Relationships Between Internalized Stigma, Hopelessness and Self-esteem and Their Sociodemographic and Clinical Characteristics in a Group of Patients with Severe Mental Illness

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Bir Grup Ağır Ruhsal Hastalığı Olan Bireyde
İçselleştirilmiş Damgalanma, Umutsuzluk ve Benlik Saygısı Arasındaki İlişkiler
ile Sosyodemografik ve Klinik Özelliklerin İncelenmesi

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Thesis Abstract

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The patients with severe mental illness (SMI) are faced with the heavy burden of stigma in addition to the symptoms of mental illness. Internalized stigma is one of the most important factors causing a decrease of the self-esteem of the patients and hope (treatment seeking) for recovery. The basic objective of the current study is determine the sociodemographic, psychosocial and clinical factors that predict internalized stigma, hopelessness and self-esteem in patients with SMI. The sample of the current study consissts of 117 outpatients diagnosed as having psychotic (N=69) and bipolar disorders (N=48) in the provinces of İstanbul and Bursa. Sociodemographic and clinical information questionnaire, Turkish forms of Internalized Stigma of Mental Illness Scale (ISMI), Beck Hopelessness Scale (BHS), and Rosenberg Self-esteem Scale (RSES), were used in the study. To investigate the predictors of sociodemographic and clinical factors of internalized stigma. Mann Whitney U and Krusskal Wallis H analyzes were conducted. It was presented some suggestions for the psychotherapeutic and other clinical services for patients with SMI are presented.

Tez Özeti

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Ağır ruhsal hastalığı olan bireyler hastalığın semptomlarına ek olarak ciddi bir damgalanma yüküyle karşı karşıyadırlar. İçselleştirilmiş damgalanma hastaların benlik saygısı ve iyileşmeye dair umutlarının (tedavi arayışı) azalmasına sebep olan en önemli etkenlerden biridir. Bu araştırmanın temel amacı ruhsal hastalığı olan bireylerde içselleştirilmiş damgalanmayı yordayan sosyodemografik, psikososyal ve klinik etkenleri belirlemektir. İkinci olarak söz konusu hastalarda içsellşetirilmiş damgalanma, benlik saygısı ve umutsuzluk arasındaki ilişkileri incelemektir. Araştırmanın örneklemi İstanbul ve Bursa illerinde ayaktan tedavi gören 117 psikotik (N=69) ve bipolar bozukluk (N=48) tanısı almış hastadan oluşmaktadır. Katılımcılara bu araştırma için hazırlanmış olan sosyodemografik ve klinik bilgi anketinin yanısıra, Ruhsal Hastalıklarda İçselleştirlmiş Damgalanma Ölçeği (RHİDÖ), Beck Umutsuzluk Ölçeği (BUÖ) ve Rosenberg Benlik Saygısı Ölçeği (RBSÖ) Türkçe formları uygulanmıştır. İçselleştirlmiş damgalanmayı yordayan sosyodemografik ve klinik etkenleri incelemek amacıyla Mann Whitney U and Krusskal Wallis H analizleri yapılmıştır. Elde edilen veriler ışığında söz konusu hasta grubu için verilen psikoterapötik ve diğer klinik hizmetler hakkında bazı öneriler sunulmuştur.

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CHAPTER ONE: INTRODUCTION

1. Introduction

During the final project for my psychodrama group psychotherapy training* I have noticed that patients with schizophrenia were often brought some problems related to stigma. Since then, I was preoccupied with the thought that stigma issues constitute a major burden in patients with severe mental illness (SMI). When we focused on patients' daily/social life challenges in the group, several patients found an opportunity to work on his/her stigma experiences (İsmanur, 2008). I realized that these experiences overlapped and built serious psychological barriers for patients concerned. Consequently, that study increased my curiosity on stigma issues and led me to concentrate on psychotherapeutic interventions for individuals with SMI.

Moreover, my clinical work with many young adult and adult individuals diagnosed with autism spectrum disorder and schizophrenia exposed me to hear stories about exclusion from social life. They were telling how they were pushed outside of society and how the attitudes were changing toward them. Basic health and education services were unavailable to them. I contemplate whether these were caused by lack of education and prejudice or something else? I observed that these complaints created expanding shame for the relatives of the patients, thus increased hopelessness. Their eroding morale looked like one of the significant variables that decreased life quality. These observations made me think, learn and do more research about stigma.

The word stigma archaically defined as "a mark branded on the skin". The words such as "disgrace", "shame", "dishonour", "mark" are synonyms. As defined in Collins' Online Dictionary (2011), used as "a distinguishing mark of social disgrace".

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defined as “any mark on the skin, such as one characteristic of a specific disease” or “any pathologically it is sign of a mental deficiency or emotional upset”.

Sociologist Erving Goffman described stigma as “the process by which the reaction of others spoils normal identity”. “an attribute that is deeply discrediting” and reduces the bearer “from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). Over the years theoreticians and researchers (e.g. Link & Phelan) building on Goffman’s work defined stigma resulting in status loss, discrimination for members of stigmatized groups. The vicious process of stigma begins with the labelling of human differences. The next step is the separation of “us” and “them”. Thereby, it results in status loss and discrimination who has those differences.

The Labeling Theory of 1960s (Mead & Becker, 2011) still holds true when looking at stigma. Labeling Theory defines unnatural as 'deviant.' Majority tend to stigmatize minority in a negative way. Stigma is characterized by a deviation from the cultural norms.

Stigma is a well-recognized phenomenon in mental health field for a long time. Generally, it is described as the status loss and discrimination triggered by negative stereotypes about individuals labelled as having mental illness (Link & Phelan, 2001). Stigma withholds recovery process by eroding individuals’ morale (Ritsher & Phelan, 2004). Therefore, stigma has a negative impact on the self-esteem and hope levels of patients with the psychiatric disorders.

The most negative attitudes towards SMI are having psychotic features (Waner, 2005). One of the most significant loss of social status for the patients with SMI is that the feeling being not a member of community. The aforementioned detrimental effects of stigma are the reason why stigma is becoming one of the key

factors when looking at the treatment processes as well as diagnosis in mental health industry.

Most of the time, stigma as the definition suggests, is conceived as an external variable. However, externality of stigma projects into human emotions and self-perception and become 'internalized.' Individuals living in a society are molded in the culture to somewhat reach a degree of stereotype acceptance. When individuals enter a state in which they can be subjected to the very stereotype they agree on, they internalize all attributes of that stigma.

This internalization process takes a toll on the the treatment process as well as the person's life. Both public [social] stigma and self-stigma [internalized] leads to diminished social support, isolation and self-esteem (Miller, 2003). Considering self-esteem and support are important aspects of treatment and recovery, understanding the inimical impacts of stigma is imperative. Soygür and Özalp (2005) found that, burdens gestated from stigma are critical obstacles in psychiatric treatment/rehabilitation of patients with SMI.

Objective effects such as to be unemployed, not be the marrying kind. Individuals diagnosed with any SMI may internalize public stigma and experience diminished self-esteem and hope levels. A study that perceived stigma results in a loss of self-esteem and limited prospects for recovery (Link, 2001).

1.1. The Conceptualization of Stigma

The studies show that stigma can be related to some conditions, as, chronic health and psychosocial cases such as sexual orientation (homosexuality), physical illness (HIV), physical disability, learning disability, minority groups (race/ethnicity), sex, having a job/profession, physical appearance (obesity) (Mark, Poon, Pun & Cheung, 2007). In any case stigma has a severe impact on daily life of

those individuals and indirectly to their families. Despite enormous cultural diversity across the world, the areas of life affected are remarkably similar.

Studies revealed that stigma effects patients with severe mental illness SMI in a negative way in terms of their mental health conditions and quality of life. Stereotypes, prejudice and discrimination are the main factors of the stigmatization. However these are the major barriers in treatment seeking for patients with SMI (Rüsch, Angermeyer & Corrigan 2005).

If social/public stigma leads to self-stigmatization (internalized), this results access to health care, vocational, housing, social life and self-esteem problems in individual's life (Yanos & Lysaker, 2010).

Corrigan and Watson (2002) argued that not all stigmatized individuals go through the process of internalization.

1.2. Theories of Stigmatization

Link and colleagues have carried out multiple studies (Link, 1987; 1989; Link, Struening & Rahav, 1997) which show the influence that labeling can have on mental patients. They developed a "modified labeling theory" indicating that expectations of labeling can have a large negative effect, withdrawing from society, and that those labeled as having a mental illness. As a result being rejected from society can heavily reduce self-esteem and this potentially decrease quality of life of individuals with severe mental illness (SMI).

Link's modified labeling theory brings a new theoretical stigmatization model suggesting that stigma exists with four specific components: (i) Individuals differentiate and "label" human variations (ii) Cultural beliefs tie those labeled to negative attributes (iii) Labeled people are placed in differentiated groups that establishing a sense of disconnection between "us" and "them" (iv)

Labeled people experience "status loss and discrimination" that leads to unequal condition and status.

From labeling theory perspective, studies assume that prior to being labeled as “mentally ill” individuals have internalized cultural/social stereotypes about mental illness (Link, 1987). Common cultural-social stereotypes about people diagnosed with mental illness include that they are incompetent, dangerous and guilty of their illness (Corrigan et al., 2005).

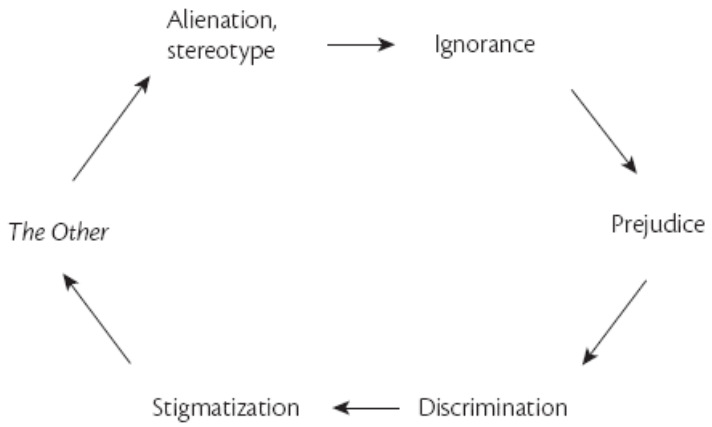

Figure 1: Vicious circle of stigmatization (Küey, 2009)

Stigmatization could be conceptualized its relationship with the concepts such as ignorance, prejudice, discrimination (Küey, 2009).

One of the most significant loss of social status for the patients with SMI is that the feeling of not being member of community.

The figure below shows the structured process of stigmatization. All individuals identify themselves with a group and legitimize some values of their perceived group. This leads to a sense of stereotype awareness and thus an agreement with the stereotype. When the condition concurs with the individual, all the knowledge and the agreement of the stereotype targets the individual, hence, it leads

to an impact on the self-esteem and self-efficacy (Watson, Corrigan, Larson & Sells, 2007).

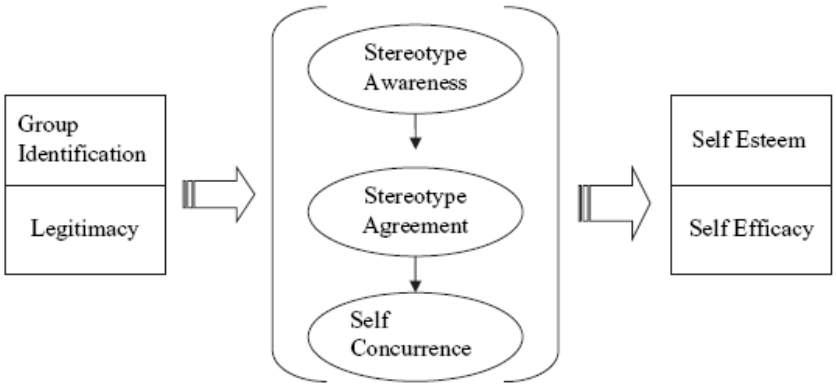

Figure 2: A theoretical model of stigma (Watson et al, 2007)

The social–cognitive model of self-stigma (Rüsch, Corrigan, Todd & Bodenhausen, 2010) suggests that, as with public/social stigma, self/internalized-stigma is made up of stereotypes, prejudice, and discrimination. Individuals with SMI have self-prejudices and tend to agree with the typical mental illness stereotypes in society. Prejudice leads to negative emotional reactions, especially low self-esteem and self-efficacy (Wright, Gronfein, Owens 2000; Rüsch, Angermeyer & Corrigan, 2005). Due to their self-prejudices, individuals with mental illness may lose their jobs, and avoid seeking treatment.

Some researchers have used structural equation models to explain stigma related concepts. Vauth and colleagues' hypothesis (Vauth, Kleim, Writz & Corrigan, 2007) is that the strategies to cope with stigma by social isolation and suppressing the illness lead to an increase in levels of anxiety. This increases the levels of perceived discrimination and devaluation, which, in turn, have a negative impact on self-efficacy and empowerment. The decrease in empowerment affects depression and leads to a reduction in the quality of life.

The work of Yanos and colleagues (Yanos, Roe, Markus & Lysaker, 2008) tests two empirical models of the relations between internalized stigma and outcomes. Their model hypothesize that internalized stigma negatively impacts occupational placing and symptoms because it erodes people's self-esteem and hope levels. This reduction could gestate the beginning of depressive symptoms, social avoidance, and an avoidant coping style. In this model, engagement in rehabilitation and recovery expectations are indicated as variables that may play an important role in the recovery process (Lysaker et al., 2007).

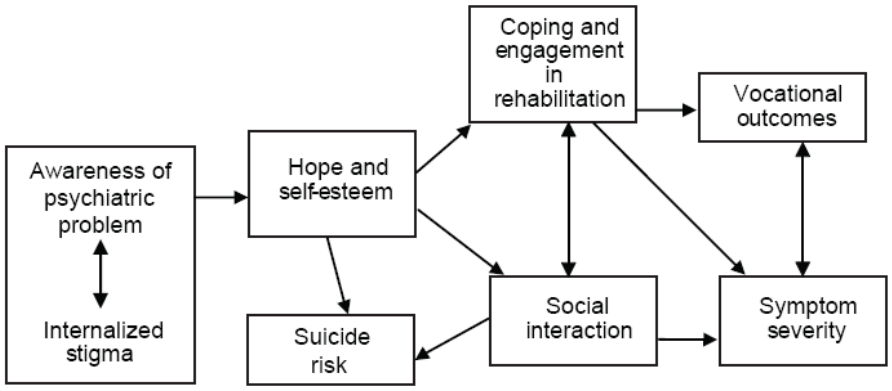

Figure 3: A model of internalized stigma on recovery-related outcomes for patients with SMI (Yanos et al., 2008)

Researchers indicate that perceived stigma leads to patients with SMI a loss of self-esteem and limited prospects for recovery (Link et. al., 2001; Wright et al, 2000). Common stereotypes about individuals with SMI include that they all are incompetent and to blame for their illness (Corrigan & Kleinlein, 2005). "Crazy people are dangerous and can attack to the others" express this statement.

1.2.1. Public stigma

Public stigma referred to as social or enacted stigma in some publications. As relatives and acquaintances of individuals diagnosed with severe mental illness (SMI), as well as professionals who work with them, are aware; stigma has deleterious effect

on the individual. Reports indicate that stigma is one of the most impactful causes to make one to avoid and averse treatment (Rüsch et al., 2005).

It has been showed by many others that stigmatization significantly hinders the social life, psychological processes and decreases life quality (Rosenfield 1997, Markowitz 1998, Yanos, Rosenfield & Horwitz, 2001).

One of the most popular statements demonstrating social stigma is "all people with mental illness are dangerous and they can attack me." The perceived unpredictability of the condition leads to stereotyping and this stereotyping leads to prejudice and discrimination.

In the stigma literature there are three interacting levels of stigma: social, structural, internalized. In today's society, stigmatization and discrimination against people with severe mental disorder causes problems on a societal level. Individuals with severe mental illnesses such as schizophrenia spectrum disorder and bipolar disorders experience decrease in self-esteem and hope levels that may result in disability in extreme cases. This phenomenon makes it harder to develop interventions that will improve their conditions (Üçok, 2008).

The effects of stigmatization, especially towards people with SMI, as deleterious as the symptoms of their disease, thus it hinders their treatment (Ritsher & Phelan, 2004). Societal awareness holds utmost importance for the prevention of stigma, as individuals who are targeted by stigma tend to stigmatize themselves or have the potential to stigmatize as a part of the society. In recent years, there have been attempts to prevent stigma around the world (WPA, 2005).

According to World Health Organization's data, schizophrenia and bipolar disorder are among the top 10 diseases that cause retardation in functioning. Attempts to prevent stigma is valuable and undoubtedly necessary. However, the clinical

evaluation of self-stigmatization is crucial. Protecting the individual from self-stigmatization and/or making this a part of the treatment is vital.

1.2.2. Internalized Stigma

Internalized stigma also known as self or felt stigma in some studies.

Variables related internalized stigma can be categorized under three groups: (1) sociodemographic, (2) psychosocial and, (3) psychiatric/clinical. In a study which reviewed 127 and analyzed 45 articles shows that sociodemographic variables are not correlated strongly in the majority of past studies (Livingston & Boyd, 2010).

The same study indicates that internalized stigma is negatively associated with psychosocial and clinical variables. Many studies revealed that higher level of internalized stigma in patients with severe mental illness (SMI) associated with lower levels of empowerment, self-efficacy, self-esteem, quality of life, social support and hope (Sibitz, Unger, Woppmann, Zidek & Amering, 2009). Findings concerning the relationship between internalized stigma and psychiatric variables indicate that some clinical variables are associated with symptom severity and treatment adherence. Symptom severity had statistically significant associations with internalized stigma in 50 studies (%83.3). Treatment adherence was examined in 7 studies (%63.6) and negatively related with internalized stigma. Other psychiatric/clinical variables – including diagnosis, illness duration, hospitalization, insight, treatment setting, functioning, medication side effects – were not significantly associated with internalized stigma in the majority of studies (Livingston & Boyd, 2010). Nevertheless, it is suggested that in the majority of patients with SMI have internalized stigma and this can be related with lower self-esteem level (Ritsher and Phelan, 2004).

