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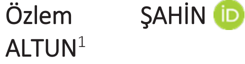
Analyzing the Relationship between Coping Strategies and Functioning Levels of Patients with Bipolar Disorder

Bipolar Bozukluk Tanısı Alan Hastaların Başa Çıkma Stratejileri ile İşlevsellik Düzeyleri Arasındaki İlişkinin İncelenmesi

Özlem ŞAHİN ALTUN[1] 

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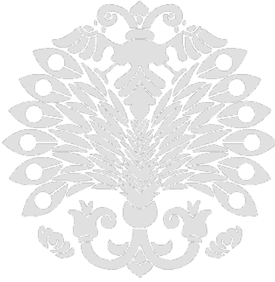

ABSTRACT

Objective: The study aims to determine the relationship between coping strategies and functioning levels of patients with bipolar disorder.
Methods: This study is a descriptive and correlational study. The study was conducted with patients diagnosed with bipolar disorder who presented to the psychiatry outpatient clinic of a hospital in the Eastern Anatolia Region between March 2017 and January 2018.
Results: A significant positive relationship was found between the mean FAST score and "focus on and venting of emotions," "substance use," "acceptance," "suppression of competing activities," "turning to religion," "denial," "behavioral disengagement," "positive reinterpretation," "using emotional social support," and "planning", which are the sub-scales of the CSS-BF.
Conclusion: The coping strategies used by the patients were found to be effective in their functioning levels.

Keywords: Bipolar disorder, coping, functioning, nursing

ÖZ

Amaç: Bu çalışma, bipolar bozukluk hastalarının başa çıkma stratejileri ile işlevsellik düzeyleri arasındaki ilişkiyi belirlemeyi amaçlamaktadır.
Yöntemler: Bu çalışma tanımlayıcı ve ilişki arayıcı bir çalışmadır. Çalışma, Mart 2017-Ocak 2018 tarihleri arasında Doğu Anadolu Bölgesi'ndeki bir hastanenin psikiyatri polikliniğine başvuran bipolar bozukluk tanılı hastalar ile yapılmıştır.
Bulgular: Bu çalışmada FAST puanı ortalaması ile "duygulara odaklanma ve dışa vurma", "madde kullanımı", "kabullenme", "yarışmacı etkinlikleri bastırma", "dine yönelme", "inkar", " davranışsal ilgiyi kesme, olumlu yeniden yorumlama, duygusal sosyal desteği kullanma ve planlama arasında pozitif yönde anlamlı bir ilişki bulunmuştur.
Sonuç: Hastaların kullandıkları başa çıkma stratejilerinin işlevsellik düzeylerinde etkili olduğu görülmüştür.

Anahtar Kelimeler: Bipolar bozukluk, başa çıkma, işlevsellik, hemşirelik

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Introduction

Bipolar disorder is a mental disorder characterized by periods of depression and periods of abnormally elevated mood that can lead to significant psychosocial impairment and disability (Vieta et al., 2018). According to the World Health Organization, bipolar disorder is the sixth leading cause of disability in the world (Nierenberg et al., 2021). Bipolar disorder causes some symptoms in most patients even during periods of remission (Fagiolini et al., 2005; Wesley et al., 2018; Seeberg et al., 2020). It has been reported that after a relapse, only 40% of the patients reach their pre-illness functional state during the period of remission (DelBello et al., 2007).

Functioning refers to an individual's capacity to efficiently perform tasks and activities associated with different areas of life (Rosa et al., 2007). Therefore, loss of function is seen as a factor complicating the lives of patients diagnosed with bipolar disorder as well as causing the disease to recur. The low level of functioning in periods of remission increases the incidence of further recurrence (Grande et al., 2016; Wesley et al., 2018). This situation makes it necessary to evaluate and monitor functioning not only in periods of exacerbation but also in periods of remission (Aydemir & Uykur, 2012). Sole et al. (2017) found that bipolar patients in symptomatic remission exhibit impairments in several areas of functioning. Therefore, one of the main goals of treatment of the disease should be an improvement in functioning, and the main result of treatment in periods of remission should be to achieve normal functioning (García et al., 2020; Lima et al., 2018).

