individuals in the general population, the fact that the patient group that was not in remission had lower life scores than the other two groups supports our view.

In our study, it was determined that there was a statistically significant and negative correlation between the total scores of ISMI, WHOQOL-BREF, and RSES and the total scores of the sub-scales. In other words, individuals with high levels of internalized stigma have a lower quality of life and lower self-esteem. Independent of perceived stigma, it was determined that individuals with a low quality of life had lower self-esteem. The fact that the relationship between the related variables is bidirectional is a situation that should be emphasized here. Stigma and internalized stigmatization, which is a phenomenon that develops due to it, bring with them many negatives in individuals with a mental illness. The relevant literature emphasizes the negative effects of negative experiences, such as embarrassment due to internalized stigma, feelings of inadequacy, avoidance of social relationships, rejection, withdrawal from society, and feelings of worthlessness, on self-esteem and quality of life variables in individuals with a mental illness.^[38,43,47] On the other hand, the number of studies examining the relationship between related variables in the literature is quite limited. Studies have shown that internalized stigma has a direct negative effect on self-esteem and an indirect negative effect on quality of life.^[49,50] Due to the design of our study, the direction of the relationship between the related variables could not be determined.

Conclusion

According to our research results, it has been determined that internalized stigma, quality of life, and self-esteem are concepts that vary according to the socio-demographic and clinical characteristics of patients with bipolar disorder and are closely related to each other. As internalized stigma increases, quality of life and self-esteem decrease in patients with bipolar disorder.

Recommendations

We recommend creating and implementing different intervention programs, especially psychoeducation, by psychiatric and community mental health nurses to reduce the perceived level of stigma in patients with bipolar disorder, improve their capacity to cope with and manage stigma, and increase their quality of life and self-esteem. At the same time, it was concluded that unemployed and low-income patients experienced more internalized stigma, had a lower quality of life, and had lower self-esteem. For this reason, it is recommended that job and vocational training courses be planned and

carried out with stakeholder institutions and organizations in order to identify the difficulties experienced by patients with bipolar disorder in their working lives. Finally, it is recommended to conduct mixed method studies with different sample groups in order to determine the direction of the relationship between internalized stigma, quality of life, and self-esteem.

Thanks To

We would like to thank the Muğla Sıtkı Koçman University Scientific Research Projects Coordination Unit for their financial support of our research.

Conflict of interest: There are no relevant conflicts of interest to disclose.

Peer-review: Externally peer-reviewed.

Authorship contributions: Concept – A.T., N.B.U; Design – A.T.; Supervision – N.B.U; Fundings - A.T., N.B.U; Materials – A.T.; Data collection &/or processing – A.T.; Analysis and/or interpretation – A.T., N.B.U; Literature search – A.T.; Writing – A.T.; Critical review – A.T., N.B.U

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