To this day, research on internalized stigma provided inconsistent results. Some researches indicate that individuals with SMI experience high levels of internalized stigma and it is negatively correlated with self-esteem (Ritsher and Phelan, 2004).

It might be useful to look at the comparing and contrasting definitions of public and internalized stigma (Figure 4).

	Public stigma
Stereotype	Negative belief about a group *(e.g., dangerousness, incompetence, character weakness)*
Prejudice	Agreement with belief and/or negative emotional reaction *(e.g., anger, fear)*
Discrimination	Behavior response to prejudice *(e.g., avoidance, withhold employment and housing opportunities, withhold help)*
	Self-stigma
Stereotype	Negative belief about the self *(e.g., character weakness, incompetence)*
Prejudice	Agreement with belief, negative emotional reaction *(e.g. low self-esteem, low self-efficacy)*
Discrimination	Behavior response to prejudice *(e.g., fails to pursue work and housing opportunities)*

Figure 4. Comparing and contrasting the definitions of public stigma and self-stigma (Corrigan & Watson, 2002)

1.3. Severe Mental Illnesses

Severe mental illnesses (SMI) are mental disorders that affect individual's life by causing psychotic episodes and may last for as long as the lifetime of an individual.

According to National Institute of Mental Health (NIMH), "psychosis is when there is a sort of disconnection with reality. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear)" (NIMH, 2016).

Severe mental illnesses include schizophrenia and schizoaffective disorders.

"Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality. Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling." (NIMH, 2016).

1.3.1. Schizophrenia and the other psychotic disorders

Schizophrenia and the other psychotic disorders defined as a general category of serious psychopathology in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR (American Psychiatric Association, 2001). An expansive body of research has investigated stigma phenomena in schizophrenia and psychotic disorders (Yanos, Roe, Markus & Lysaker, 2015; Watson, Corrigan, Larson & Sells, 2007; Lysaker, Tsai, Yanos & Roe, 2008; Sibitz et al., 2011). It is clear that psychosis is the most influential mental illness affected by stigma.

It is specified that "people who are close to the psychotic person may feel frightened, helpless, or exasperated…" in PDM (Psychodynamic Diagnostic Manual) (2006). This statement may lead to great contemplation as the feelings and emotions of the close ones may lead to stigmatization and discrimination.

1.3.2. Bipolar disorders

Bipolar disorders are defined as a psychiatric illness under the general category of mood disorders in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR (American Psychiatric Association, 2001). According to PDM (2006) "bipolar disorders are characterized by the presence of an episode with manic features in addition to a depressive episode and/or milder depressive symptoms."

Some studies show that patients with bipolar disorder are stigmatized in society and they suffer in the vicious cycle of stigmatization process. Internalized stigma in psychosis –mostly schizophrenia- is a well-known issue that has been investigated. The results of a study which conducted by Sarısoy and colleagues (Sarısoy, Kaçar, Pazvantoğlu, Korkmaz, Öztürk, Akkaya, Yılmaz, Böke, Şahin, 2013) are significant in terms of demonstrating that internalized stigma is also frequent in bipolar disorder patients. In another study conducted by Üstündağ and Kesebir (2013) internalized stigmatization was determined in 46% of the patients diagnosed Bipolar Disorder. Those patients had higher functionality and shorter regression periods than those without internalized stigmatization. Clinical characteristics of the disorder and internalized stigma were observed affecting each other. Stigmatization also affects treatment course and quality of life.

Patients are going through stressful treatment processes due to internalized stigmatization. Stigmatization of mental illnesses is mostly studied within psychotic patients and thus there are not many studies looking at how patients diagnosed with affective disorders experience stigma. Current study, however, is also investigating affective disorders.

1.4. Internalized Stigma, Hopelessness and Self-esteem in Patients with SMI

In this section three main variables of the current study; internalized stigma, hopelessness and self-esteem were examined. Literature reviewed under three title of patients with SMI.

1.4.1. Internalized Stigma in Patients with SMI

Individuals suffering from mental disorders are faced with two main problems. First, they have to live and cope with the symptoms of their disease. Second, is the presumptions of the society about their mental disorder (Rüsch et. al., 2005).

A research done in a Turkish university with 209 participants indicates that stigmatization, especially individuals diagnosed with schizophrenia spectrum disorder, is very common among people with mental disorders and the most significant obstacle against treatment (Arslantaş, Gültekin, Söylemez & Dereboy, 2010). In addition, the percentage of participants who reported that they would marry was %7,2. Only %29,6 reported that they would seek professional help without hesitation. Stigmatization was found to be more prevalent in schizophrenia than depression, anxiety and other psychiatric disorders. Finally they found that people who sought help from hospitals and polyclinics were more tolerant towards mental disorders.

Another research with 200 participants (Taşkın, Yüksel, Deveci & Özmen, 2009) report that %50,5 of their participants would not be willing to marry with someone diagnosed with depression and %28 of these participants reported that they think people diagnosed with depression disorders can engage in aggressive behavior.

In conclusion, individuals who apply to psychiatric polyclinics are more knowledgeable and more tolerant towards mental diseases. However, they were more likely to pursue more social distance towards people with mental disorders as well as practiced discriminatory behaviors. Assessment of this information implicate that raising awareness of the public itself is not enough to tackle the issue of stigmatization. Therapeutic interventions by mental health professionals aiming to understand the viewpoint of the patient might be more effective.

One can see that awareness of the disease, psychiatric symptoms, self-esteem, hopelessness and coping ability variables are assessed together, especially on the research about schizophrenia (Yanos, Roe, Markus & Lysaker, 2015; Watson, Corrigan, Larson & Sells, 2007; Lysaker, Tsai, Yanos & Roe, 2008; Sibitz et al., 2011). Results indicate that there is a negative correlation with variables such as self-esteem and hopelessness and internalized stigma (Yanos et al. 2008).

Yanos et al. (2008) claims that "narrative enhancement approach" in which the patients tell their own stories and restructure the story, is an effective way to intervene.

A study that carried out by Hasson-Ohayon et. al. (Hasson-Ohayon, Levy, Kravetz, Vollanski-Narkis & Roe, 2011) showed that there is a positive relationship between insight into psychiatric illness and family burden. The study that searching for levels of insight into a children's mental illness included 127 parents of individuals with a SMI. Self-stigma (internalized) was found to mediate the relationship between insight and burden. Accordingly, parent insight into the mental illness of a child increase parent burden due to increasing parent self-stigma. Parents who experience greater levels of insight reported to have higher levels of burden.

The activation of negative stereotypic attitudes towards the mental illness during the post-diagnosis period may be due to one's personality organization, past experiences and self-esteem. One can conclude that an intervention by a clinician is the best way to arbitrate the best results.

There is a significant amount of controversy on the extent demographics are related to internalized stigma. A meta-analysis was conducted by Livingston & Boyd (2010) and their results, within the body of literature, indicate consistent significant relationship between gender, age, education, employment, marital status, income, and

ethnicity and internalized stigma. However, the relationships they found had diverse directions. “The direction of the relationship was mixed in the studies, with higher levels of internalized stigma associated with being older in 36.4% of the studies and being younger in 63.6% of the studies. Because none of the sociodemographic variables was significantly related to internalized stigma in the majority of studies.” (Livingstone & Boyd, 2010).

Other studies found that greater age had a weak correlation with the ability to reject stigma, whereas no relationship was found with any measure of self-esteem. A weak correlation was also found between lesser education and higher defensiveness but no relationship was found between stigma or any self-esteem related scores.

Another research that has been conducted with a Turkish sample indicates that marital status, diagnosis and employment status are not significantly correlated with internalized stigma and self-esteem (Havva & Pınar, 2012).

Previous body of research indicates that adolescents experience stigma differently than their elders. Cases of secrecy about their conditions and medication usage are observed. Social distancing and more interaction with peers who also experience similar conditions are also prevalent (Kranke, Floersch, Townsend & Munson, 2010).

A review of 53 international studies show that women were at least 5-7 years older than men to show symptoms than men. They also indicate that the handling of such cases are very different as age differences are important parts of planned intervention in such cases (Kulkarni, 2006). Higher stigma among women is associated with elevated depressive symptoms comparing to women with lower levels of internalized stigma (Hong, Fang, Li, Liu, Li & Tai-Seale, 2009). These findings

indicate that interventions and approaches should require additional focus to look at the differences in stigma experience.

Ethnicity, depressive symptoms and suicidal attempt were all found to be associated with self-perceived stigma (Hong et. al., 2009).

In contrast to aforementioned demographic variables, most psychosocial variables was shown to have significant relationships with internalized stigma and vice versa. "For example, self-esteem had been examined in 34 (26.8%) of the included studies, and was significantly associated with internalized stigma in 30 (88.2%) of those studies. In addition, the direction of these relationships was consistently negative in all of the studies with significant findings. This consistent pattern indicates that internalized stigma is negatively associated with a range of psychosocial variables." (Livingston & Boyd, 2010).

Similar to the findings about demographics, psychiatric variables presented mixed relationships. All the reviewed literature in their study points out that symptom severity is positively correlated with internalized stigma. (Livingston & Boyd, 2010).

The conclusion one can infer is that no consistent relationship was found between demographics and stigma (Lysaker et. al., 2008).

Schizophrenia is known to be the most stigmatized mental disorder among an array of mental disorders. This 'extreme' stigmatization mainly arise from the misconception /conception that people diagnosed with schizophrenia are dangerous and unpredictable (Angermeyer & Schulze, 2001).

Livingston & Boyd's (2010) meta-analysis also looked at longitudinal designs in which researchers observed the changes in levels of internalized stigma over time after an intervention. These researchers were mainly investigating two questions: "To what extent is internalized stigma dynamic (i.e., changeable) or static (i.e.,

unchangeable)? Which outcomes does internalized stigma predict? Which variables predict internalized stigma?" In regards to the first question, researchers found significant changes in internalized stigma after an internet based intervention for people experiencing depression as well as in a structured group based cognitive intervention. In relation to the second question, "four studies have found that baseline levels of internalized stigma are negatively associated with levels of self-esteem at follow-up." (Livingston & Boyd, 2010).

They found that most of the sample had higher levels of internalized stigma. Moreover, participants experienced alienation, social withdrawal and believed that they were routinely discriminated and the modicum amount of the participants reported to have endorsed stereotypes and contrarily held stigma-resisting beliefs.

Alienation was found to be a predictor worsened symptoms. However, if one believes that they are discriminated against, no changes in depressive symptoms were observed.

Similarly, alienation is shown to predict reduced self-esteem levels. Alienation is shown to have the most deleterious effects on people with severe mental disorders. Post-test during the 4 months follow up showed that the participants' morale eroded (Ritsher & Phelan, 2004).

A consistent array of literature indicates that greater levels of stigma is generally associated with lower self-esteem. Individuals who had greater social distance demonstrated an inability to reject stigma and held a negative self-view. Their negative self-view about themselves included less lovability and possessing modicum perceived influence on the social world. (Lysaker, Tsai, Yanos & Roe, 2008). Thus, one can understand how social support and participation is important for

the SMI patients on multifarious dimensions such as self-esteem, morale, hope and symptom severity.

People who are failing to exhibit abilities to think about their own and others' thinking, as well as affirming stereotypes about mental illnesses tended to tell more banal stories about themselves and the challenges they face because of their mental illness (Lysaker, Tsai, Yanos, & Roe, 2008). Stigma affirmation prevents the individual from self-reflecting, causing them to feel negative about themselves and their own stories.

Higher levels of internalized stigma is shown to have a correlational relationship with the number of hospitalization. People who are hospitalized tend to show more internalized stigma and social distancing (Havva & Pınar, 2012).

Rüsch and colleagues (2005) indicate the matter of stigma in SMI transparently. "Research has shown that empowerment and self-stigma are opposite poles on a continuum At one end of the continuum are persons who are heavily influenced by the pessimistic expectations about mental illness, leading to their having low self-esteem. These are the self-stigmatized. On the other end are persons with psychiatric disability who, despite this disability, have positive self-esteem and are not significantly encumbered. Persons with a stigmatizing condition like serious mental illness perceive and interpret their condition and the negative responses of others. The collective representations in the form of common stereotypes influence both the responses of others and the interpretation of the stigmatized. Persons with a stigmatizing condition who do not identify with the stigmatized group are likely to remain indifferent to stigma because they do not feel that prejudices and discrimination actually refer to them."

Individuals with SMI improve less on vocational functioning if they endorse stereotypes about their disorder (Yanos, Lysaker & Roe, 2010)

Another phenomena that researchers tie internalized stigma to is the number of hospitalization. There is an invalidated allegation that internalized stigma cause people to stay away from seeking medical health, however there is a dearth of data to make that kind of an assumption. However, other reports suggest that increased self-stigma (internalized) could be associated with lower intention to seek help (Rüsch, Corrigan, Wassel, Michaels, Larson, Olschewski & Batia, 2009).

It is shown that patients with bipolar disorders are more likely to acquire college or university degrees comparing to those who are diagnosed with schizophrenia (Williams and Collins, 2002).

People with SMI reported that their relatives found excuses to stay away from them and if not the only subject they would talk about is their mental condition. They also reported a different type of stigmatization from mental health professionals as they were seen as cases; not actual persons with histories, sentiments and emotions (Schulze & Angermeyer, 2003).

1.4.2. Hopelessness in Patients with SMI

Hope is the most important indicator of recovery process. If there is no hope than there is not recovery. Roe and colleagues (2004) indicate that hope provides the 'fuel' for patients coping with the symptoms of the mental illness and also helps to overcome.

A negative correlation was found between social avoidance and avoidant coping (Yanos et al., 2008). Expectancy of future (hope) of patients, and self-evaluation (self-esteem) has arose a need for new research.

Higher levels of internalized stigma is shown to be associated with lower levels of hope, self-esteem, empowerment, self-efficacy and quality of life. (Livingston & Boyd, 2010).

It was seen that although patients with mental illness and their families experience stigma and discrimination from society the stigmatization comes within. Individuals with mental health problems stigmatized themselves before social stigma process. It begins with the diagnosis and "mentally ill person" awake individual's inner world. As this stereotype is negative, so perceived stigma is high level. This concept is known as internalized stigma. Objectively, it is independent of the experience of discrimination. In this process, individual evaluate himself negatively without any concrete evidence. Thus he experiences as if the society stigmatize and discriminate him for being a patient (Çam and Çuhadar, 2009). In this sense, it is important to investigate the process of internalized stigma in mental health in terms of creating a backlog for future research.

Link et. al. (1991) suggested that negative attitudes towards mental illness affects individual with SMI in a negative way and they have difficulties in coping with the symptoms of their illness.

A study conducted in Turkey which looked at perceived social support in normal and pathological groups that individuals with severe mental illness perceived less social support in comparison with normal population and physical/medical patients (Eker & Arkar, 1995).

1.4.3. Self-esteem in Patients with SMI

Self-esteem belongs to the early periods of human life. If a relationship between self-esteem and severe mental illness (SMI) will be examined; the question

whether people with low self-esteem are the ones who suffer from these diseases arises. Another question is whether the disease decreases self-esteem or not.

Research projects are being conducted on the psychological phenomena that are hypothesized to have a relationship with internalized stigma (i.e. quality of life and social functioning). Recent studies indicate that internalized stigma can be associated with self-esteem (Havva & Pınar, 2012; Lysaker et al., 2008; Crocker & Major, 1989).

When people with SMI internalize their stigmatization as a label they start to negatively perceive their self-efficacy and self-esteem. It can be argued that this hindrance may result in an increase in symptom severity. Research projects have shown that this deters the treatment process. It has been reported that a decrease in self-stigmatization has a positive impact on the treatment process (Ritsher, Otilingam & Grajales, 2003).

1.5. The Present Study

A few studies were conducted on the subject of internalized stigma in Turkey. However, many mental health professionals who treated patients with severe mental illness report that stigma is one of the main barriers in clinical process.

I hope that the current study will contribute for the scientific data on stigma in Turkey.

1.5.1. Aim of the study

The primary aim of this study is to investigate (1) the relationships between internalized stigmatization and some factors which are thought to be influential on internalized stigma of a group of patients diagnosed with a severe mental illness (SMI) in Turkey, (2) to look at the relationships between internalized stigma, self-esteem and hope in people with SMI.

In the present study another aim is to examine the possible relationships between these variables in psychotic and bipolar patients receiving outpatient treatment. Thus, it will present some suggestions for mental health professionals who work with the outpatients with SMI treated with psychotherapy and rehabilitation.

There are many research articles that suggest that psychotic patients experience stigma in the most detrimental way comparing to others (Schulze & Angemeyer, 2003). It is generally accepted that individuals who suffer the most from stigmatization are the individuals who suffer from psychotic diseases. In addition there are also several findings that suggest bipolar disorder is also a target for stigmatization. (Williams & Collins, 2003). The present study aims to investigate the relationship between the diagnosis variable and the impact of stigmatization on hopelessness and self-esteem levels.

The present study aims that find internalized stigma levels and related factors of a group of outpatients with SMI. In this study we tried taking a different approach to stigma that examined inner subjective experience of stigma and its psychological effects to get donnee and to deduce.

1.5.2. Research Questions and Hypotheses

In order to understand the concepts; internalized stigma, self-esteem and hopelessness of patients diagnosed with a SMI, hypotheses with regard to research questions are specified for this study. Each of those research questions have one or more hypothesis. The current research examines ten main questions which have totally 23 hypotheses.

Research question #1: Is there any significant relationship between sociodemographic characteristics (age, gender, marital status, educational

years, employment, social insurance and perceived socioeconomic level) and the internalized stigma, hopelessness and self-esteem levels of patients with SMI?

Hypothesis 1a: The patients who are older are expected to have higher internalized stigma and hopelessness, and lower self-esteem levels. Level of these variables can be associated with duration of illness.

Hypothesis 1b: Females are expected to have higher internalized stigma and hopelessness, and lower self-esteem levels than males.