Individuals suffering from bipolar disorder have been reported to experience problems in education, having a profession, marriage, sexual functioning, establishing good relationships with the environment, and enjoying leisure time due to their loss of function (Rosa et al., 2007; Rosa et al., 2009). In order for patients not to experience such problems, they must be able to cope with and fight against the disease. Since coping responses have the capacity to significantly affect the course of the disease in mental disorders, they are among the psychosocial variables that should be assessed in the treatment process (Fletcher et al., 2013; Bridi et al., 2018).

Patients' responses to the problems caused by the disease vary significantly depending on the variables such as personality and environment. These differences also lead to variations in the way each patient copes with the disease (Fletcher et al., 2013; Holahan & Moos, 1987). Coping strategies are the responses individuals give to resist events that cause stress to them (Carver, 1997). Some of these coping attitudes are effective in solving problems, whereas some have been reported to be ineffective. If the coping process is successful, problems can be successfully managed (Holahan & Moos, 1987). However, if this process fails, the individual becomes more likely to experience mental, physical, and social problems. For this reason, it is very important for patients to develop effective coping skills (Şahin et al., 2009).

Developing healthy coping mechanisms to deal with disease-related problems can increase patients' level of functioning in various professional, social, and cognitive domains by enabling them to fight the disease in a more effective manner (Au et al., 2019; Çuhadar et al., 2015). The literature review indicates that very few studies have been conducted to investigate the relationship between coping strategies and functioning levels of patients with bipolar disorder (Au et al., 2019; Çuhadar et al., 2015; Apaydin & Atagun, 2018). The present study is expected to provide information about the functioning and coping strategies as well as elaborate on the relationship between these two concepts. This study was planned to determine the relationship between coping strategies and functioning levels of patients with bipolar disorder.

Methods

This study is a descriptive and correlational study. The study was conducted with patients diagnosed with bipolar disorder who presented to the psychiatry outpatient clinic of a hospital in a province located in the Eastern Anatolia Region between March 2017 and January 2018.

Data collection

The population of the study consists of all patients who presented to the outpatient clinic of the relevant hospital between the specified dates and who met the inclusion criteria. The patients to participate in the research were informed about the purpose and method of the research, the time they would spare for the research, and that participation in the research would not do any harm to them and was completely voluntary. Research data were collected through face-to-face interviews with patients in a private room. It took about 10-15 minutes to fill out the research forms. Posthoc power analysis was performed using the G-Power 3.1.9.4 program to determine that the sample size was sufficient. These values indicate that the sample size is at the desired level.

Inclusion criteria:

- Being over 18 years old,
- Having been diagnosed with bipolar disorder according to DSM-V diagnostic criteria for at least

two years

- Having no physical (speech, hearing impairment, etc.) and neurological disorders that prevent the participant from filling in data collection forms
- Being in the period of remission (the period when the patient's clinical treatment is completed, active period symptoms are not observed, and insight is developed)
- Not having been diagnosed with a comorbid psychiatric diagnosis (depression, personality disorder, substance abuse, etc.)
- Having no communication problems and being open to cooperation

Exclusion criteria:

- Participants are under the age of 18
- Existence of physical (speech, hearing, etc.) and neurological disorders that prevent the participant from completing the data collection forms
- Having a comorbid psychiatric diagnosis of the participants
- Participants are in the active disease phase.

Data Collection Tools

"Personal Information Form," "Functioning Assessment Short Test (FAST)," and "Coping Styles Scale Brief Form (CSS-BF)" were used for data collection.

Personal Information Form: The form consists of nine questions to state the patients' age, gender, education level, employment status, marital status, place of residence, monthly income, household members, and whether their first-degree relatives have any disease.