Hypothesis 1c: The patients who are married are expected to have lower internalized stigma and hopelessness, and higher self-esteem level.

Hypothesis 1d: The patients who currently employed and have social insurance are expected to have lower internalized stigma and hopelessness, and higher self-esteem level. The patients who have high and mid perceived SES level is expected to lower internalized stigma and hopelessness, and higher self-esteem level

Research question #2: Is there a significant relationship between psychiatric diagnosis (any type of psychotic disorders and bipolar disorder), first age of diagnosis and internalized stigma, hopelessness and self-esteem levels?

Hypothesis 2a: The patients diagnosed with any type of psychosis (schizophrenia, schizoaffective disorder, other psychotic disorder) are expected to have higher internalized stigma level in proportion to patients diagnosed with bipolar disorder.

Hypothesis 2b: The patients who had longer duration of illness are expected to have higher internalized stigma and hopelessness, and lower self-esteem level.

Hypothesis 2c: The patients who have ongoing medication are expected to have higher internalized stigma and hopelessness, and lower self-esteem level.

Research question #3: Is there a significant relationship between hospitalization and internalized stigma, hopelessness and self-esteem levels?

Hypothesis 3a: The patients who have hospitalized due to mental illness expected to have higher level of internalized stigma and hopelessness, and lower level of self-esteem level.

Hypothesis 3b: Internalized stigma, hopelessness and self-esteem levels increase or decrease depending on the patient's first age of hospitalization. The patients who hospitalized in early ages are expected to have higher internalized stigma and hopelessness levels and lower self-esteem and level.

Hypothesis 3c: Patient's total length of hospitalizations (week) are expected to increase internalized stigma and hopelessness level, and decrease self-esteem.

Research question #4: Is there a significant relationship between psychosocial/psychoeducational support and/or membership of a non-governmental organization related to a mental illness and internalized stigma, hopelessness and self-esteem levels?

Hypothesis 4a: The patients who had received psychosocial/psychoeducational support at least once expected to have lower internalized stigma and hopelessness levels, and higher self-esteem.

Hypothesis 4b: The relatives of the patients with SMI had received any psychosocial/psychoeducational support are expected to have lower internalized stigma and hopelessness levels, and higher self-esteem.

Hypothesis 4c: The patients who have membership in an non-governmental organization due to mental illness expected to have lower internalized stigma and hopelessness level, and higher self-esteem.

Hypothesis 4d: The patients who had taken both psychosocial support and had membership in NGO due to mental illness are expected to have lower internalized stigma and hopelessness level, and higher self-esteem

Research question #5: Is there a significant relationship between comorbidity and internalized stigma, hopelessness and self-esteem?

Hypothesis 5a: The patients who have psychiatric comorbidity are expected to have higher internalized stigma and hopelessness levels, and lower self-esteem.

Research question #6: Is there a significant relationship between suicide attempt and internalized stigma, hopelessness, and self-esteem?

Hypothesis 6a: The patients who have attempted suicide are expected to have higher internalized stigma and hopelessness, and lower self-esteem.

Research question 7: Is there a significant relationship between having psychiatric illness in family members or first-degree relatives and internalized stigma, hopelessness and self-esteem?

Hypothesis 7a: The patients who have psychiatric illness in family members or first-degree relatives are expected to have higher internalized stigma and hopelessness and lower self-esteem.

Research question 8: Is there a significant relationship between physical illness and receiving medical treatment and internalized stigma, hopelessness and self-esteem?

Hypothesis 8a: The patients who have physical illness are expected to have higher internalized stigma and hopelessness, and lower self-esteem.

Hypothesis 8b: The patients who have physical illness but not receiving medical treatment are expected to have higher level internalized stigma and hopelessness, and lower self-esteem.

Hypothesis 8c: The patients who have both physical illness and receiving medical treatment are expected to have lower level internalized stigma and hopelessness, and higher self-esteem.

Research question 9: Is there a significant relationships between experiencing social loss due to mental illness and internalized stigma, hopelessness and self-esteem?

Hypothesis 9a: The patient who had reported experiencing a social loss due to mental illness is expected to have higher level internalized stigma, hopelessness and lower self-esteem.

Research question 10: Is there a significant relationship between perceived discrimination and internalized stigma?

Hypothesis 10a: The patients who have perceived discrimination due to mental illness expected to have higher internalized stigma and hopelessness, lower self-esteem.

Hypothesis 10b: The patients who have perceived discrimination other than mental illness expected to have higher internalized stigma and hopelessness, and lower self-esteem.

CHAPTER TWO: METHOD

2. Method

A questionnaire which includes sociodemographic and clinical data scales was applied in order to determine the relationship between variables internalized stigma, hopelessness, self-esteem, socio-demographic and clinical in patients with severe mental illness (SMI). The data obtained from the questionnaires and scales evaluated and interpreted.

2.1. Sample

The research sample is composed of individuals who have severe mental illness (SMI) in this research. Sample of the current study was chosen from outpatients with SMI who were living in İstanbul and Bursa. A total of 117 individuals who have diagnosed as a SMI participated in the present study. The sample of this research consist of individuals who have diagnosed as psychotic disorder (schizophrenia, schizoaffective disorder, other psychotic disorders) and bipolar disorder which meet the diagnostic criteria in DSM-IV (APA, 2000). "Psychotic disorders due to… [indicate the general medical condition]" were excluded. The individuals who have diagnosed as any type of bipolar disorder were included.

In the present study patient who met the following criteria were recruited: (1) the patient currently being treated with a diagnosed as schizophrenia, schizoaffective disorder, other psychotic disorders or bipolar disorder. (2) the patient is literate and given informed consent. (3) the patient being received outpatient treatment.

Participants were recruited at the Department of Psychiatry at Uludağ University in Bursa and various non-governmental organizations ([1] Şizofreni Gönüllüleri ve Dayanışma Derneği [Schizoprenia Volunteers and

SolidatiryAssociation], [2] Şizofreni Gönüllüleri Derneği [Schizoprenia Volunteers Association], [3] İstanbul Şizofreni Derneği [İstanbul Schizoprenia Association]) related to mental illness in İstanbul. The study was conducted with the approval of the Ethics Committee of Uludağ University (Appendix F).

2.2. Instruments

In order to assess internalized stigma level of the sample Internalized Stigma of Mental Illness (ISMI) Scale (Appendix C), hopelessness level Beck Hopelessness Scale (BHS) (Appendix D) and self-esteem Rosenberg Self-Esteem Scale (RSES) (Appendix D) were administered. In addition, to assess socio-demographic and clinical data of participants Socio-demographic and Clinical Information Questionnaire (Appendix B) were formed. More information about the questionnaire and the scales are presented below.

2.2.1. Socio-demographic and Clinical Information Questionnaire

For this study, a sociodemographic and clinical self-report questionnaire was developed in order to collect demographic and clinical data; covering information about education, psychiatric and physical illnesses, psychiatric treatment, employment and socioeconomic status of the subjects. There are twenty-two questions in the questionnaire and they consist of open-ended and multiple choice questions. Questions are based on facts associated with internalized stigma. These facts were chosen from scientific studies as well as the researcher's focus of scientific interest and curiosity.

2.2.2. Internalized Stigma of Mental Illness Scale

In recent studies, one of the most commonly used scales to assess internalized stigma is Internalized Stigma of Mental Illness (ISMI) scale (Ritsher et al, 2003). ISMI scale constitutes of 29 items from “strongly disagree” to “strongly agree” with

the range of four Likert-type scale. The scale aimed at internalized stigma level of patients with SMI developed by Ritsher and his colleagues (2003). ISMI has 5 subscales, including 1. Alienation (6 items), 2. Stereotype Endorsement (7 items), 3. Discrimination Experience (5 items), 4. Social Withdrawal (6 items) ve 5. Stigma Resistance (5 items). Total ISMI (4 to 91 points) score is obtained by summing the five sub-scales scores. High ISMI scores show that high level of internalized stigma of person.

The external and internal validity of the Turkish translation of the survey was validated by implementing the survey to 203 patients who are diagnosed with a variety of mental illnesses at a mental health clinic. ISMI's Turkish Survey is found to be a reliable (.89) and a valid (.93) questionnaire to measure the internalized stigma among Turkish natives with severe mental illnesses (Ersoy & Varan, 2007).

2.2.3. Beck Hopelessness Scale

Beck Hopelessness Scale (BHS) is a survey tool that is being used to measure people's expectations and hopes about the future. It was designed by Beck and colleagues (Beck, Weissman & Trexler, 1974) to measure three major aspects of hopelessness: (i) feelings about the future, (ii) loss of motivation, and (iii) expectations. This survey that includes 20 questions that can be implemented to both adults and adolescents is scored between 0-1. As the score increase it indicates that the hopelessness levels are high for the individual.

Beck and colleagues used two different sources to develop the survey. These are; 1) Future Attitudes Scale, 2) Expressions of Pessimism Reported by Clinicians. The information received by these two sources are investigated by clinicians and implemented on people who do not suffer from any mental disorder. Later, the survey developed into its actual form.

BHS' reliability test in Turkey (Seber, Dilbaz, Kaptanoğlu & Tekin, 1993) was done with 37 patients who are diagnosed with major depression, dysthymia defined in DSM-III-R and who attempted suicide. Moreover the control group consisted of 70 people who did not have any mental or physical disorders. The depression and hopelessness scores of the experiment group was significantly higher than the control group's. This research shows that BHS is a reliable instrument to use in research projects in Turkey.

Another research to assess the reliability of BHS' validity was done on 373 participants age between 15-65 who do not possess any mental or physical disability, psychiatric patients, cancer, epileptic and chronic kidney malfunction patients. The analysis of the sample data proved that BHS is a reliable survey. The result of the factor analysis indicate that there are three factors in the construct 1) attitudes about future 2) motivation loss 3) hope (Durak and Palabıyıkoğlu, 1994). In conclusion BHS is proved to be a reliable measure for normal, chronically ill and psychiatric patients, respectively. However, it has been reported that due to the small sample count of the validation study, generalizability of the instrument is not reliable.

2.2.4. Rosenberg Self-Esteem Scale

The Rosenberg self-esteem scale (RSES), developed by Morris Rosenberg (1963). It is a ten-item Likert-type scale with items answered on a four-point scale (from strongly agree to strongly disagree). RSES' reliability and validity tests were conducted by Rosenberg himself in 1965 and used in many other research projects since. It includes 63 questions and 12 subtests. In 1986, Çuhadaroğlu conducted the reliability test and found that the survey was reliable with a 0.75 coefficient (Çuhadaroğlu, 1986). The first ten questions are used to measure self-esteem as 0-1 being high, 2-4 medium and 5-6 low self-esteem. On the Rosenberg Self Esteem

Scale, scale ranges from 0-30. Scores between 15-25 are within normal range; scores below 15 suggest low self-esteem.

2.3. Procedure

The socio-demographic and clinical information questionnaire, Internalized Stigma of Mental Illness (ISMI) Scale, Beck Hopelessness Scale (BHS), and Rosenberg Self-Esteem Scale (RSES) were administered respectively. In addition, all participants signed an Informed- Consent Form before entering the study and were informed about the aim of the study. This research is approved by Uludağ University Faculty of Medicine Research Ethics Committee.

A pilot study was conducted to asses how the tools work. Eighteen patients (diagnosed as; 10 schizophrenia, 4 schizoaffective disorder and 4 bipolar disorders) at İstanbul Şizofreni Derneği and Şizofreni Dostları Derneği were accidentally assigned for the pilot administration. The questionnaire and scales were administered according to procedure respective above between 17.05.2011-10.06.2011. Pilot study group consists of 7 females and 11 males. During this first application participants did not have any specific challenge about answering the survey items and scales. Average administration time of the questionnaire and scales was calculated as 35 minutes. The shortest answering took 22 minutes and the longest one 70 minutes (M= 35 min.). During the application only one patient needed short rests intervally. Another patient had difficulty in reading and answering the questionnaire. The questions were read one by one and then asked to be answered. Survey was completed in a similar duration (40 minutes).

2.4. Data Analysis

Several statistical testing methods were used in order to figure out the relationship between dependent variables (internalized stigma, hopelessness, self-

esteem) and independent variables such as age, gender, marital status, perceived socioeconomic status, psychiatric diagnosis, hospitalization, suicide attempt, comorbidity, recieving psychosocial/psychoeducational support, having physical illness, percieved discrimination and percieved discrimination other than mental illness.

Statistical Package for Social Sciences (SPSS ver. 11.5) was used for data analyses. Kruskall Wallis H, and Mann Whitney U tests were applied in order to investigate the significance of relationships between categorical variables as "internalized stigma by gender", "…by parents' work status", "… by perceived socioeconomic status".

CHAPTER THREE: RESULTS

3. Results

The purpose of the current study was to measure relationships between internalized stigma, hopelessness and self-esteem. This study also attempted to demonstrate the relationship between sociodemographic and clinical factors and internalized stigma, hopelessness and self-esteem in the patients with severe mental illness (SMI). Descriptive results were introduced in the first section of this chapter including "sociodemographic and clinical characteristics of the sample", "descriptive characteristics of the sample by internalized stigma, hopelessness and self-esteem". The comparison of internalized stigma, hopelessness and self-esteem to the sociodemographic and clinical variables (i.e., analytic results) were presented in the second section.

3.1. Descriptive Results

Descriptive characteristics of the research sample such as age, gender, marital status, educational years and clinical characteristics such as psychiatric diagnosis, physical illness/disability, psychiatric comorbidity, suicide attempt, hospitalization of the subjects are presented in this section.

3.1.1. Sociodemograpic and Clinical Characteristics of the Sample

Sociodemographic characteristics of the sample are shown in Table 1.

Table 1. *The distribution of sample by sociodemographic variables.*

Variables	Groups	n	%
Age	20-29	17	14.5
	30-39	55	47
	40-49	33	28.2
	50 >	12	28.2
	Total	117	100.0
Gender	Male	71	60.7
	Female	46	39.3
	Total	117	100.0
Marital status	Married	33	28.2
	Single	77	65.8
	Divorced	7	6.0
	Total	117	100.0
Employment	Employed	31	26.5
	Unemployed	86	73.5
	Total	117	100.0
Social insurance	Yes	103	88.0
	No	14	12.0
	Total	117	100.0
Perceived socioeconomic status	Low	26	22.2
	Mid	86	73.5
	High	4	3.4
	Missing	1	
	Total	117	100.0

Ages of the sample (N=117) are between 20 and 65 and the mean age of the sample is 37,65. There are 17 subjects (%14.5) in the age group between 20 – 29 ages, 55 subjects (%47) in the age group between 30 – 39 ages, 33 subjects (%28.2) in the age group between 40 - 49 ages and 12 subjects (%10.3) in the age group 50 and

older. As the percents show, nearly the half of the participants is middle-aged subjects.

The sample (N=117) includes %60.7 male and %39.3 female patients. %28.2 of the patients are married, %77 are single and %6 are divorced. As the percents show, more than half of the subjects is single subjects and also male. 31 of the subjects (%26.6) are still working, 86 (%73.5) are non-working. 103 (%88.0) of the subjects have a social insurance, but 14 subjects (%12.0) haven't got any social insurance. 26 of the subjects (%22.2) perceive themselves at low socioeconomic status, 86 subjects (%73.5) at middle and 4 subjects (%3.4) are at high socioeconomic status.

Among the sociodemographic variables total educational years of the subjects were also explored. The mean total length of the educational years of the group is calculated as 11.53 years. Minimum was found 1 and maximum was found 25 (SD=4.76). Most of the subjects reported that they had to extend studying during their high school and university periods due to the very first years of mental illnesses. Some of these subjects reported that they had to drop out. This data was not found valuable due to fact that it does not reflect the reality in institutional/educational process. Educational years was not included as a variable since it is higher level than the average length of study in Turkey. Hence, the data was not used in analytic measures.

Table 2. *The distribution of sample by clinical variables.*

Variables	Groups	n	%
Psychiatric diagnosis	Schizophrenia	53	45.3
	Schizoaffective dis.	7	6
	Other psychotic dis.	9	7.7
	Bipolar disorder	48	41
Duration of illness (years)	1-5	32	27,4
	6-10	25	21,4
	11-15	26	22,2
	16-20	18	15,4
	21-25	9	7,7
	26-30	3	2,6
	30>	2	1,7
Psychiatric comorbidity	Yes	98	83.8
	No	18	15.4
Suicide attempt	Yes	42	35.9
	No	75	64.1
Psychiatric illness in family	Yes	45	38.5
	No	72	61.5
Psychosocial/ Psychoeducational support	Yes	46	39.3
	No	70	59.8
Psychosocial/ Psychoeducational support for any family member	Yes	17	85.5
	No	100	14.5
Membership in association of people with mental illness	Yes	47	40.2
	No	70	59.8

The sample includes 53 patients with schizophrenia diagnosis (%45.3), 7 with schizoaffective disorder diagnosis (%6), 9 with other psychotic disorder diagnosis (%7.7) and 48 with bipolar disorder diagnosis (%41). The sample has 18 patients (%15.4) with comorbidity and 98 patients (%83.8) without.

42 subjects have a history of attempted suicide (%64.1), 75 subjects (%35.9) did not. 45 subjects (%38.5) have a psychiatric illness in family members, but 72 subjects (%61.5) don't have a psychiatric illness in family.

46 subjects reported taking part in a psychosocial support group at least once during their illness, but 70 subjects did never take part in such work.

When the same question was asked about their family members, 17 subjects (%85.5) answered yes, 100 subjects (%14.5) answered no. 47 of the subjects (%40.2) reported having membership in associations relevant to the mental illness, but 70 subjects (%59.8) reported not having a membership.

Table 3. *The distribution of the sample by hospitalizations*

Variables	**n**	**M (SD)**	**Min.-Max.**
Lifetime number of hospitalizations	100	4.32 (5.48)	1-30 *
Age at first hospitalization	100	24.86 (7.33)	10-44 **
Approx. total length of hospitalizations *(week)*	100	11.04 (12.68)	1-52 ***

*Times in duration of illness
** Age
*** Total weeks

After evaluating 100 subjects with hospitalization due to their psychiatric illnesses, it was found that the number of hospitalizations is ranging between 1 and 30 (M=4.32, SD=5.48). Age of the first hospitalization is ranging between 7 and 44 (M= 24.76, SD= 7.5) and the approximate length of hospitalization vary from 1 to 52 weeks (M= 11.04, SD= 12.68).

Table 4. *The distribution of the sample by physical illnesses, disabilities and ongoing treatment.*

Variables	Groups	n	%
Ongoing physical illness	Yes	24	20.5
	No	93	79.5
	Total	117	100.0
Ongoing treatment for physical illness	Yes	19	16.2
	No	98	83.8
	Total	117	100.0
Physical disability	Yes	0	0.0
	No	117	100.0
	Total	117	100.0

24 subjects (%20.5) stated still having a physical illness, 93 subjects (%79.5) stated not having any physical illnesses. 19 of the subjects (%16.2) are in an ongoing physical treatment. None of the subjects has any physical disabilities (%0).

Table 5. *The distribution of the sample by treatment characteristics*

Variables	Groups	n	%
Hospitalization history	Yes	17	14.5
	No	100	85.5
	Total	117	100.0
Current medication	Yes	113	97.4
	No	3	2.6
	Total	116	

17 subjects (%14) received psychiatric treatment (hospitalization) at least once during their illness but 100 subjects did never hospitalize; large majority of the

subjects do not have a history of hospitalization. 113 subjects (% 97.4) have received ongoing medical treatment for their psychiatric treatment but 3 subjects (% 2.6) have not.

Table 6. *The distribution of the sample by perceived social loss and discrimination.*

Variables	**Groups**	**n**	**%**
Social loss due to mental illness	Yes	69	59.0
	No	47	40.2
	Missing	1	
	Total	117	100.0
Having an idea of discrimination due to mental illness	Yes	22	18.8
	Sometimes	32	27.4
	No	62	53.0
	Missing	1	
	Total	117	100.0
Discrimination for any reasons other than mental illness	Yes	17	14.5
	No	100	85.5
	Total	117	100.0

The number of the subjects who reported having at least one social loss because of a psychiatric illness is 69 (%59). It was found that number of subjects who reported only 1 social loss is 47(% 40.2). The other 22 (% 18.8) subjects reported multiple loss. The number of the subjects without any social loss is 47 (%40.2). 22 subjects (%18.8) perceived discrimination due to mental illness, 32 subjects (%27.4) perceived discrimination occasionally and 62 subjects (%53.0) didn't perceive any discrimination. 17 subjects (%14.5) perceived discrimination for any reasons other than mental illness, whereas 100 subjects (%85.5) did not.

Table 7. *Frequencies of subjects who reported social loss*

Groups	n
Reporting one social loss	75
Reporting multiple social loss	23
Missing	19
Total	117

N=117
Social loss: Social relations/marriage, economic/occupation/employment, education, health care/medical service, military service

Frequencies of subjects who reported social loss (n=98) showed in Table 7. As presented in the table participants who reported only one social loss 75 (%64). The other 23 (%20) subjects reported multiple loss. Missing is 19 (%16). The areas of social loss stated by the participants presented in the Table 7.

Table 8. *The areas of social loss stated by the sample*

Categories	n	%
Social relations/marriage	17*	17.3
Economic/occupation/employment	40**	40.8
Education	26	26.5
Health care/medical service	4	4.08
Military service	11	11.22
Total	98	100.0

*friends (1), marriage (15), social reputation (1)
** regular working life (1), hope (1), occupation/employment (36)

The question "did you have any social loss due to the mental illness" was asked, 98 (% 83.76) of 117 answered. 17 (%17.3) subjects answered this question "social relations/marriage". 40 (%40.8) of 98 reported having

“economic/occupation/employment”. 26 (%26.5) subjects “education”, 4 (%4.08) “healthcare/medical service” answered the question. 11 (%11.22) subjects responsed military related responses. Military service is compulsory for men in Turkey. In Turkish culture to be a “man” every young man has to serve in the army. It is the key of marriageability in some regions of Anatolia. It is a traditional viewpoint and also represents that man is healthy. Hence, “military service” is considerable answer as a social loss.

Table 9. *The areas of percieved discrimination other than mental illness*

Categories	n	%
Ideological/ethnic	1	
Economic status	1	
Social relations	5	
Physical illness	1	
I dont know	1	
No reasons stated	8	
Total	17	

The areas of percieved discrimination other than mental illness showed in Table 9.

3.1.2. Descriptive Characteristics of the Sample by Internalized Stigma, Hopelessness and Self-Esteem

Internalized stigma, hopelessness and self-esteem levels of the sample in terms of psychiatric diagnoses are presented below in the tables 10 through 13.

Table 10. *ISMI, BHS, RSES total and subscale scores of the sample (N=117)*

	N	M	SD	Min.	Max.
ISMI Total	117	61,87	15,1	31	91
Alienation	117	12,57	4,01	6	24
Stereotype Endorsement	117	13,90	4,33	7	26
Discrimination Exp.	117	10,56	3,58	5	19
Social Withdrawal	117	12,72	4,08	6	24
Stigma Resistance	117	12,14	2,89	6	20
BHS Total	117	6,20	4,94	0	20
RESES Total	117	0,43	0,405	0	2
KSUREK	117	3,27	1,20	0	5
IGUVDUY	117	1,88	0,967	0	4
ELESDUY	117	2,13	1,02	0	3
DEPDUY	117	2,42	1,36	0	6
HYLPRS	117	1,13	1,34	0	4
PSKSOMB	117	2,13	1,71	0	5
KILSTHD	117	1,59	0,990	0	3
TKATDRC	117	0,61	0,730	0	2
ABILGI	117	2,11	1,89	0	7
BABAILS	117	1,44	1,42	0	6
PSKIZLYN	117	0,79	0,760	0	2

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-Esteem Scale

Table 10 shows that total mean scores of the sample. ISMI mean score 61.89 (SD=15,1), BHS mean score 6,20 (SD=4,94), and RSES mean score 43 (SD=0,405) were measured. As presented in the table ISMI minimum score was 31 and maximum was 91. It was found that BHS minimum-maximum score is ranging between 0-20 and RSES minimum-maximum score is 0-2. ISMI and RSES subcscales' mean scores were also presented in Table 9.

Table 11 demonstrates internalized stigma level of the sample. Furthermore the subscale scores of ISMI are shown in terms of psychotic and bipolar disorder.

Table 11. *The comparison of ISMI total and subscale scores between psychotic and bipolar disorders (N=117)*

	A	SE	DE	SW	SR	ISMI Total
Psychotic disorders*	66.36	66.37	66.11	67.58	62.88	67.62
Bipolar disorder	48.43	48.41	48.78	46.67	53.43	46.61

*Psychotic disorders include only schizophrenia, schizoaffective disorder and other psychotic disorders.
ISMI: Internalized Stigma of Mental Illness, A: Alienation, SE Stereotype Endorsement, DE: Discrimination Experience, SW: Social Withdrawal, SR: Stigma Resistance.

Table 12 demonstrates internalized stigma level of the psychotic group (67.62) is higher than the internalized stigma level of the bipolar group (46.61). On each sub-scales of ISMI scale, psychotic group had higher levels of internalized stigma then the bipolar group.

Table 12. *BHS total scores of the sample by psychiatric diagnose (N=117)*

	Min. score	Max. score	M	SD
Psychotic disorders*	0	20	6, 87	,600
Bipolar disorder	0	9	5, 23	,689

* Schizophrenia, schizoaffective disorder and other psychotic disorders
BHS: Beck Hopelessness Scale

It was showed in the Table 11 BHS minimum and maximum scores in terms of psychiatric diagnose. Maximum score of psychotic group (20) in hopelessness was higher than the maximum score of the bipolar group (9).

Table 13 *RSES scores of the sample by psychiatric diagnose (N=117)*

	Min. Score	Max. score	M.	SD
Psychotic disorders*	0	2	,51	,051
Bipolar disorder	0	1	,32	,051

* Schizophrenia, schizoaffective disorder and other psychotic disorders
RSES: Rosenberg Self-Esteem Scale

It was showed in the Table 13 RSES minimum and maximum scores in terms of psychiatric diagnose. Maximum score of psychotic group (2) in self-esteem was higher than the maximum score of the bipolar group (1).

3.2. Analytic Results

Mann Whitney U and Krusskal Wallis H tests were used to determine the relationship between variables in the tables 14 through 37.

3.2.1. Comparison of Internalized Stigma, Hopelessness and Self-esteem to the Sociodemographic and Clinical Variables

Sample's internalized stigma (ISMI), hopelessness (BHS) and self-esteem (RSES) mean scores according to the sociodemographic and clinical variables are depicted in tables between 14 - 37.

Table 14. *Internalized stigma, hopelessness and self-esteem scores of the subjects by age groups*

	Age groups	N	Mean Rank	H
ISMI	20-29	17	52,68	
	30-39	55	63,84	
	40-49	33	55,89	,812
	50-65	12	54,33	
	Total	117		
BHS	20-29	17	38,62	
	30-39	55	63,13	
	40-49	33	58,85	1,601
	50-65	12	69,38	
	Total	117		
RSES	20-29	17	66,53	
	30-39	55	66,41	
	40-49	33	47,94	2,176
	50-65	12	44,79	
	Total	117		

p>.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

To compare level of internalized stigma, hopelessness and self-esteem between the age groups Kruskal Wallis test was used. Significant differences were obtained in terms of self-esteem and hopelessness levels (for ISMI F=, 812; for BHS F= 1,601; for RSES F=2,176 p>.05). To compare between group differences in terms of three variables Mann Whitney U testes were applied. The results were showed in table 15.

Table 15. *The comparison of age groups in terms of internalized stigma, hopelessness and self-esteem*

	Age Groups	ISMI U	BHS U	RSES U
20-29	30-39	379	281*	454*
	40-49	263	173*	199.5
	50-65	100.5	49.5*	68.5
30-39	20-29	379	281	454
	40-49	778.5	833.5	616.5*
	50-65	281.5	296.5	200*
40-49	20-29	263	173*	199.5
	30-39	778.5	833.5	616.5*
	50-65	189	159.5	191
50-65	20-29	100.5	49.5*	68.5
	30-39	281.5	296.5	200
	40-49	189	159.5	191

*p < .05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

The results showed that there were significant differences between the age group of 20-29 and 30-39 in terms of hopelessness and self-esteem (U=281; U=454, respectively p<.05). Another difference was seen between the age groups of 20-29 and 40-49 and 50-65 in terms of hopelessness (U=173; U=49,5 respectively p<.05). Regarding the age group of 30-39 and 40-49 a significant difference was obtained in self-esteem (U=616,5 p < .05). Also the same group was different from the age group of 50-65 in terms of self-esteem (U=200; p<.05).

Table 16. *Internalized stigma, hopelessness and self-esteem scores of the sample by gender*

	Gender	N	Mean Rank	Sum of Ranks	U
ISMI	Male	71	59,55	4228,00	1594
	Female	46	58,15	2675,00	
	Total	117			
BHS	Male	71	60,83	4319,00	1503
	Female	46	56,17	2584,00	
	Total	117			
RSES	Male	71	59,61	4232,50	1589,5
	Female	46	58,05	2670,50	
	Total	117			

$p > .05$
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of gender on three parameters. As presented in Table 16 results showed that there were no significant differences between males and females in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 1594; for BHS U= 1503; for RSES U= 1589,5; $p > .05$).

Table 17. *Internalized stigma, hopelessness and self-esteem scores of the sample by marital status*

	Marital Status	N	Mean Rank	H
ISMI	Married	33	53,97	1,812
	Single	77	61,97	
	Divorced	7	50,00	
	Total	117		
BHS	Married	33	57,79	3,180
	Single	77	61,44	
	Divorced	7	37,86	
	Total	117		
RSES	Married	33	51,59	2,336
	Single	77	61,99	
	Divorced	7	61,07	
	Total	117		

p >.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of marital status on three parameters. The results showed that there were no significant differences between three groups in terms of internalized stigma, hopelessness and self-esteem (for ISMI H= 1,812; for BHS H= 3,180; for RSES H= 2,336; p >.05).

Table 18. *Internalized stigma total and subscale scores by psychiatric diagnose*

	Diagnose	N	Mean Rank	U
ISMI Total	Psychotic dis.	69	67.62	
	Bipolar dis.	48	46.61	
	Total	117		1061.5*
A	Psychotic dis.	69	66.36	
	Bipolar dis.	48	48.43	
	Total			1148.5*
SE	Psychotic dis.	69	66.37	
	Bipolar dis.	48	48.41	
	Total	117		1147.5*
DE	Psychotic dis.	69	66.11	
	Bipolar dis.	48	48.78	
	Total	117		1165.5*
SW	Psychotic dis.	69	67.58	
	Bipolar dis.	48	46.76	
	Total	117		1064.0*
SR	Psychotic dis.	69	62.88	
	Bipolar dis.	48	53.43	
	Total	117		1388.5*

*p<.05

Note: Psychotic disorders include only schizophrenia, shcizoaffective disorder and other psychotic disorders

ISMI: Internalized Stigma of Mental Illness, A: Alienation SE: Stereotype Endorsement, DE: Discrimination Experience, SW: Social Withdrawal, SR: Stigma Resistance

Mann Whitney U test was used to look at the effect of psychiatric diagnose on the parameter of internalized stigma. The results showed that there were significant differences between the subjects who had psychotic disorder and who had bipolar disorder in terms of internalized stigma (for ISMI U=1061,1; p.<.05). As presented in Table 18 results showed that there were significant differences between psychotic

group and bipolar group in all subscales of ISMI (for ISMI A U=1148,5; for ISMI SE U=1147,5; for ISMI DE U=1165,5; for ISMI SW= 1064,0; for ISMI SR U=1388,5).

Table 19. *Hopelessness and self-esteem scores of the sample by psychiatric diagnosis*

	Groups	**N**	**Mean Rank**	**U**
BHS	Psychotic dis.*	69	64.32	
Total	Bipolar dis.	48	51.35	
	Total	117		1289,000*
RSES	Psychotic dis.*	69	66.23	
Total	Bipolar dis	48	48.60	
	Total	117		1157,000*
KSUREK	Psychotic dis.*	69	62.13	
	Bipolar dis	48	54,50	
	Total	117		1140,00
IGUVDUY	Psychotic dis.*	69	62.84	
	Bipolar dis	48	53,48	
	Total	117		1391,00
ELESDUY	Psychotic dis.*	69	61.54	
	Bipolar dis	48	55.34	
	Total	117		1480,50
DEPDUY	Psychotic dis.*	69	61.52	
	Bipolar dis	48	55.38	
	Total	117		1482,00
HYLPRS	Psychotic dis.*	69	64.4	
	Bipolar dis	48	51.23	
	Total	117		1283,00*
PSKSOMB	Psychotic dis.*	69	59.26	
	Bipolar dis	48	58.63	
	Total	117		1638,00*
KILSTHD	Psychotic dis.*	69	67.64	
	Bipolar dis	48	46.57	
	Total	117		1059,50*

TKATDRC	Psychotic dis.*	69	55.19	
	Bipolar dis	48	64.48	
	Total	117		1393,00
ABILGI	Psychotic dis.*	69	62.04	
	Bipolar dis	48	54.64	
	Total	117		1446,50
BABAILS	Psychotic dis.*	69	58.59	
	Bipolar dis	48	59.59	
	Total	117		1627,50
PSKIZLYN	Psychotic dis.*	69	62.83	
	Bipolar dis	48	53.50	
	Total	117		1392,00

*p<.05
BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale
Alt ölçeklerin kısaltmalarını yaz

Mann Whitney U test was used to look at the effect of psychiatric diagnosis on two parameters hopelessness and self-esteem. The results showed that there were significant differences between the subjects who had psychotic and bipolar disorder in terms of hopelessness and self-esteem (for BHS U= 1289,000; for RSES U=1157,000, p<.05). As presented in Table 19 results showed that there were significant differences between psychotic group and bipolar group in three subscales of RSES (for RSES HYLPRS U=1283,00; for RSES PSKSOMB U=1638,00; for RSES KILSTHD U=1059,50; p<.05).

Table 20. *Internalized stigma, hopelessness and self-esteem scores of the sample by psychiatric comorbidity*

	Comorbidity	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	18	76,22	1372,00	
	No	98	55,24	5414,00	563*
	Missing	1			
	Total	117			
BHS	Yes	18	80,69	1452,50	
	No	98	54,42	5333,50	482,5*
	Missing	1			
	Total	117			
RSES	Yes	18	80,44	1448,00	
	No	98	54,47	5338,00	487*
	Missing	1			
	Total	117			

*p<.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of comorbidity on three parameters. The results showed that there were significant differences between the subjects who had psychiatric comorbidity and who did not in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 563; for BHS U= 482,5; for RSES U= 487; $p < .05$).

Table 21. *Internalized stigma, hopelessness and self-esteem scores of the sample by suicide attempt*

	Suicide Attempt	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	42	72,64	3051,00	
	No	75	51,36	3852,00	1002*
	Total	117			
BHS	Yes	42	71,89	3019,50	
	No	75	51,78	3883,50	1033,5*
	Total	117			
RSES	Yes	42	61,04	2563,50	
	No	75	57,86	4339,50	1489,5*
	Total	117			

*p<.05

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of suicide attempt on three parameters. The results showed that there were significant differences between the subjects who had suicide attempts and who did not in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 1002; for BHS U= 1033,5; for RSES U= 1489,5; $p < .05$).

Table 22. *Internalized stigma, hopelessness and self-esteem scores of the sample by psychiatric illness in family members*

	Psychiatric Illness in family members	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	45	63,03	2836,50	
	No	72	56,48	4066,50	1438,5
	Total	117			
BHS	Yes	45	65,90	2965,50	
	No	72	54,69	3937,50	1309,5
	Total	117			
RSES	Yes	45	62,86	2828,50	
	No	72	56,59	4074,50	1446,5
	Total	117			

p>.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of psychiatric illness in family members on three parameters. No significant differences were held in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 1483,5; for BHS U= 1309,5; for RSES U= 1446,5; $p > .05$).