Functioning Assessment Short Test (FAST): FAST developed by Rosa et al. in 2007. The scale was adapted to Turkish in 2012 by Aydemir and Uykur. This 24-item scale was developed to assess functioning. It consists of 4-point Likert-type items (0= no difficulty, 1= a little difficulty, 2= moderate difficulty, 3= extreme difficulty). The cut-off score of the scale was not calculated. High scores indicate poorer functioning (Aydemir & Uykur, 2012). The Cronbach alpha coefficient of the scale is 0.96. Cronbach's alpha value for this study was 0.90.

Coping Styles Scale Brief Form (CSS-BF): It is a 28-item scale developed by Carver in 1997 based on the long form of the Coping Styles Scale. Planning (thinking about how to deal with stress) Seeking purposeful social support (seeking direction, help, information) Seeking emotional social support (providing moral support, sympathy and understanding) Expressing emotions (focusing on stress and expressing one's emotions) Behavioral distancing (reducing one's efforts to cope with stress or even not trying to reach a goal), Diverting attention (directing one's attention to something other than the stress situation), Reinterpreting it in a positive way (recreating the stress situation as a positive), Rejection (refusing to believe the stressful situation exists), Acceptance (acknowledging the existence of the stressful situation), Religion (creating a source of emotional support through positive reinterpretation of the situation), Substance use (includes the use of alcohol and other substances), Humor (joking about the stress situation) being made fun of or made fun of), self-blame (a tendency to criticize oneself). Reliability study of the scale was conducted by Bacanlı Sürücü, & İlhan, in 2013. The scale consists of 14 sub-scales. Each item is coded on a four-point scale: (1= I never do this, 2= I rarely do this, 3= I do this occasionally, and 4=I do this frequently). The score that can be obtained from each subscale varies between 2 and 8 (Bacanlı et al., 2013). Total score is not calculated in this scale. In the Turkish version, Cronbach's alpha values for the subscales ranged from .39 to .92. In this study, Cronbach's alpha values for subscales were found to be between .60 and .86.

Evaluation of Data

SPSS 21 statistical package program was used to evaluate the research data. Numbers, averages, percentages, standard deviation, Cronbach's alpha coefficient, and Pearson Correlation analysis were used to evaluate the data.

Ethics Statement

For the study, approval was obtained from the Ethics Committee and written permission was obtained from the hospital where the study was conducted.

Results

The findings of the study conducted to determine the relationship between coping strategies and functioning levels of patients with bipolar disorder are given below. The personal information of the patients is given in Table 1. It was determined that 49.1% of the patients were in the 28-37 age range, 68.8% were male, 39.3% were primary school graduates, 25.0% were employed as a worker, 65.2% were single, and 61.6% were living in urban areas. Also, it was found that 42.9% of the patients perceived their income as moderate, 78.6% lived with their families, and 68.8% had no first-degree relative with bipolar disorder.

The patients' minimum and maximum scores and mean scores from CSS-BF sub-dimension and FAST scale are given in Table 2. It was observed that the total mean score of the patients from FAST scale was 36.08±14.68.

Table 1. *Distribution of the Introductory Characteristics of the Patients*		
Features	Number	Percent
Age		
18-27	38	33.9
28-37	55	49.1
38-47	13	11.6
48 and ↑	6	5.4
Gender		
Woman	35	31.2
Male	77	68.8
Education Status		
Primary Education Graduate	44	39.3
High school graduate	36	32.1
Graduated from a Universty	32	28.6
Working condition		
Housewife	16	14.3
Officer	27	24.1
Worker	28	25.0
Self-employment	18	16.1
Not working	23	20.5
Marital status		
The married	39	34.8
Single	73	65.2
living place		
Village	30	26.8
County / Town	13	11.6
Province	69	61.6
Income Status		
Good	27	24.1
Middle	48	42.9
Low	37	33.0
Living Person		
Family	88	78.6
Alone	9	8.0
Friend	15	13.4
Bipolar Disorder in First Degree Relatives Disease Status		
Yes	35	31.2
No	77	68.8

Regarding the sub-dimensions of CSS-BF, the patients scored 4.66±1.79 from "use of instrumental social support," 3.96±1.57 from "humor," 4.56±2.08 from “focus on and venting of emotions,” 4.35±1.90 from “substance use,” 5.01±2.13 from “acceptance,” 4.50±1.90 from “suppression of competing activities,” 5.08±2.11 from “turning to religion,” 4.36±1.87 from “denial,” 4.52±1.88 from “behavioral disengagement,” 4.52±1.88 from "mental disengagement," 4.44±1.55 from "restraint," 5.00±1.84 from “positive reinterpretation,” 4.98±1.85 from “using emotional social support and from planning .”