Table 23. *Internalized stigma, hopelessness and self-esteem scores of the sample by physical illness*

	Physical illness	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	24	69,02	1656,50	875,5
	No	93	56,41	5246,50	
	Total	117			
BHS	Yes	24	65,23	1565,50	
	No	93	57,39	5337,50	966,5
	Total	117			
RSES	Yes	24	49,38	1185,00	
	No	93	61,48	5718,00	885
	Total	117			

p>.05

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of physical illness on three parameters. No significant differences were held in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 875,5; for BHS U= 966,5; for RSES U= 885; $p > .05$).

Table 24. *Internalized stigma, hopelessness and self-esteem scores of the sample with &without hospitalizations*

	Hospitalization	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	100	58,36	5836,00	
	No	17	62,76	1067,00	786
	Total	117			
BHS	Yes	100	58,80	5879,50	
	No	17	60,21	1023,50	829,5
	Total	117			
RSES	Yes	100	56,92	5692,00	
	No	17	71,24	1211,00	642
	Total	117			

p>.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of hospitalization of on three parameters. No significant differences were held in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 786; for H U= 829,5; for RSES U= 642; p>.05).

Table 25. *Internalized stigma, hopelessness and self-esteem scores of the sample by age at first hospitalization*

	Age at first hospitalization	N	Mean Rank	H
ISMI	0-10	21	55,43	
	10-20	30	51,17	3,033
	20-30	45	43,49	
	Total	96		
BHS	0-10	21	53,62	
	10-20	30	54,43	4,430
	20-30	45	42,16	
	Total	96		
RSES	0-10	21	57,74	
	10-20	30	49,50	4,025
	20-30	45	43,52	
	Total	96		

p>.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of age at first hospitalization on three parameters. The results showed that there were no significant differences between three groups in terms of internalized stigma, hopelessness and self-esteem (for ISMI H= 3,033; for BHS H=4,430; for RSES H= 4,025; p > .05).

Table 26. *Internalized stigma, hopelessness and self-esteem scores of the sample by total length of hospitalizations*

	Lenght of Hospitalization (week)	N	Mean Rank	H
ISMI	1-4	37	44,85	
	5-12	37	47,09	
	13-24	10	51,45	2,277
	24-52	11	58,50	
	Total	95		
BHS	1-4	37	46,20	
	5-12	37	47,09	,859
	13-24	10	53,85	
	24-52	11	51,77	
	Total	95		
RSES	1-4	37	53,27	
	5-12	37	44,34	2,389
	13-24	10	44,85	
	24-52	11	45,45	
	Total	95		

p>.05

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of total length of hospitalizations on three parameters. The results showed that there were no significant differences between three groups in terms of internalized stigma, hopelessness and self-esteem (for ISMI H= 2,277; for BHS H= ,859; for RSES H= 2389; p > .05).

Table 27. *Internalized stigma, hopelessness and self-esteem scores of the sample by ongoing medication*

	Medication	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	113	58,23	6580,50	
	No	3	68,50	205,50	139,5
	Missing	1			
	Total	117			
BHS	Yes	113	59,12	6680,00	
	No	3	35,33	106,00	100
	Missing	1			
	Total	117			
RSES	Yes	113	58,13	6568,50	
	No	3	72,50	217,50	127,5
	Missing	1			
	Total	117			

p>.01
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of ongoing medication on three parameters. No significant differences were held in terms of internalized stigma, hopelessness and self-esteem (for ISMI U= 139,5; for BHS U= 100; for RSES U= 127,5; $p > .01$).

Table 28. *The effect of psychosocial support on internalized stigma, hopelessness and self-esteem*

	Psychosocial Support	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	46	57,73	2655,50	
	No	70	59,01	4130,50	1574,5
	Total	116			
BHS	Yes	46	55,99	2575,50	
	No	70	60,15	4210,50	1494,5
	Total	116			
RSES	Yes	46	60,28	2773,00	
	No	70	57,33	4013,00	1528
	Total	116			

$p > .05$
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

The effect of psychosocial support was measured by Mann Whitney U test. No significant differences were found between the psychosocial support takers and non takers. (for ISMI U= 1574,5; for BHS U= 1494,5; for RSES U= 1528; $p > .05$).

Table 29. *Internalized stigma, hopelessness and self-esteem scores of the subjects by current employment status*

	Employment	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	31	43,03	1334,00	838*
	No	86	64,76	5569,00	
	Total	117			
BHS	Yes	31	51,19	1587,00	
	No	86	61,81	5316,00	1091
	Total	117			
RSES	Yes	31	50,06	1552,00	
	No	86	62,22	5351,00	1056
	Total	117			

*p<.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

The effect of current employment status was measured by Mann Whitney U test. A significant difference was found in terms internalized stigma (U=838; p<.05) however no significant differences were obtained for hopelessness and self-esteem (for BHS U= 1091; for RSES U= 1056; p > .05, respectively).

Table 30. *Internalized stigma, hopelessness and self-esteem scores of the subjects by current social insurance status*

	Insurance	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	103	58,04	5978,50	622,5
	No	14	66,04	924,50	
	Total	117			
BHS	Yes	103	57,22	5894,00	538
	No	14	72,07	1009,00	
	Total	117			
RSES	Yes	103	56,43	5812,50	
	No	14	77,89	1090,50	456,6*
	Total	117			

*p<.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

The effect of current social insurance status was measured by Mann Whitney U test. A significant difference was found in terms of self-esteem (U=456,6; p<.05) however no significant differences were obtained for internalized stigma and hopelessness (for ISMI = 622,5; for BHS U= 538; p > .05, respectively).

Table 31. *Internalized stigma, hopelessness and self-esteem scores of the subjects by percieved socioeconomic status*

	SES	N	Mean Rank	H
ISMI	Low	26	65,44	
	Mid	86	56,78	1,563
	High	4	50,38	
	Total	116		
BHS	Low	26	64,44	
	Mid	86	55,93	2,304
	High	4	75,13	
	Total	116		
RSES	Low	26	63,31	
	Mid	86	57,80	1,582
	High	4	42,38	
	Total	116		

$p > .05$
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of perceived socioeconomic status on three parameters. The results showed that there were no significant differences between three groups in terms of internalized stigma, hopelessness and self-esteem (for ISMI H= 1,563; for BHS H=2,304; for RSES H= 1,582 $p > .05$).

Table 32. *The effect of non-governmental organization membership on internalized stigma, hopelessness and self-esteem*

	NGO Membership	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	47	63,22	2971,50	
	No	70	56,16	3931,50	1446,5
	Total	117			
BHS	Yes	47	61,96	2912,00	
	No	70	57,01	3991,00	1506
	Total	117			
RSES	Yes	47	60,49	2843,00	
	No	70	58,00	4060,00	1575
	Total	117			

$p > .05$

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann Whitney U test was used to look at the effect of membership of non-governmental organization (NGO) on internalized stigma, hopelessness and self-esteem. No significant differences were seen between members and non members of NGO. (for ISMI U= 1446,5; for BHS U= 1506; for RSES U= 1575; $p > .05$).

Table 33. *The comparison between the group who take both psychosocial support and NGO and the group who take neither in terms of internalized stigma, hopelessness and self-esteem*

	PsychSoc +NGO	N	Mean Rank	Sum of Ranks	U
ISMI	Yes	39	53,56	2089,00	1148
	No	63	50,22	3164,00	
	Total	102			
BHS	Yes	39	51,67	2015,00	1222
	No	63	51,40	3238,00	
	Total	102			
RSES	Yes	39	52,95	2065,00	1172
	No	63	50,60	3188,00	
	Total	102			

$p > .05$
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Mann-Whitney U Test was applied to look at the difference between the group who take both psychosocial support and NGO and the group who take neither in terms of internalized stigma, hopelessness and self-esteem. The results showed that psychosocial support and membership of NGO did not have any significant effect on internalized stigma, hopelessness and self-esteem (for ISMI U= 1148; for BHS U= 1222; for RSES U= 1172; $p > .05$).

Table 34. *Internalized stigma, hopelessness and self-esteem scores of the subjects by social loss due to mental illness*

	Social Loss	N	Mean Rank	Sum of Ranks	U
ISMI	No	47	42,74	2009,00	881*
	Yes	69	69,23	4777,00	
	Total	116			
BHS	No	47	50,49	2373,00	1245*
	Yes	69	63,96	4413,00	
	Total	116			
RSES	No	47	54,10	2542,50	1414,5
	Yes	69	61,50	4243,50	
	Total	116			

*p<.05

ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

The effect of current social loss due to mental illness was measured by Mann Whitney U test. A significant difference was found in terms internalized stigma (U=881; p<.05) and hopelessness (U=1245; p<.05) however no significant difference was held for self-esteem (U=1414,5; p>.05).

Table 35. *Internalized stigma, hopelessness and self-esteem scores of the subjects by percieved discrimination due to mental illness*

	Discrimination	N	Mean Rank	H
ISMI	Yes	22	80,64	19,46*
	No	62	46,41	
	Sometimes	32	66,70	
	Missing	1		
	Total	117		
BHS	Yes	22	81,32	13,03*
	No	62	51,48	
	Sometimes	32	56,41	
	Missing	1		
	Total	117		
RSES	Yes	22	74,86	7,505*
	No	62	52,69	
	Sometimes	32	58,52	
	Missing	1		
	Total	117		

*p<.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of perceived discrimination due to mental illness on three parameters. The results showed that there were significant differences between three groups in terms of internalized stigma, hopelessness and self-esteem (for ISMI H= 19,46; for BHS H=13,03; for RSES H= 7,505; $p < .05$).

Table 36. *Discrimination scores of the subjects by percieved discrimination due to mental illness*

	Discrimination	N	Mean Rank	H
ISMI DE	Yes	22	83,05	22,611*
	No	62	45,73	
	Sometimes	32	66,38	

*p<.05
ISMI: Internalized Stigma of Mental Illness, DE: Discrimination Experience

Kruskal-Wallis H test was used to look at the effect of perceived discrimination due to mental illness on perceived discrimination subscale of ISMI. The result showed that there was a significant difference between three sub-groups (H= 22,611; p<.05). This means that subjects who perceived discrimination scored higher on the subscale on perceived discrimination. This result is in line with the above-mentioned result.

Table 37. *Internalized stigma, hopelessnes and self-esteem scores of the subjects by percieved discrimination for any reasons other than mental illness*

	Discrimination	N	Mean Rank	Sum of Ranks	H
ISMI	Yes	17	66,32	1127,50	
	No	100	57,76	5775,50	725,5
	Total	117			
BHS	Yes	17	70,18	1193,00	660
	No	100	57,10	5710,00	
	Total	117			
RSES	Yes	17	74,12	1260,00	
	No	100	56,43	5643,00	593*
	Total	117			

p<.05
ISMI: Internalized Stigma of Mental Illness, BHS: Beck Hopelessness Scale, RSES: Rosenberg Self-esteem Scale

Kruskal-Wallis H test was used to look at the effect of percieved discrimination for any reasons other than mental illness on three parameters. The results showed that there was a significant difference between three groups with regards to self-esteem ($H=593$, $p<.05$) but no significant differences were found in terms of internalized stigma and hopelessness (for ISMI $H= 725,5$; for BHS $H= 660$, $p < .05$). A further analysis was made to look at the effect of percieved discrimination for any reasons other than mental illness on the perceived discrimination subscale of ISMI. No significant difference was found ($U= 559,5$, $p>.05$). This means that subjects perceiving discrimination for any reasons other than mental illness did not score higher on the subscale.

CHAPTER FOUR: DISCUSSION

4. Discussion

The aim of the current study was to examine the relationship between sociodemographic and clinical variables associated with the internalized stigma, and also relationship between internalized stigma, hopelessness and self-esteem in the patients with SMI were examined. The main findings of the current study are discussed from the point of research questions and the hypotheses.

4.1. Discussion of the Findings

Following part evaluates sociodemographics based on internalized stigma, hopelessness and self-esteem. Then, all hypotheses are discussed and analytical data is evaluated based on the purposes of the study.

4.1.1. Descriptive Findings

Sample findings suggest that patients with psychosis are subjected to internalized stigma more than their bipolar counterparts. This is parallel with the former knowledge that psychotics are the population that is impacted by internalized stigma. The fact that patients with affective disorder (bipolar) are perceived as 'normal' and functioning may explain this difference. Thus, patients may strip themselves from the stigma of being 'ill.' It can be inferred that patients with bipolar disorders are more protected towards internal and external stigma comparing to psychotic patients. It is known that the life quality and social relations of psychotic patients are impaired more comparing to patients with affective disorders. This suits to the "crazy" stereotype that public have about mentally ill. Hence it is harder for psychotic patients to protect themselves toward the stigma they face.

Similarly it has been observed that hopelessness levels of psychotic patients in the sample are lower than other groups. Same mechanisms regarding symptom

severity may play a role here. In addition, the demographics consisting of the sample may gestate this results. More than %85 of the sample is older than 35 and %73.5 are unemployed. Thus, they do not seem to have hope for the future. %65.8 are single; they did not reach the point where they can build a life for themselves as individuals. Almost half of the sample are receiving treatment more than ten years. %64.1of the sample attempted suicide and %38.5 reported that a relative has a mental disorder. %59.8 of the sample population did not have any psychosocial/psychoeducational support and almost %60 of them do not possess a non-governmental organization (NGO) membership. This may illustrate the boundaries of their hopelessness.

%59 of the sample reported social loss due to mental illness. Moreover, participants reporting and idea of discrimination due to mental illness are %46.2. %14.5 of the sample reported discrimination due to something other than their mental illness. This illustrates how self-esteem is lower in both bipolar and psychotic patients.

4.1.2. Analytic Findings

The first research question was “Is there any significant relationship between sociodemographic characteristics (age, gender, marital status, educational years, employment, social insurance and perceived socioeconomic level) and the internalized stigma, self-esteem and hope levels of patients with severe mental illnesss (SMI)?” **[RQ1]**

The first hypothesis evaluated the relationship between internalized stigma, hopelessness and self-esteem levels **[Hyp 1a].** Data analysis suggests that are significant differences in age groups regarding the hopelessness and self-esteem levels.

Age was found to be a significant variable regarding self-esteem and hopelessness. Hopelessness and self-esteem levels can be connected to the duration of the mental disorder. Duration is crucial even when treatment process, severity and progress is not considered.

The order of severity was 50-65, 30-39, 40-49 and 20-29, age 50-65 being the most severe. It can be inferred that the eldest group is hopeless the most as they do not expect anything ro change. The group that breaks the order (30-39) is when people need hope the most. That age group is when individuals can become the most productive and functional, but their condition prevents them from accomplishing their potential thus hopelessness increase.

A negative correlation was found between age and self-esteem. This explains why older individuals who devalue themselves have higher hopelessness levels.

It is found that the group between ages 30-39 have the highest levels internalized stigma. Then comes 40-45, 50-65, 20-29 (Table 13-14). Although no significant relationship between internalized stigma and age it is noteworthy to evaluate the findings. Middle-aged patients showed higher internalized stigma levels than their young adult and elder counterparts. It may be because younger patients are just experiencing living with their condition and the elderly accepted it. Middle-aged group is just stuck between these two conditions; they experience and internalize stigma easier than the other groups.

The significant difference between self-esteem and hopelessness levels of age groups 20-29 and 30-39 confirms the aforementioned prediction. Participants in their 30s have lower self-esteem and higher hopelessness levels. Participants who are unemployed and did not receive proper psychosocial support faced their condition more impactful.

There is no difference between the gender and marital status to internalized stigma, hopelessness or self-esteem according to the results **[Hyp 1b].** The gendered attributions on mental disorders is a complicated one. Destructiveness is attributed to men whereas vulnerability is attributed to women. Attributions toward mental disorder stigma contain stereotypes from both gender. No significant differences were found between men and women when looking at hopelessness and self-esteem levels. Thus, it can be concluded that socio-demographics such as gender cannot fully explain the issue of stigma on mental disorders.

Marital status was investigated by considering Turkey's sociocultural standards **[Hyp 1c].** Being single, married, divorced or separated have cultural underpinnings. Present study looked at if mental disorder stigma could predict some sociocultural outcomes. No significant differences was found between marital status and internalized stigma. However, being single after an age is attributed negatively in Turkey. Hence, most of the participants who are single may perceive this as social loss and failure in life. They may developed a reactionary defense mechanism when answering the survey.

The data collected from the ISMI survey suggest that participants who are in the workforce scored lower than the ones who are not. It can be inferred that people who do not work internalize stigma more than the ones do not. Participants who have social security scored lower in self-esteem tests than the ones who do not possess social security. No relationship was found between socioeconomic status and internalized stigma, hopelessness and self-esteem **[Hyp 1d].** When looked at the sample, most of them are unemployed, posses social insurance and middle socioeconomic status. These answers may be misleading. People who are unemployed are expected to feel hopelessness and failure. Turkish population tend to report their

status as middle without proper knowledge. Thus, socioeconomic status should be investigated broadly.

A meta-analysis conducted by using data from 127 article (Livingstone & Boyd, 2010) suggest that there are significant relationships between gender, age, education, employment status, income and internalized stigma. However, the relationship directions were diverse. It can be inferred that other variables should be considered when looking at internalized stigma.

The second research question was "Is there a significant relationship between psychiatric diagnosis (any type of psychotic disorders and bipolar disorder), first age of diagnosis and internalized stigma, hopelessness and self-esteem levels?" **[RQ2]** There are two hypotheses regarding this question: The patients diagnosed with any type of psychosis (schizophrenia, schizoaffective disorder, other psychotic disorder) are expected to have higher internalized stigma level in proportion to patients diagnosed with bipolar disorder [**Hyp 2a]**. It was expected that psychotic patients would have higher internalized stigma levels comparing to bipolar patients. Moreover, a difference in hopelessness and self-esteem levels was expected. Higher levels of internalized stigma and lower levels hopelessness and self-esteem was found, thus the hypothesis holds true and consistent with the literature. The most impacted group from the internalized is schizophrenia (Kocabaşoğlu & Aliustaoğlu, 2003; Schulze & Angermeyer, 2003).