Table 2. *Distribution of Min-Max and Average Scores of the Patients from BCSS and FAST*				
Scales		Min	Max	$\overline{X}$ ± SS
CSS-BF SUB-DIMENSIONS	Use of Instrumental Social Support	2	8	4.66±1.79
	Humor	2	8	3.96±1.57
	Focus on and Venting of Emotions	2	8	4.56±2.08
	Substance Use	2	8	4.35±1.90
	Acceptance	2	8	5.01±2.13
	Suppression of Competing Activities	2	8	4.50±1.90
	Turning to Religion	2	8	5.08±2.11
	Denial	2	8	4.36±1.87
	Behavioral Disengagement	2	8	4.52±1.88
	Mental Disengagement	2	8	4.85±1.67
	Restraint	2	8	4.44±1.55
	Positive Reinterpretation	2	8	5.00±1.84
	Using Emotional Social Support	2	8	4.98±1.85
	Planning	2	8	5.01±1.97
FAST	**Total**	1	60.00	36.08±14.68

Regarding the relationship between the CSS-BF sub-dimension and FAST scale total mean scores of the patients (Table 3), a significant positive relationship was found between the mean FAST scale total score and the sub-scales of “focus on and venting of emotions,” “substance use,” “acceptance,” “suppression of competing activities,” “turning to religion,” “denial,” “behavioral disengagement,” “positive reinterpretation,” “using emotional social support,” and “planning.”

Discussion

In this section, the findings of the study conducted to determine the relationship between coping strategies and functioning levels of patients with bipolar disorder are discussed based on the literature. In this study, it was determined that the functioning levels of the patients were moderate. Similarly, in their studies conducted in Turkey with patients diagnosed with bipolar disorder, Şahin et al. (2019), and Hacimusalar and Doğan (2019), also reported moderate levels of functioning in patients. The review of the international literature indicates that bipolar patients do not have high levels of functioning and that this issue should be studied (Comes et al., 2017; Lewandowski et al., 2014). Patients diagnosed with bipolar disorder are recommended to go to polyclinic controls regularly, even if they do not show active symptoms.

Table 3.
Relationship Between the Patients' BCAS and FAST Scores

SCALES			FAST
CSS-BF SUB-DIMENSIONS	Use of Instrumental Social Support	r=	-0.018
		p=	0.848
	Humor	r=	0.103
		p=	0.280
	Focus on and Venting of Emotions	r=	0.350**
		p=	0.000
	Substance Use	r=	0.478**
		p=	0.000
	Acceptance	r=	0.250**
		p=	0.008
	Suppression of Competing Activities	r=	0.255**
		p=	0.007
	Turning to Religion	r=	0.295**
		p=	0.002
	Denial	r=	0.431**
		p=	0.000
	Behavioral Disengagement	r=	0.442**
		p=	0.000
	Mental Disengagement	r=	-0.158
		p=	0.096
	Restraint	r=	-0.182
		p=	0.055
	Positive Reinterpretation	r=	0.347**
		p=	0.000
	Using Emotional Social Support	r=	0.333**
		p=	0.000
	Planning	r=	0.321**
		p=	0.001

**p<0.01

Since this study was conducted in a psychiatry outpatient clinic, it is thought that the functioning of the patients was not high during periods of remission. The international literature also indicates that the functioning of bipolar patients is not high even in periods of remission (Fagiolini et al., 2005; Seeberg et al., 2020).

DelBello et al. (2007) reported that only 40% of the patients reached their pre-illness functional state in the period of remission. These results support the findings of this study.