The patients who had longer duration of illness are expected to have higher internalized stigma and hopelessness, and lower self-esteem level **[Hyp 2b].**

The third research question was "Is there a significant relationship between hospitalization and internalized stigma, hopelessness and self-esteem levels?" **[RQ3].** Three hypotheses investigated the relationship between these variables. First

hypothesis suggested that hospitalized patients have higher internalized stigma and hopelessness levels and lower self-esteem levels **[Hyp 3a].** Second hypothesis assumed that the first age of hospitalization would affect internalized stigma and hopelessness positively and self-esteem negatively **[Hyp 3b].** The number of hospitalizations would have a similar relationship.

No significant relationships were found for these hypotheses. However, there are findings that suggest a relationship. More research on this issue is necessary. (Internalized stigma can even be conceptualized as a side effect of treatment, if the treatment generates the label or the SMI identity that triggers the application of the stereotypes**.)**

The fourth research question was "Is there a significant relationship between psychosocial/psychoeducational support and/or membership of a non-govermental organization related to a mental illness and internalized stigma, hopelessness and self-esteem levels?" **[RQ4].**

NGO membership was taken as an indicator of social engagement. Results suggest that there are no differences between the groups. A tendency for lower levels of internalized stigma and higher levels self-esteem was found in individual who are exposed to empowering variables. NGO memberships are recommended for SMI patients. Nevertheless, the reason why the hypotheses were not confirmed may be due to Turkey's NGO culture. Most NGO members are not actively involved. Most organizations and treatment facilities do not possess the competence to make a change.

Fifth research question suggested that patients who possess comorbidity would have higher levels of internalized and hopelessness and lower levels of self-esteem **[RQ 5].** All variables were higher for patients who possess comorbidity. However, no

significant relationships were found. The non-significant relationship may be caused because patients already experience deficits from one disorder. Stigma is already placed for one disorder, the second one hardly causes more damage.

Another question suggested that there will be a significant relationship between suicide attempt and internalized stigma, hopelessness and self-esteem levels **[RQ 6].** Data reveals higher internalized and hopelessness levels and lower self-esteem levels. Suicide attempt is one of the most impactful result of human psyche. It is something that the individual cannot ignore once it happened. Even one attempt may prime the idea that one's mental disorder is fatal. Suicide attempt may cause the individual to lose self-esteem and hope.

Seventh research question looked at if there are other people who are struggling from a mental disorder in participants' family **[RQ 7].** No significant differences were found regarding internalized stigma, hopelessness and self-esteem. An idea like "I am like this because of my parents/relatives" do not increase the impact of internalized stigma.

Eighth research question was investigating whether participants have any physical disabilities and if their disabilities have an effect on their internalized stigma, hopelessness and self-esteem levels **[RQ 8].** It was expected that participants with physical disabilities would have lower self-esteem and higher hopelessness. No differences were found between those variables. Comorbidity of psychiatric illnesses did not have any extra effect on the individual. For the same reason physical illness do not possess any significant relationship with the variables.

The ninth question was about social loss. It was hypothesized that participants who experienced social loss would have higher internalized stigma and hopelessness levels and lower self-esteem levels **[RQ 9].** Data suggest that participants who

experienced social loss had higher levels of internalized stigma and hopelessness. No significant differences were found between two groups regarding self-esteem. Social relations/marriage, economic/occupation/employment, education, health care/medical service and military service were taken as indicators of social loss. These points, when taken with the statistical results indicate that these variables have important consequences and more about society's perception than the individuals'.

The last research question was about the relationship between perceived discrimination and internalized stigma, hopelessness and self-esteem levels **[RQ 10].** It was proposed that people with higher perceived discrimination would have higher internalized stigma, hopelessness and lower self-esteem levels **[Hyp 10a]**. Analyses reveals that hypothesis holds true for internalized stigma and hopelessness but not for self-esteem. It was found that participant who perceived higher levels of discrimination had higher self-esteem scores. It is understandable to see higher levels of internalized stigma and hopelessness but it is surprising to see higher self-esteem levels. It may be inferred that this unexpected results are due to a defense mechanism in order to manage feelings of worthlessness and preserve a sense of self against the stigma and hopelessness.

Table 36 compared internalized stigma and perceived discrimination to validate findings. It is found that internalized stigma sub-scales discrimination is parallel with perceived discrimination. This indicates that stigma can come internally as well as externally. Individuals agree and embrace stigma before they are subjected to them.

It was found that people who perceived discrimination other than their mental illness have lower levels of self-esteem. No relationship was found between internalized stigma and hopelessness regarding this. These inferences are parallel with

the aforementioned relationship with perceived discrimination. Most of the participants did not report other types of discrimination other than their mental illness.

In conclusion, there were no consistent relationship between demographics and internalized stigma, hopelessness and self-esteem. People who are diagnosed with a psychotic disorder experienced internalized stigma more severely. No relationships were found between NGO membership and internalized stigma, hopelessness and self-esteem. Levels of these variables were higher in participants with comorbidity but no significant relationships were found. Participants who attempted suicide reported higher levels of internalized stigma and hopelessness but lower levels of self-esteem. No significant results were found for the internalized stigma, hopelessness and self-esteem levels when looking at relatives who also possess a mental disorder. No relationship was found between a physical disability and higher levels of internalized stigma. Participants who experienced social loss found to have higher levels of internalized stigma, and hopelessness but there was no relationship with self-esteem. Participants with higher levels of perceived discrimination had higher levels of internalized stigma, hopelessness and self-esteem.

CHAPTER FIVE: CONCLUSION

5. Conclusion

In the following sections, the findings are discussed on the basis of previous studies and then the limitations of the current study are indicated. Finally, recommendations for further research are presented at the end of this chapter.

5.1. Results of the Study and Discussion

According to the results significant relationships were found below:

1. Significant relationships has been found in some age groups, hopelessness and self-esteem.
2. Psychiatric diagnosis and internalized stigma have a significant relationship.
3. Psychiatric diagnosis, self-esteem and hopelessness have a significant relationship.
4. Patients with psychosis were found to have significantly higher internalized stigma, psychosomatic symptoms and experienced threat in interrelations comparing to their bipolar counterparts.
5. A significant relationship was found between psychiatric comorbidity, internalized stigma, hopelessness and self-esteem.
6. A significant relationship was found between suicide attempt, internalized stigma, hopelessness and self-esteem.
7. Social insurance status and self esteem were found to have a significant relationship.
8. Social loss, internalized stigma and hopelessness were found to have a significant relationship.

9. Perceived discrimination and internalized stigma, hopelessness and self-esteem have a significant relationship.
10. Perceived discrimination other than mental illness and self-esteem have a significant relationship.

According to the study no relationship was found for the variables below:

1. Gender and internalized stigma, hopelessness and self-esteem have no significant relationship.
2. Marital status and internalized stigma, hopelessness and self-esteem have no significant relationship.
3. Psychiatric illness in family members and internalized stigma, hopelessness and self-esteem has no significant relationship.
4. Physical illness and internalized stigma, hopelessness and self-esteem has no significant relationship.
5. Hospitalization and internalized stigma, hopelessness and self-esteem has no significant relationship.
    a. Age at first hospitalization and internalized stigma, hopelessness and self-esteem has no significant relationship.
    b. Total length of hospitalization and internalized stigma, hopelessness and self-esteem has no significant relationship.
6. Ongoing medication and internalized stigma, hopelessness and self-esteem has no significant relationship.
7. Receiving psychosocial/psychoeducational support and internalized stigma, hopelessness and self-esteem has no significant relationship.
8. Social insurance status and internalized stigma and hopelessness has no significant relationship.

9. Perceived socioeconomic status and internalized stigma, hopelessness and self-esteem has no significant relationship.
10. Non-governmental organization (NGO) membership and internalized stigma, hopelessness and self-esteem has no significant relationship.
    a. NGO membership and psychosocial support together assessed with internalized stigma, hopelessness and self-esteem has no significant relationship.
11. Social loss and self-esteem has no significant relationship.
12. Perceived discrimination other than mental illness and internalized stigma and hopelessness has no significant relationship.

The conclusions we reached, especially the ones that are contradictory with the literature can be explained with the sociodemographic and cultural differences of our sample. The reason why there is no relationship with non-governmental organization (NGO) membership and stigma may be due to the inactivity of the NGOs in Turkey. It is clear that researchers should do more research with bigger samples to infer more reliable conclusions.

Strategies to prevent stigma aims to formulize (i) protest (ii) education (iii) contact. Corrigan and Penn (1999) suggest that protest strategies may result in psychological reactance and education would be insufficient resist against strong stigmas. These strategies should be channelized using a promoting contact offering institutional support and cooperative interaction. Opportunities for NGOs to take initiative should be created. Events bringing mental health professionals, artists, officials and academics should be organized to tackle issues relating to stigma. Direct exposure is the best way to decrease and fight stigma.

Due to a variety of variables, it has been reported that the social support for individuals with severe mental illness (SMI) is higher (Sartorius, Schulze; 2005). Thus, it can be considered that patients with SMI in Turkey experience stigma (public and/or self) is intensive. Other than that currently there is not enough scientific studies on this subject in Turkey.

A report propounds that mental health and rehabilitation services for individuals with SMI in Turkey provided both quantitatively and qualitatively as not adequate (RUSİHAK, 2008). It can be inferred that this situation increases internalized stigma. It would be fallacious to construe that hope and self-esteem levels would increase without ameliorating internalized stigma levels.

Individuals can live with their families within the society that they live in. The approach taken for this individuals is culturally different than the developed countries. The attitude towards the reason of the mental disorders cause a more tolerant approach. The recent urbanization in Turkey, which is among the developing countries, drastically caused a change in the family units and the approach towards the mentally ill. Individuals with severe mental illness, most of the time, are excluded from the work process. As the present study shows, sole treatment is merely a step forward, inclusion in the society is crucial.

According to the study, social loss is due to discrimination. On the other hand discrimination other than mental illness is connected to lower self-esteem. This can be the result of shame. It can be inferred that this emotion that starts in early periods of life causes reactionary denial mechanisms. A similar conclusion can be reached when looking at relatives of the individuals with mental disorders. Individual carries the burden with his closest ones. These variables should be looked at when designing treatment procedures.

We need to ask questions about how relatives perceive stigma if we want to understand stigma. Clinical trials show that relatives experience stigma as well. We can infer that this is a defense mechanism against public stigma. They think that their loss in self-esteem is resulting from their mental illness. Same might apply to their relatives. Future research may explore this phenomena more deeply.

Art therapy can be an effective method to prevent and reduce stigma. Art therapy can aid patients in symbolizing 'hard-to-describe' feelings. They can also find the opportunity to make use of the collective, healing aspects of art.

It is hard to achieve short-term change with internalized stigma. Change is ardous as concept of stigma is multifaceted. Awareness campaigns are not enough to tackle prejudice on an emotional level. Sociodramatic interventions may turn tables on negative, prejudicial behaviors and cause positive inclusive behaviors. Different professionals from a variety of disciplines (i.e. physicians, lawyers, artists etc.) should take part in this interventions. Awareness of the multifaceted nature of stigma should be crucial.

Research on the attitudes (Nordt, Rössler & Lauber, 2006) on psychiatric symptoms and mental disorders found that public stigma and and professionals' attitudes were similar in terms of stigma. If professionals are not immune to the culturally learned stigma, awareness interventions are at utmost importance.

Amin Maalouf (2000) in his book the "Les Identités Meurtrieres" [Ölümcül Kimlikler] says that being parallel with the zeitgeist is not enough for a change to be embraced. It should not be hurtful on a symbolic level and not alienate the subjected group. How can patients recover without losing their identity? Psychopathology, especially severe mental illnesses have a limit when it comes to recovery. They will be needing opportunities to live decently after their symptom severity is alleviated.

Who is going to provide these opportunities? Stigma is a humanitarian issue whether it is on a societal or an individual level and all people are responsible for it. Individuals with SMI should be able to participate in social and cultural life and contribute to the work force. As mental health professionals and members of the society we need to strive to make this a reality.

The results are parallel with the Labeling Theory perspective. People diagnosed with SMI should be treated as people who are impacted from the societal and cultural stereotypes and prejudices. This should be evaluated as a perspective for the clinicians who see the concept of internalized stigma everyday.

Finally, when we consider that the public opinion on the disorder is arbitrary, the prevention/abatement interventions toward the stigma against SMI are limited. The research about different parts of society is critical to decrease and prevent stigma. Early interventions on young groups would be at utmost importance. Psychosocial education for children and young adults is recommended. Decreasing and/or preventing stigma require longterm commitment and work.

In conclusion, a need for a multifarious approach is required to prevent stigma. Accordingly, three variables should be considered based on the current situation in Turkey: (i) a focus on making resources that mental health patients can make use of such as psychotherapy, psycho-education, rehabilitation etc. available (ii) organizing social awareness campaigns against mental health stigma (iii) betterment of the legal, vocational, educational and health systems for patients with SMI.

5.2. Limitations of the Study

Some of this study's results are contradictory with the existing literature. This may be explained with several reasons.

There are some limitations regarding the sample count and the sample's representation. The data was collected from individuals from Bursa and Istanbul. Studies with bigger samples will generate more information on the issue of internalized stigma.

Another limitation is the fact that all participants were outpatients. A study with hospitalized participants, thus people with more severe mental illnesses may overcome this limitation and provide broader information.

This research looked at bipolar and psychotic disorders as the subgroup of severe mental illness. A study done with neurotic patients (e.g. anxiety disorders, major depression, phobic disorders, obsessive compulsive disorders) developmental disorders and other disabled samples may give us a broader sense of internalized stigma. Also may provide wider perspective about hopelessness and self-esteem.

5.3. Recommendations for Further Research

One suggestion for future research would be to focus on social elements related to stigma. Because according to results of the current study, seemingly, those societal factors are in the root of the matter.

Another consideration for future research is to consider about how we can overcome public and internalized stigma. Studies done with close relatives of patients with severe mental illness (SMI) may generate ample research questions. Although socio-demographics like age do not have any significant relationships with self-esteem, hopelessness and internalized stigma; developmental periods are worth investigating. Research done with adolescents may luminescence the path of more knowledge about internalized stigma, as that age period is when social rules are embraced. The results from those studies may help professionals to develop more sustainable prevention interventions.

Yanos et al. (2008) claims that “narrative enhancement approach” in which the patients tell their own stories and restructure the story, is an effective way to intervene. By restructuring their stories patients’ their negative view of themselves and their internalized stigma levels are alleviated. In addition, research has showed acceptance and commitment therapies (ACT) decreased internalized stigma significantly in a month follow-up (Masuda, Hayes, Fletcher, Seignourel, Bunting, Herbst & Lillis, 2007). These therapeutic interventions may be a useful tool to fight with internalized stigma in patients.

In addition the use phenomenological methods in psychotherapeutic interventions can be considered. Art psychotherapy, which is a growing method, can ease the complicity of the issues of stigma. Emotions that are hard to symbolize can be expressed via art therapy. Moreover, it can help patients develop coping skills by unveiling creativity. Like art psychotherapy, psychodrama can be a useful tool as well. Opportunities arising from the support from group psychotherapy, re-experiencing the moment, developing empathy can be a subject for future research.

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Appendix A

Informed consent Form [in Turkish]

BİLGİLENDİRME VE ONAM FORMU

Değerli katılımcı,

Aşağıda araştırmaya katılmayı kabul ettiğiniz takdirde karşılaşacağınız sorulara ilişkin temel açıklamalar bulunmaktadır. Lütfen soruları yanıtlamaya geçmeden önce bu açıklamaları dikkatlice okuyunuz.

Araştırmayı Yapan: Bu araştırma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans programında yürütülen bir tez çalışmasıdır.

Araştırmanın Amacı: Bu çalışmanın amacı, psikiyatrik hastalığı olan bireylerde içselleştirilmiş damgalanma, benlik saygısı ve umut arasındaki ilişkiyi incelemek ve değerlendirmektir.

Uygulama: Size 4 adet form verilecektir. Bu formlardaki soruları kendi görüş ve yaşantılarınıza göre yanıtlamanız istenmektedir. Uygulama yaklaşık 30-35 dakika sürecektir. Sizden samimi yanıtlar vermeniz ve hiçbir soruyu boş bırakmamanız beklenmektedir.

Gizlilik: Dolduracağınız formlarda, kimliğinizi belirleyecek herhangi bir soru (ad, soyad, kimlik numarası, doğum yeri vs) bulunmamaktadır. Verdiğiniz tüm bilgiler saklı tutulacaktır. Herkesin doldurduğu formlar birleştirilip beraber değerlendirileceği için size özel sonuçlar elde etmek ve paylaşmak söz konusu değildir. Araştırmaya katılmak tamamen gönüllülük ilkesine dayanmaktadır.

Sonuçlar: Araştırmaya katılan herkesin doldurduğu formlar birleştirilerek genel sonuçlar elde edilecektir. Kişiye özel değerlendirme ve sonuç söz konusu değildir. Araştırmanın sonuçları tezde ve bilimsel yazılarda kullanılacaktır. Ancak bu yayınlarda hiçbir katılımcının kimlik bilgileri bulunmayacaktır. Kütüphane veritabanlarından teze, yayınlara ya da araştırmacı kanalıyla genel özetlere ulaşmak mümkün olacaktır.

Okuduğunuz bu açıklamadan sonra araştırmaya katılmayı kabul ediyorsanız formları yanıtlamaya başlayabilirsiniz.

☐ Kabul ediyorum.

☐ Kabul etmiyorum.

Katılımınız için şimdiden teşekkür ederiz.

Oğuz Burak İsmanur
İstanbul Bilgi Üniversitesi
Klinik Psikoloji Yüksek Lisans Programı

Doç. Dr. Levent Küey
İstanbul Bilgi Üniversitesi
Klinik Psikoloji Yüksek Lisans Programı

Appendix B

Sociodemographic and Clinical Information Questionnaire [in Turkish]

SOSYODEMOGRAFİK BİLGİ FORMU

Bu form psikiyatrik hastalığı olan bireylerle ilgili yapılan bir araştırma için bilgi toplama amacıyla hazırlanmıştır. Cevaplarınızı doğru ve bir şekilde vermeniz araştırmacı için önem taşımaktadır. Seçenekli soruları kendinize uygun olan cevabın yanındaki kutucuğa (X) işareti koyarak, seçenekli olmayan soruları ise cevabı bizzat yazarak yanıtlayınız. Katılımınız için teşekkür ederiz.

Kimlik bilgileri

1. Doğum yılınız: ……
2. Cinsiyetiniz:

☐ Erkek

☐ Kadın

3. Şu anki medeni haliniz

☐ Evli

☐ Bekar

☐ Boşanmış

Eğitim hayatı

4. Gördüğünüz toplam öğrenim süresi ne kadardır? (yıl olarak) …….. yıl.

Psikiyatrik hastalık

5. Şu anki psikiyatrik hastalığınızın tanısı nedir?

☐ Şizofreni

☐ Şizoafektif bozukluk

☐ Diğer psikotik bozukluklar

☐ Bipolar bozukluk

6. Bu tanı ilk kez kaç yıl önce kondu? …. Yıl.
7. Bu tanı dışında eşlik eden psikiyatrik hastalığınız var mı?

☐ Evet

☐ Hayır

8. Bugüne kadar intihar girişiminiz oldu mu?

☐ Evet

☐ Hayır

9. Ailenizde, birinci dereceden akrabalarınız arasında psikiyatrik hastalığı olan var mı?

☐ Evet

☐ Hayır

Fiziksel hastalık

10. Halen herhangi bir bedensel hastalığınız var mı? (tansiyon, şeker, kalp vb.)

☐ Evet. Bu bedensel hastalığınızın tanısı nedir? Yazınız. …….

☐ Hayır

Cevabınız evet ise;

10a. Bu bedensel hastalığınıza dair tedavi görüyor musunuz?

Evet☐

Hayır☐

11. Herhangi bir bedensel engeliniz var mı? (görme, işitme, yürüme vb.)

☐ Evet

☐ Hayır

Lütfen kâğıdın arkasındaki sayfaya geçiniz.

Psikiyatrik tedaviye ilişkin

12. Bugüne dek hastanede yatarak psikiyatrik tedavi gördünüz mü?

☐ Evet

☐ Hayır

Cevabınız evet ise;

12a. ☐ stanede kaç kez yattınız? …….. kez.

12b. ☐ hastane yatışınızda kaç yaşındaydınız? …… yaşındaydım.

12c. ☐ güne dek toplam hastane yatış süreniz yaklaşık kaç haftadır? …. Hafta

13. Halen ilaç tedavisi görüyor musunuz?

☐ Evet

☐ Hayır

14. Bugüne kadar herhangi bir psikososyal destek veya psikoeğitim çalışmasına katıldınız mı? (örneğin; psikososyal grup çalışması, rehabilitasyon çalışması, hastalığınızla ilgili bilgilendirme çalışması, hastalığınızla ilgili dernek faaliyetleri gibi)

☐ Evet

☐ Hayır

15. Ailenizden herhangi biri psikososyal destek veya psikoeğitim çalışmasına katıldı mı?

☐ Evet

☐ Hayır

İş yaşamı – Sosyoekonomik durum

16. Halen çalışıyor musunuz?

☐ Evet

☐ Hayır

17. Halen bir sosyal güvenlik kurumuna bağlı mısınız? (Örnek: Emekli Sandığı, BağKur, SSK, SGK)

☐ Evet

☐ Hayır

18. Kendinizi sosyoekonomik düzey açısından hangi gruba ait buluyorsunuz?

☐ Alt

☐ Orta

☐ Üst

19. Hastalığınızla ilgili herhangi bir dernekle ilişkiniz var mı?

☐ Evet

☐ Hayır

20. Sizce hastalığını nedeniyle uğradığını bir sosyal kayıp var mı? (Örnek: eğitim, iş/meslek, evlilik, askerlik, sağlık hizmetleri vb.)

☐ Evet. Bu kayıp nedir? Belirtiniz. ……

☐ Hayır

21. Psikiyatrik hastalığınız nedeniyle herhangi bir ayrımcılığa uğradığınızı düşünüyor musunuz?

☐ Evet

☐ Bazen

☐ Hayır

22. Hastalığınız dışı herhangi bir sebeple ayrımcılığa uğradığınızı düşünüyor musunuz?

☐ Evet. Bu sebep nedir? Belirtiniz. ……..

☐ Hayır

Cevaplarınız ve dikkatiniz için teşekkür ederiz.

Appendix C

Internalized Stigma of Mental Illness Scale (ISMI) [Turkish version]

RUHSAL HASTALIKLARDA İÇSELLEŞTİRİLMİŞ DAMGALANMA ÖLÇEĞİ (RHİDÖ)

Bu testte sık sık geçen "ruhsal hastalık" terimi, en geniş anlamda kullanılmıştır.
Her bir cümleyi dikkatle okuduktan sonra eğer;

"Kesinlikle aynı fikirde değilim"	diyorsanız	(1)	rakamını;
"Aynı fikirde değilim"	diyorsanız	(2)	rakamını ;
"Aynı fikirdeyim"	diyorsanız	(3)	rakamını ;
"Kesinlikle aynı fikirdeyim"	diyorsanız	(4)	rakamını daire içine alarak

Okuduğunuz cümleye ne ölçüde katıldığınızı ya da katılmadığınızı belirtiniz. Her cümle için rakamlardan sadece bir tanesini işaretleyiniz.

	Kesinlikle aynı fikirde değilim	Aynı fikirde değilim	Aynı fikirdeyim	Kesinlikle aynı fikirdeyim
1. Ruhsal bir hastalığım olduğu için kendimi bu dünyada bir yabancı gibi hissediyorum.	1	2	3	4
2. Ruhsal hastalığı olan kişiler saldırgan olmaya eğilimlidirler.	1	2	3	4
3. Ruhsal bir hastalığım olduğu için insanlar bana farklı davranıyorlar.	1	2	3	4
4. Reddedilmemek için, ruhsal hastalığı olmayan kişilere yaklaşmaktan kaçınıyorum.	1	2	3	4
5. Ruhsal bir hastalığım olduğundan dolayı utanıyorum.	1	2	3	4
6. Ruhsal hastalığı olan kişiler evlenmemelidir.	1	2	3	4
7. Ruhsal hastalığı olan kişiler topluma önemli katkılarda bulunurlar.	1	2	3	4
8. Kendimi ruhsal hastalığı olmayan kişilerden daha aşağı hissediyorum.	1	2	3	4
9. Ruhsal hastalığım benim "garip" görünmeme ya da davranmama neden olabileceğinden dolayı eskisi kadar sosyal değilim.	1	2	3	4
10. Ruhsal hastalığı olan kişiler iyi ve doyum verici bir hayat yaşayamazlar.	1	2	3	4
11. İnsanları ruhsal hastalığımla sıkmak istemediğimden dolayı, kendi hakkımda fazla konuşmam.	1	2	3	4
12. Halk arasındaki ruhsal hastalıklarla ilgili olumsuz düşünceler, benim "normal" yaşamın dışında kalmama neden oluyor.	1	2	3	4
13. Ruhsal hastalığı olmayan kişilerle birlikteyken, kendimi sanki o ortama ait değilmiş ve yetersizmişim gibi hissediyorum.	1	2	3	4

14. Ruhsal hastalığı açıkça anlaşılan biriyle toplum içinde birlikte görülmek beni rahatsız etmez.	1	2	3	4
15. Sırf ruhsal hastalığımdan dolayı insanlar bana sık sık ne yapmam gerektiğini söyleyip, sanki çocukmuşum gibi davranırlar.	1	2	3	4
16. Ruhsal hastalığım olduğu için kendimden memnun değilim.	1	2	3	4
17. Ruhsal hastalığımın olması hayatımı berbat etti.	1	2	3	4
18. İnsanlar görünüşümden ruhsal bir hastalığımın olduğunu anlayabilirler.	1	2	3	4
19. Ruhsal hastalığımdan dolayı benimle ilgili çoğu kararı başkalarının vermesine ihtiyaç duyarım.	1	2	3	4
20. Ailemi ve arkadaşlarımı utandırmamak için sosyal ortamlardan uzak dururum.	1	2	3	4
21. Ruhsal hastalığı olmayanların beni anlamaları mümkün değildir.	1	2	3	4
22. Sırf ruhsal hastalığım olduğu için insanlar beni göz ardı eder ya da pek ciddiye almazlar.	1	2	3	4
23. Ruhsal hastalığım olduğu için topluma hiçbir katkım olamaz.	1	2	3	4
24. Ruhsal bir hastalıkla yaşamak beni mücadeleci bir insan yaptı.	1	2	3	4
25. Ruhsal bir hastalığım olduğu için kimse bana yakınlaşmak istemez.	1	2	3	4
26. Genel olarak, hayatı istediğim şekilde yaşayabiliyorum.	1	2	3	4
27. Ruhsal hastalığıma rağmen, iyi ve dolu dolu yaşadığım bir hayatım var.	1	2	3	4
28. İnsanlar ruhsal bir hastalığım olduğu için hayatta fazla başarılı olamayacağımı düşünüyorlar.	1	2	3	4
29. Akıl hastalarıyla ilgili olumsuz yaygın inanışlar benim durumum dikkate alındığında hiç de yanlış sayılmaz.	1	2	3	4

Appendix D

Beck Hopelessness Scale (BHS) [Turkish version]

BECK UMUTSUZLUK ÖLÇEĞİ

Aşağıda geleceğe ait düşünceleri ifade eden bazı cümleler verilmiştir. Lütfen her bir ifadeyi okuyarak bunların size ne kadar uygun olduğuna karar veriniz. Örneğin okuduğunuz ilk ifade size uygun ise "evet" uygun değilse "hayır" ifadesinin altındaki kutunun içine (X) işareti koyunuz.

	EVET	HAYIR
1. Geleceğe umut ve coşku ile bakıyorum.	( )	( )
2. Kendim ile ilgili şeyleri düzeltemediğime göre çabalamayı bıraksam iyi olur.	( )	( )
3. İşler kötüye giderken bile her şeyin hep böyle kalmayacağını bilmek beni rahatlatıyor.	( )	( )
4. Gelecek on yıl içinde hayatımın nasıl olacağını hayal bile edemiyorum.	( )	( )
5. Yapmayı en çok istediğim şeyleri gerçekleştirmek için yeterli zamanım var.	( )	( )
6. Benim için çok önemli konularda ileride başarılı olacağımı umuyorum.	( )	( )
7. Geleceğimi karanlık görüyorum.	( )	( )
8. Dünya nimetlerinden sıradan bir insandan daha çok yararlanacağımı umuyorum.	( )	( )
9. İyi fırsatlar yakalayamıyorum. Gelecekte yakalayacağıma inanmam için de hiçbir neden yok.	( )	( )
10. Geçmiş deneyimlerim beni geleceğe iyi hazırladı.	( )	( )
11. Gelecek benim için hoş şeylerden çok tatsızlıklarla dolu görünüyor.	( )	( )
12. Gerçekten özlediğim şeylere kavuşabileceğimi ummuyorum.	( )	( )
13. Geleceğe baktığımda şimdikine oranla daha mutlu olacağımı umuyorum.	( )	( )
14. İşler bir türlü benim istediğim gibi gitmiyor.	( )	( )
15. Geleceğe büyük inancım var.	( )	( )
16. Arzu ettiğim şeyleri elde edemediğime göre bir şeyler istemek aptallık olur.	( )	( )
17. Gelecekte gerçek doyuma ulaşmam olanaksız gibi.	( )	( )
18. Gelecek bana bulanık ve belirsiz görünüyor.	( )	( )
19.Kötü günlerden çok iyi günler bekliyorum.	( )	( )
20. İstediğim her şeyi elde etmek için çaba göstermenin gerçekten yararı yok nasıl olsa onu elde edemeyeceğim.	( )	( )

Appendix E

Rosenberg Self-Esteem Scale (RSES) [Turkish version]

ROSENBERG BENLİK SAYGISI ÖLÇEĞİ

D – 1

MADDE 1

1.Kendimi en az diğer insanlar kadar değerli buluyorum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

2. Bazı olumlu özelliklerim olduğunu düşünüyorum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

3. Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

MADDE 2

4. Ben de diğer insanların birçoğunun yapabildiği kadar bir şeyler yapabilirim.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

5. Kendimde gurur duyacak fazla bir şey bulamıyorum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

MADDE 3

6. Kendime karşı olumlu tutum içindeyim.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

MADDE 4

7. Genel olarak kendimden memnunum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

MADDE 5

8. Kendime karşı daha fazla saygı duyabilmeyi isterdim.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

9. Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

10. Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.

a. ÇOK DOĞRU b. DOĞRU c. YANLIŞ d. ÇOK YANLIŞ

D – 2

11. Kendiniz hakkındaki düşünceleriniz değişkenlik gösterir mi, yoksa her zaman aynı mıdır?

a. ÇOK DEĞİŞİR b. ZAMAN ZAMAN DEĞİŞİR

c. ÇOK AZ DEĞİŞİR d. HİÇ DEĞİŞMEZ

12. Hiç kendiniz hakkında bir gün bir görüşe, başka bir gün farklı bir görüşe sahip olduğunuzu fark ettiğiniz oldu mu?

a. EVET, SIK SIK OLUR b. EVET, BAZEN OLUR

c. EVET, NADİREN OLUR d. HAYIR, HİÇ OLMAZ

13. Kendim hakkındaki görüşlerimin **çok çabuk** değiştiğini fark ettim.

a. DOĞRU b. YANLIŞ

14. Kendim hakkında bazı günler olumlu bazı günlerse olumsuz düşüncelere sahip oluyorum.

a. DOĞRU b. YANLIŞ

15. Şu günlerde kendim hakkındaki görüşlerimi hiçbir şeyin değiştiremeyeceğini düşünüyorum.

a. DOĞRU b. YANLIŞ

D – 3

16. Başınıza gerçekten bir şey geldiğinde kimse sizin durumunuzla pek ilgilenmeyecektir.

a. DOĞRU b. YANLIŞ

17. İnsan doğasında yardımlaşma gerçekten vardır.

a. DOĞRU b. YANLIŞ

18. Dikkatli davranmazsanız insanlar sizi kullanacaklardır.

a. DOĞRU b. YANLIŞ

19. Bazı kişiler, insanların büyük çoğunluğunun güvenilir olduğunu, bazıları ise insanlarla ilişkilerinde çok güvenilemeyeceğini söylerler. Siz bu konuda ne düşünüyorsunuz ?
a. İnsanların çoğuna güvenilebilir.
b. İnsanlarla ilişkilerde çok güvenilmez.
20. İnsanların daha çok başkalarına yardım etmeye mi, yoksa kendi çıkarlarını düşünmeye mi eğilimlidirler?
a. Başkalarına yardım etmeye
b. Kendi çıkarlarını düşünmeye

D – 4
21. Eleştiriye karşı ne kadar hassassınızdır?
a. Çok fazla hassas b. Oldukça hassas c. Az hassas d. Hassas değil
22. Eleştiri ya da azarlama beni çok fazla incitir.
a. DOĞRU b. YANLIŞ
23. Yanlış yaptığınız bir şey için biri size güldüğünde veya suçladığında ne kadar rahatsız olursunuz?
a. Çok fazla b. Oldukça c. Rahatsız olmam

D – 5
24. Genelde ne kadar mutsuzsunuzdur?
a. Çok mutlu b. Mutluc. Pek mutlu değil d. Çok mutsuz
25. Genelde oldukça mutlu bir kişi olduğumu düşünüyorum.
a. DOĞRU b. YANLIŞ
26. Genel olarak kendinizi neşeli bir ruh hali içinde mi, yoksa neşesiz bir ruh hali içinde mi hissedersiniz?
a. Çok neşeli bir ruh hali içinde b. Oldukça neşeli bir ruh hali içinde
c. Ne neşeli ne neşesiz ruh halinde d. Oldukça neşesiz ruh hali içinde
27. Hayattan çok zevk alıyorum.
a. DOĞRU b. YANLIŞ
28. Ben de mutlu gördüğüm diğer kişiler kadar mutlu olabilmeyi isterdim.
a. DOĞRU b. YANLIŞ
29. Kendinizi kederli ve karamsar hissettiğiniz olur mu?
a. ÇOK SIK b. SIK c. ARA SIRA d. NADİREN e. HİÇBİR ZAMAN

D – 6
30- Çoğu zaman başka bir şey yapmaktansa oturup hayal kurmayı tercih ediyorum.
a. DOĞRU b. YANLIŞ
31. Bana hayalperest denilebilir.
a. DOĞRU b. YANLIŞ
32. Zamanımın büyük bir kısmını hayal kurmakla geçiririm.
a. DOĞRU b. YANLIŞ
33. Gelecekte nasıl bir insan olacağınız konusunda hayal kurar mısınız?
a. ÇOK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN

D – 7
34- Hiç uykuya dalma ya da uykunun sürekliliği açısından sorununuz oldu mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
35. Hiç ellerinizin sizi rahatsız edecek kadar titrediği olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
36. Hiç sizi rahatsız edecek kadar sinirlendiğiniz olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
37. Hiç sizi rahatsız edecek kadar çarpıntı hissettiğiniz olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN

38. Hiç sizi rahatsız edecek kadar başınızın içinde basınç hissettiğiniz olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
39. Şu sıralarda hiç tırnak yiyor musunuz?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
40. Egzersiz veya çalışma zamanları dışında hiç sizi rahatsız edecek kadar nefes darlığı hissettiğiniz olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
41. Hiç sizi rahatsız edecek kadar ellerinizde terleme olur mu?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
42. Hiç rahatsız edici baş ağrıları çeker misiniz?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN
43. Hiç rahatsız edici kâbuslar görür müsünüz?
a. SIK SIK b. BAZEN c. NADİREN d. HİÇBİR ZAMAN

D – 8
44. Ulusal veya uluslararası önemli bir konuda görüşünüzü belirttiğinizde biri size gülerse ne hissedersiniz?
a. Çok incinirim ve rahatsız olurum. b. Biraz incinirim ve rahatsız olurum.
c. Beni pek fazla etkilemez.
45. Ulusal veya uluslararası sunumlar tartışıldığında genellikle kötü izlenim bırakacak bir şey söylemektense hiçbir şey söylememeyi tercih ederim.
a. DOĞRU b. YANLIŞ
46. Toplumsal konularla ilgili tartışmalarda insanları kızdıracak bir şey söylemektense hiçbir şey söylememeyi tercih ederim.
a. DOĞRU b. YANLIŞ

D – 9
47. Uluslararası konuları tartışır mısınız?
a. PEK ÇOK b. Oldukça c. ÇOK AZ d. HİÇBİR ZAMAN
48. Arkadaşlarınızla birlikte uluslararası konuları tartıştığınız zaman tutumunuz nasıl olur?
a. Sadece dinlerim. b. Arada bir görüş bildiririm.
c. Konuşmaya eşit oranda katılırım. d. Diğerlerini ikna etmeye çalışırım.