In this study, it was determined that patients diagnosed with bipolar disorder mostly used the methods of "turning to religion," "acceptance," and "positive reinterpretation." Other studies conducted in our country with patients with bipolar disorder also reported that patients preferred these coping methods more (Çuhadar et al., 2015; Apaydin & Atagun, 2018). In this regard, findings obtained in this research are consistent with the results of other studies. In this study, it was determined that the patients mostly used the coping strategy of "turning to religion." In the literature, it is emphasized that religious beliefs and practices are an important part of patients' lives and should be taken into account when assessing bipolar patients (So & Wong, 2008; Stroppa & Moreira-Almeida, 2013). Pesut et al. (2011) conducted a literature review of religion and spirituality in patients with bipolar disorder and revealed that religious belief plays an important role in bipolar disorder. Mitchell and Romans (2003) reported in their study of 147 patients with bipolar mood disorder that a significant majority (78%) of the patients had strong religious or spiritual beliefs. Religious beliefs and rituals vary from culture to culture and constitute an important element of the culture (Darma et al., 2021). In Turkish culture, religion, and spirituality there are two important concepts that are considered divine. In the region where the research was conducted, the Eastern culture, in which the society adheres to religious values, prevails (Gündüz et al., 2019). This is thought to be effective in the patients' preference for the coping strategy of turning to religion.

Studies on coping attitudes in the international literature report that patients with bipolar disorder use coping strategies of self-blaming, focusing on the problem, venting of emotions, substance use, and risk-taking more frequently (Fletcher et al., 2013; Bridi et al., 2018; Souza et al., 2014). On the other hand, this study found that the patients used coping methods that are different than those stated in international studies. It is thought that the reason for this difference is cultural differences as well as the fact that the majority of the individuals in the study group live with their families. In this study, a significant positive relationship was found between the patients' functioning levels and the sub-scales of "Focus on and Venting of Emotions," "Substance Use," "Acceptance," "Suppression of Competing Activities," "Turning to Religion," "Denial," "Behavioral Disengagement," "Positive Reinterpretation," "Using Emotional Social Support," and "Planning." This result shows that the coping methods used by the patients affect their functioning levels. Researchers examine coping strategies in two groups: adaptive and maladaptive strategies (Holahan & Moos, 1987; Fischer et al., 2021). Substance use, suppression of competing activities, denial, and behavioral disengagement are seen as maladaptive coping strategies while focusing on emotions, acceptance, planning, and using emotional social support are considered adaptive strategies (Holahan & Moos, 1987). Grassi-Oliveira et al. (2010) suggested that the use of inappropriate coping skills in bipolar disorder affects the executive functions of the brain. Thus, it increases the individual's vulnerability to stressful life events and negatively affects the course of bipolar disorder.

Nitzburg et al. (2016) revealed that coping strategies of bipolar patients are effective on their functionality levels. Paans et al. (2018) reported a positive relationship between functioning and coping. Garnefski and Kraaij (2007) reported that positive refocusing, positive reappraisal, acceptance,

and refocus on planning strategies, which are thought to be among adaptive coping strategies, are positively correlated with functioning. Faurholt-Jepsen et al. (2019) stated that there is a significant relationship between patients' positive interpretation of stress and functioning. Asıcı and Uygur (2017) stated that it is a functional approach for individuals to produce positive emotions in order to make positive appraisals in the face of stressful situations, and the perceived stress level decreases with the change of emotions and thoughts. Apaydın and Atagun (2018) found that functioning positively affected coping attitudes, while carelessness and inability to plan negatively affected functioning. It has been reported that turning to religion positively affects functionality and ability to manage the disease in bipolar patients (Mitchell and Romans 2003; Pesut et al. 2011). These findings are consistent with the findings obtained in this study.

It is stated that making more individual efforts to actively solve the problems, getting more social support from the environment, and getting more professional help can help bipolar patients to use adaptive methods in coping with stress (Fagiolini et al., 2005). Maladaptive coping attitudes can make the solution to a problem even more complicated by affecting the normal course of the stress that the disease causes. In this context, knowing the coping attitudes used by a person in the face of a stressful situation will help determine the goals of the treatment and monitor therapeutic effectiveness (Asıcı & Uygur, 2017; Henken et al., 2020). Studies examining the relationship between coping strategies and functionality in bipolar patients are very limited in the literature (Nitzburg et al., 2016). It is thought that attempts to increase the use of appropriate coping methods against stress in individuals with bipolar disorder may reduce in these patients the loss of functioning, which is an important problem, and help them to become more active in their personal and social lives.

In line with this study, the following recommendations were made for future clinical practices, research and educational practices. Clinical practice and treatment approaches; It is important to consider the effects of coping strategies when evaluating the functionality levels of patients diagnosed with bipolar disorder. In this way, individuals can be supported more effectively and appropriate interventions can be made when necessary. In treatment processes, therapeutic approaches should be developed for patients to develop and use adaptive coping strategies. These strategies can help patients cope with stress in a healthier way and increase functionality. Patients' religious beliefs and values should be taken into account in the formulation of treatment plans. Religion and spirituality can have an impact on coping strategies and functioning. Therefore, it may be helpful to support patients in ways they can draw strength from their religious resources.

Research and education areas: Health professionals can develop appropriate educational materials to inform and educate patients on coping strategies. These materials can help patients cope with stress more effectively and increase functionality.

Conclusion and Recommendations

The study concludes that patients with bipolar disorder have moderate levels of functioning. Moreover, the coping strategies used by the patients were found to be effective in their functioning levels. Healthcare professionals are recommended to assess the functioning levels and coping methods of patients with bipolar disorder and to inform them about using the correct approaches.

Limitations of the Study

Not using randomization in the sampling method in this study is a limitation of the study. Besides, the use of the self-reported questionnaire in the study and the relatively small sample size are other limitations.

The limitations of this study provide some opportunities for further research. Conducting similar studies with larger sample groups may increase the generalizability of the findings. Long-term follow-up studies may be considered to understand how the effects of coping strategies on functioning may change over time. Further research can be conducted to examine the effects of cultural differences on coping strategies and functioning.

Etik Komite Onayı: Bu çalışma için etik komite onayı Atatürk Üniversitesi'nden (Tarih: 09.01.2017,No:2016/12/08) alınmıştır.
Hasta Onamı: Çalışmaya katılan hastalardan onam alındı.
Hakem Değerlendirmesi: Dış bağımsız.
Yazar Katkıları: Fikir – Ö.Ş.A,Z.Ö; Tasarım– M.D., Z.Ö.; Denetleme – Ö.Ş.A.; Kaynaklar – M.D., Z.Ö.; Veri Toplama ve/ veya İşlemesi – M.D.; Analiz ve/veya Yorum – Ö.Ş.A., Z.Ö.; Literatür Taraması –M.D.,Z.Ö.; Yazıyı Yazan – Ö.ŞA.,Z.Ö.,M.D.; Eleştirel İnceleme – Ö.Ş.A.,M.D.,Z.Ö.
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Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Atatürk University (Date: January 9, 2017, Number: 2016/12/08).
Informed Consent: Consent was obtained from the patients participating in the study.
Peer-review: Externally peer-reviewed.
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Ö.Ş.A.; Resources – M.D., Z.Ö.; Data Collection and/or Processing – M.D.; Analysis and/or Interpretation – Ö.Ş.A., Z.Ö.; Literature Search –

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Genişletilmiş Özet

Bipolar bozukluk, önemli psikososyal bozulma ve yetersizliğe yol açabilen, depresyon dönemleri ve anormal derecede yüksek ruh hali dönemleri ile karakterize edilen bir zihinsel bozukluktur. Dünya Sağlık Örgütü'ne göre, bipolar bozukluk dünyadaki altıncı önde gelen engellilik nedenidir. Bipolar bozukluk çoğu hastada remisyon dönemlerinde bile bazı belirtilere neden olur. Bir nüksetmeden sonra hastaların sadece %40'ının remisyon döneminde hastalık öncesi fonksiyonel durumuna ulaştığı bildirilmiştir. İşlevsellik, bireyin yaşamın farklı alanlarıyla ilişkili görevleri ve etkinlikleri verimli bir şekilde gerçekleştirme kapasitesini ifade eder. Bu nedenle fonksiyon kaybı, bipolar bozukluk tanısı alan hastaların hayatını zorlaştıran ve hastalığın tekrarlamasına neden olan bir faktör olarak görülmektedir. İyileşme dönemlerindeki işlevsellik düzeyinin düşük olması, tekrarlama insidansını artırmaktadır. Bu çalışmanın, işlevsellik ve baş etme stratejileri hakkında bilgi vermesi ve bu iki kavram arasındaki ilişkiyi detaylandırması beklenmektedir. Bu çalışma, bipolar bozukluk hastalarının başa çıkma stratejileri ile işlevsellik düzeyleri arasındaki ilişkiyi belirlemek amacıyla planlanmıştır.

Bu çalışma betimsel ve ilişkisel bir çalışmadır. Araştırma, Mart 2017-Ocak 2018 tarihleri arasında Doğu Anadolu Bölgesi'nde bulunan bir ilde bulunan bir hastanenin psikiyatri polikliniğine başvuran bipolar bozukluk tanılı hastalar ile yapılmıştır.

Araştırmanın evrenini ilgili hastanenin polikliniğine belirtilen tarihler arasında başvuran ve dahil edilme kriterlerini karşılayan tüm hastalar oluşturmaktadır. Örnekleme yapılmadı: Çalışma 112 hasta ile gerçekleştirildi.

Dahil edilme kriterleri:

- 18 yaşından büyük olmak,
- En az iki yıldır DSM-V tanı ölçütlerine göre bipolar bozukluk tanısı almış olmak,
- Katılımcının veri toplama formlarını doldurmasına engel fiziksel (konuşma, işitme vb.) ve nörolojik rahatsızlığı bulunmaması,
- Remisyon döneminde olmak (hastanın klinik tedavisinin tamamlandığı, aktif dönem semptomlarının görülmediği, içgörünün geliştiği dönem).
- Eşlik eden bir psikiyatrik tanı almamış olmak (depresyon, kişilik bozukluğu, madde kullanımı vb.)
- İletişim sorunu yaşamamak ve işbirliğine açık olmak.

Veri toplama aracı olarak "Kişisel Bilgi Formu", "İşlev Değerlendirme Kısa Testi (FAST)" ve "Başa Çıkma Tarzları Ölçeği Kısa Formu (CSS-BF)" kullanılmıştır. Kişisel Bilgi Formu: Form, hastaların yaşını, cinsiyetini, eğitim durumunu, çalışma durumunu, medeni durumunu, ikamet ettiği yeri, aylık gelirini, hanehalkı üyelerini ve birinci derece yakınlarının herhangi bir hastalığı olup olmadığını belirten dokuz sorudan oluşmaktadır. İşlevsel Değerlendirme Kısa Testi (FAST): Rosa ve diğerleri tarafından geliştirilen FAST. Ölçek 2012 yılında Aydemir ve Uykur tarafından Türkçe'ye uyarlanmıştır. Bu 24 maddelik ölçek, işlevselliği değerlendirmek için geliştirilmiştir. Ölçeğin özerklik, mesleki işlevsellik, bilişsel işlevsellik, finansal konular, kişilerarası ilişkiler ve boş zaman olmak üzere altı alt boyutu vardır. 4'lü Likert tipi maddelerden oluşmaktadır (0= zorluk yok, 1= biraz zorluk, 2= orta zorluk, 3= aşırı zorluk). Ölçeğin kesme puanı hesaplanmamıştır. Yüksek puanlar daha zayıf işlevselliğe işaret etmektedir. Başa Çıkma Tarzları Ölçeği Kısa Formu (CSS-BF): Başa Çıkma Tarzları Ölçeği'nin uzun formundan yola çıkılarak 1997 yılında Carver tarafından geliştirilmiş 28 maddelik bir ölçektir. Ölçeğin güvenirlik çalışması Bacanlı Sürücü, & İlhan tarafından 2013 yılında yapılmıştır. Ölçek 14 alt ölçekten oluşmaktadır. Her madde dörtlü bir ölçekte kodlanmıştır: (1=Bunu asla yapmam, 2=Bunu nadiren yaparım, 3=Bunu ara sıra yaparım ve 4=Sık sık yaparım). Her bir alt ölçekten alınabilecek puan 2 ile 8 arasında değişmektedir.

Araştırma verilerinin değerlendirilmesinde SPSS 21 istatistik paket programı kullanılmıştır. Verilerin değerlendirilmesinde sayı, ortalama, yüzde, standart sapma, Cronbach alfa katsayısı ve Pearson Korelasyon analizi kullanılmıştır. Çalışma için Etik Kurul onayı ve çalışmanın yapıldığı hastaneden yazılı izin alındı. Araştırmaya katılacak hastalara, araştırmanın amacı ve yöntemi, araştırmaya ayıracakları zaman, araştırmaya katılmanın kendilerine herhangi bir zarar vermeyeceği ve tamamen gönüllülük esasına dayalı olduğu anlatıldı. Bipolar bozukluğu olan hastaların başa çıkma stratejileri ile işlevsellik düzeyleri arasındaki ilişkiyi belirlemek amacıyla yapılan çalışmanın bulguları aşağıda verilmiştir. Hastaların kişisel bilgileri Tablo 1'de verilmiştir. Hastaların %49,1'inin 28-37 yaş aralığında, %68,8'inin erkek, %39,3'ünün ilkokul mezunu, %25,0'inin işçi olarak çalıştığı belirlendi. , %65,2'si bekardı ve %61,6'sı kentsel alanlarda yaşıyordu. Ayrıca hastaların %42,9'unun gelirini orta düzeyde algıladığı, %78,6'sının ailesiyle yaşadığı ve %68,8'inin birinci derece akrabasında bipolar bozukluk bulunmadığı saptandı. Hastaların CSS-BF ve FAST puan ortalamaları ile minimum ve maksimum puanları Tablo 2'de verilmiştir. Hastaların FAST puan ortalamalarının 36,08±14,68 olduğu görüldü. BBÖ-BF'nin alt boyutlarına göre hastalar "araçsal sosyal destek kullanımı" 4,66±1,79, "mizah" 3,96±1,57, "duygulara odaklanma ve dışa vurma" 4,56±2,08, 4,35±1,90 puan aldı. “madde

kullanımı" 5,01±2,13 "kabullenme", 4,50±1,90 "yarışmacı etkinliklerin bastırılması", 5,08±2,11 "dine dönme", 4,36±1,87 "inkar", 4,52±1,88 "davranışsal uzaklaşma, " 4,52±1,88 "zihinsel gevşeme"den, 4,44±1,55 "kendini tutma"dan, 5,00±1,84 "olumlu yeniden yorumlamadan", 4,98±1,85 "duygusal sosyal desteği kullanmaktan ve planlamadan." puan aldıkları belirlendi. Hastaların CSS-BF ve FAST puan ortalamaları arasındaki ilişkiye bakıldığında (Tablo 3), FAST puan ortalamaları ile "duygulara odaklanma ve duyguları dışa vurma", "madde kullanımı" alt ölçekleri arasında pozitif yönde anlamlı bir ilişki bulunmuştur. ," "kabullenme", "yarışan etkinliklerin bastırılması", "dine yönelme", "inkar", "davranıştan uzaklaşma", "olumlu yeniden yorumlama", "duygusal sosyal desteği kullanma" ve "planlama" puan aldıkları belirlendi.

Çalışma, bipolar bozukluğu olan hastaların orta düzeyde işlevselliğe sahip olduğu sonucuna varmıştır. Ayrıca hastaların kullandıkları başa çıkma stratejilerinin işlevsellik düzeylerinde etkili olduğu görülmüştür. Bipolar hastalarının işlevsellik düzeylerini ve başa çıkma yöntemlerini değerlendirmek için sağlık uzmanlarına tavsiye edilir.