D – 10
49. Siz 10-11 yaşlarınızdayken **anneniz** arkadaşlarınızı tanır mıydı?
a. Hepsini tanırdı. b. Çoğunu tanırdı.
c. Bazıları tanırdı. d. Hemen hemen hiçbirini tanımazdı.
50. Bu dönemde **babanız** arkadaşlarınızı tanır mıydı?
a. Hepsini tanırdı. b. Çoğunu tanırdı.
c. Bazılarını tanırdı. d. Hemen hemen hiçbirini tanımazdı.
51. 5.-6. Sınıflardayken karneniz **iyi** olduğunda **anneniz** çoğu zaman ilgilenmezdi.
a. DOĞRU b. YANLIŞ
52. 5.-6. Sınıflardayken karneniz **iyi** olduğunda **babanız** çoğu zaman ilgilenmezdi.
a. DOĞRU b. YANLIŞ
53. 5.-6. Sınıflardayken karneniz **kötü** olduğunda **anneniz** çoğu zaman ilgilenmezdi.
a. DOĞRU b. YANLIŞ
54. 5.-6. Sınıflardayken karneniz **kötü** olduğunda **babanız** çoğu zaman ilgilenmezdi.
a. DOĞRU b. YANLIŞ
55. Sizce diğer aile bireyleri sizin söylediğiniz şeylerle ne kadar ilgilenirler?
a. Çok ilgilenirler b. Oldukça ilgilenirler c. İlgilenmezler

D – 11

56. Büyümekte olduğunuz dönemde babanızın en çok tuttuğu çocuğu kimdi?

a. Ben b. Ağabeyim c. Ablam d. Erkek kardeşim

e. Kız kardeşim f. Bildiğim kadarıyla çok tuttuğu birisi yoktu.

57. Bu dönemde babanız arkadaşlarınızı tanır mıydı?

a. Hepsini tanırdı. b. Çoğunu tanırdı.

c. Bazılarını tanırdı. d. Hemen hemen hiçbirini tanımazdı.

58. Anne ve babanızın hangisi ile daha rahat konuşabiliyorsunuz?

a. Babamla çok daha fazla b. Babamla biraz daha fazla

c. Her ikisi ile eşit oranda d. Annemle biraz daha fazla

e. Annemle çok daha fazla

59. Anne ve babanızın hangisi sizi daha çok över?

a. Babam çok daha fazla b. Babam biraz daha fazla

c. Her ikisi ile eşit oranda d. Annem biraz daha fazla

e. Annem çok daha fazla

60. Anne ve babanızın hangisi size daha çok şefkat gösterir?

a. Babam çok daha fazla b. Babam biraz daha fazla

c. Her ikisi ile eşit oranda d. Annem biraz daha fazla

e. Annem çok daha fazla

61. Anne ve babanız anlaşamadıkları zaman siz genellikle hangisinden yana olursunuz?,

a. Çok daha fazla olarak babamdan yana b. Biraz fazla olarak babamdan yana

c. Eşit oranda her ikisinden yana d. Biraz fazla olarak annemden yana

e. Çok daha fazla olarak annemde yana

D – 12

62. Yalnız bir insan olmaya eğilimli misinizdir?

a. EVET b. HAYIR

63. İnsanların çoğu sizin nasıl bir kişi olduğunuzu bilirler mi, yoksa çoğunun sizi gerçekten tanımadıklarını mı düşünürsünüz?

a. Çoğu benim nasıl biri olduğumu bilir.

b. Çoğu gerçekten beni tanımaz.

ROSENBERG BENLİK SAYGISI ENVANTERİ ALT ÖLÇEKLERİ

D – 1 (Benlik Saygısı); D – 2 (Kendilik Kavramının Sürekliliği); D – 3 (İnsanlara Güven Duyma); D – 4 (Eleştiriye Duyarlılık); D – 5 (Depresif Duygulanım); D – 6 (Hayalperestlik); D – 7 (Psikosomatik Belirtiler); D – 8 (Kişilerarası İlişkilerde Tehdit Hissetme); D – 9 (Tartışmalara Katılabilme Derecesi); D – 10 (Ana – Baba İlgisi); D – 11 (Babayla İlişki); D – 12 (Psişik İzolasyon)

Appendix F

Uludağ University Faculty of Medicine Research Ethics Commitee Approval
[Uludağ Üniversitesi Tıp Fakültesi Araştırma Etik Kurul Onayı]

T.C.
ULUDAĞ ÜNİVERSİTESİ
TIP FAKÜLTESİ ARAŞTIRMA ETİK KURULU
Görükle Yerleşkesi, 16059 Nilüfer/ BURSA

ARAŞTIRMA BAŞVURUSU ONAYI

BAŞVURU BİLGİLERİ	ARAŞTIRMANIN ADI	**Ağır Ruhsal Hastalığı Olan Bireylerde İçselleştirilmiş Damgalanma, Benlik Saygısı ve Umut Arasındaki İlişkinin Araştırılması**
	ARAŞTIRMA SORUMLULARI	Doç.Dr.Aslı Sarandöl
	YARDIMCI ARAŞTIRICILAR	Psikilojik Danışman Oğuz Burak İsmanur, Doç.Dr.Cengiz Akkaya
	ARAŞTIRMANIN TAHMİNİ SÜRESİ KATILACAK GÖNÜLLÜ SAYISI	2 ay 100
	DESTEKLEYİCİ KURULUŞ	Masraflar araştırıcı tarafından karşılanacaktır.
	ARAŞTIRMANIN TÜRÜ / NİTELİĞİ	Anket çalışması / Yüksek lisans tez çalışması

	Belge Adı	Tarihi	Dili
DEĞERLENDİRİLEN İLGİLİ BELGELER	ARAŞTIRMA BAŞVURU FORMU	12.09.2011	Türkçe
	BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU	12.09.2011	Türkçe
	BİLGİ FORMU - ANKET FORMU	-	Türkçe
	ARAŞTIRICILAR İÇİN TAAHHÜTNAME FORMU	12.09.2011	Türkçe

KARAR BİLGİLERİ

Karar No : 2011-18/3 Tarih : 27 Eylül 2011

Fakültemiz Ruh Sağlığı ve Hastalıkları Anabilim Dalı Öğretim Üyesi Doç.Dr.Aslı Sarandöl'ün sorumluluğunda yürütülmesi planlanan ve yukarıda başvuru bilgileri verilen araştırma başvuru dosyası ve ilgili belgeler araştırmanın gerekçe, amaç, yaklaşım ve yöntemleri dikkate alınarak incelenmesi sonucunda;

1- Araştırmanın yapılmasının uygun olduğuna.
2- Etik Kurul kaşesi bulunan *"Onam"* formunun kullanılması ve bu formun gönüllüye çalışma hakkında sözlü bilgi verilmesi sonrasında eksiksiz bir şekilde doldurulmasına.
3-Araştırmanın başlama tarihinin bildirilmesi ve araştırma tamamlandığında özet bir sonuç raporunun hazırlanarak kurulumuza iletilmesine.
4- Araştırma protokolünde ve başvuru formunda yapılacak tüm değişiklikler için Etik Kuruldan izin alınması gerektiğinin sorumlu araştırıcılara iletilmesine oybirliği ile karar verildi.

ETİK KURUL BİLGİLERİ

ÇALIŞMA ESASI	İYİ KLİNİK UYGULAMALAR KILAVUZU

ÜYELER

Unvanı / Adı / Soyadı EK Üyeliği	Uzmanlık Dalı	Kurumu	Cinsiyeti	İlişki (*)	Katılım (**)	İmza
Prof. Dr. Mine Sibel GÜRÜN Başkan	Farmakoloji	U.Ü.T.F. Farmakoloji ve Klinik Farmakoloji AD.	K	☐ E ■ H	■ E ☐ H	
Prof.Dr.Betül Berrin SEVİNİR Başkan Yardımcısı	Çocuk Sağlığı ve Hastalıkları	U.Ü.T.F. Çocuk Sağlığı ve Hastalıkları AD.	K	☐ E ■ H	■ E ☐ H	
Prof.Dr.Engin ULUKAYA Üye	Biyokimya	U.Ü.T.F. Tıbbi Biyokimya AD.	E	☐ E ■ H	☐ E ■ H	Katılmadı
Doç.Dr.Necdet KARLI Üye	Nöroloji	U.Ü.T.F. Nöroloji AD.	E	☐ E ■ H	☐ E ■ H	Katılmadı
Doç.Dr.Elif BAŞAĞAN MOĞOL Üye	Anesteziyoloji	U.Ü.T.F. Anesteziyoloji ve Reanimasyon AD.	K	☐ E ■ H	■ E ☐ H	
Doç.Dr.Murat CİVANER Üye	Deontoloji	U.Ü.T.F. Tıp Tarihi ve Etik AD.	E	☐ E ■ H	■ E ☐ H	
Yrd.Doç.Dr.Bülent EDİZ Üye	Biyoistatistik	U.Ü.T.F. Biyoistatistik ve Tıbbi Bilişim AD.	E	☐ E ■ H	☐ E ■ H	Katılmadı

* Araştırma ile İlişki
** Toplantıda Bulunma

T.C.
ULUDAĞ ÜNİVERSİTESİ
TIP FAKÜLTESİ ARAŞTIRMA ETİK KURULU
Görükle Yerleşkesi, 16059 Nilüfer/ BURSA

ARAŞTIRMA BAŞVURUSU ONAYI

Doç.Dr.Şaduman BALABAN ADIM Üye	Patoloji	U.Ü.T.F. Tıbbi Patoloji AD.	K	☐ E ■ H	☐ E ■ H	Katılmadı
Yrd.Doç.Dr.Pınar VURAL Üye	Psikiyatri	U.Ü.T.F. Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları AD.	K	☐ E ■ H	■ E ☐ H	
Yrd.Doç.Dr.Tuna GÜLTEN Üye	Tıbbi Genetik	U.Ü.T.F. Tıbbi Genetik AD.	K	☐ E ■ H	■ E ☐ H	
Yrd.Doç.Dr.Çiğdem Mine YILMAZ Üye	Hukuk	U.Ü.Hukuk Fakültesi	K	☐ E ■ H	■ E ☐ H	
Ecz.Zeynep Gözde TUNCER Üye	Eczacı	UÜ.SUAM	K	☐ E ■ H	■ E ☐ H	
Ahmet GÖREN Üye	Sağlık mesleği mensubu olmayan üye	Serbet Meslek	E	☐ E ■ H	■ E ☐ H	

* Araştırma ile İlişki
** Toplantıda Bulunma

LÜTFEN BU DÖKÜMANI DİKKATLİCE OKUMAK İÇİN ZAMAN AYIRINIZ

Sayın .....

Sizi Uludağ Üniversitesi Psikiyatri AD tarafından yürütülen ***"AĞIR RUHSAL HASTALIĞI OLAN BİREYLERDE İÇSELLEŞTİRİLMİŞ DAMGALANMA, BENLİK SAYGISI VE UMUT ARASINDAKİ İLİŞKİNİN ARAŞTIRILMASI"*** başlıklı ankete dayalı bir **araştırmaya** davet ediyoruz. Bu araştırmaya katılıp katılmama kararını vermeden önce, araştırmanın neden ve nasıl yapılacağını, bu araştırmanın gönüllü katılımcılara getireceği olası fayda ve rahatsızlıklarını bilmeniz gerekmektedir. Bu nedenle bu formun okunup anlaşılması büyük önem taşımaktadır. Aşağıdaki bilgileri dikkatlice okumak için zaman ayırınız. İsterseniz bu bilgileri aileniz ve/veya yakınlarınız ile tartışınız. Eğer anlayamadığınız ve sizin için açık olmayan şeyler varsa, ya da daha fazla bilgi isterseniz bize sorunuz. Bu anket çalışmasına katılmayı kabul ettiğiniz takdirde, gerekli yerleri siz ve sorumlu araştırmacı tarafından doldurulmuş bu formun bir kopyası saklamanız için size verilecektir.

Araştırmaya katılmak tamamen **gönüllülük** esasına dayanmaktadır. Size verilen **anket formlarındaki** soruları yanıtlarken kimsenin baskısı veya telkini altında olmayın. Bu formlardan elde edilecek bilgiler tamamen araştırma amacı ile kullanılacaktır ve kimlik bilgileriniz kesinlikle gizli tutulacaktır.

Çalışmaya katılmama veya herhangi bir anda çalışmadan çıkma hakkında sahipsiniz. Her iki durumda da bir ceza veya hakkınız olan yararların kaybı kesinlikle söz konusu olmayacaktır.

Araştırma Sorumlusu
Aslı Sarandöl

Araştırmanın Amacı:

Bu çalışmanın amacı, psikiyatrik hastalığı olan bireylerde içselleştirilmiş damgalanma, benlik saygısı ve umut arasındaki ilişkiyi incelemek ve değerlendirmektir.

İzlenecek Olan Yöntem ve Yapılacak İşlemler:
Size 4 adet form verilecektir. Bu formlardaki soruları kendi görüş ve yaşantılarınıza göre yanıtlamanız istenmektedir. Uygulama yaklaşık 30-35 dakika sürecektir. Sizden samimi yanıtlar vermeniz ve hiçbir soruyu boş bırakmamanız beklenmektedir.

Araştırmanın Süresi:

Katılması Beklenen Gönüllü Sayısı: 100

Size Getirebileceği Olası fayda ve Rahatsızlıklar:

Çalışmanın adı: Ağır Ruhsal Hastalığı Olan Bireylerde İçselleştirilmiş Damgalanma, Benlik Saygısı Ve Umut Arasındaki İlişkinin Araştırılması
Tarih: 12.09.2011

Uludağ Üniversitesi
Tıp Fakültesi
Araştırma Etik Kurulu
tarafından onaylanmıştır.
Tarih : 27 Eylül 2011
Kara No: 18/3

Araştırmanın Yapılacağı Yer(ler): Uludağ Üniversitesi Psikiyatri AD, İstanbul Şizofreni Derneği, Şizofreni Gönüllüleri Derneği, Şizofreni Gönüllüleri Dayanışma Derneği

Araştırmaya Katılan Araştırıcılar: Aslı Sarandöl, Oğuz Burak İsmanur, Cengiz Akkaya

Katılma ve Çıkma:
Bu anket çalışmasına katılmak tamamen gönüllülük esasına dayanmaktadır. Çalışmaya katılmama veya herhangi bir anda çalışmadan çıkma hakkına sahipsiniz. Ayrıca sorumlu araştırıcı gerek duyarsa sizi çalışma dışı bırakabilir. Çalışmaya katılmama, çalışmadan çıkma veya çıkarılma durumlarında bir ceza veya hakkınız olan yararların kaybı kesinlikle söz konusu olmayacaktır.

Masraflar:
Araştırmanın tüm masrafları araştırıcının kendisi tarafından karşılanmaktadır.

Gizlilik:
Bu çalışmadan elde edilen bilgiler tamamen araştırma amacı ile kullanılacak ve kimlik bilgileriniz kesinlikle gizli tutulacaktır.

Ben,.....[gönüllünün adı, soyadı (kendi el yazısı ile)] yukarıdaki metni okudum ve katılmam istenen anket çalışmasının amacını, gönüllü olarak üzerime düşen sorumlulukları tamamen anladım. **Çalışma hakkında soru sorma ve tartışma imkanı buldum ve tatmin edici yanıtlar aldım. Bu çalışmayı istediğim zaman ve herhangi bir neden belirtmek zorunda kalmadan bırakabileceğimi ve bıraktığım zaman herhangi bir olumsuzlukla karşılaşmayacağımı anladım.**

Bu koşullarda söz konusu söz konusu anket çalışmasına kendi rızamla, hiçbir baskı ve zorlama olmaksızın katılmayı (çocuğumun/vasimin bu çalışmaya katılmasını) kabul ediyorum.

Gönüllünün(Kendi el yazısı ile)
Adı-Soyadı:
İmzası:
Adresi:
(varsa Telefon No, Faks No):
Tarih (gün/ay/yıl): ..../..../....

Velayet veya Vesayet Altında Bulunanlar İçin
Veli veya Vasisinin (kendi el yazısı ile)
Adı Soyadı:
İmzası:
Adresi:

Çalışmanın adı: Ağır Ruhsal Hastalığı Olan Bireylerde İçselleştirilmiş Damgalanma, Benlik Saygısı Ve Umut Arasındaki İlişkinin Araştırılması
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Araştırma Etik Kurulu
tarafından onaylanmıştır.
Tarih : 27 Eylül 2011
Kara No: