Labels, Opinions, Beliefs and Attitudes Regarding Mental Illness Among University Students : A Multi-Method Approach to Studying Stigma

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Üniversite Öğrencilerinde Ruhsal Rahatsızlığa Dair Etiketler, Fikirler, İnançlar, ve Tutumlar: Damgalamanın Araştırılmasında Çoklu Metod Yaklaşımı

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7. Tema analizi

Abstract

The goal of this study was to approach stigma of mental illness on multiple layers using multiple methods. The aim was to explore labeling of people with mental illness through a qualitative approach; opinions, beliefs and attitudes regarding two specific mental illnesses (major depression and paranoid-type schizophrenia) through a quantitative, case vignette type survey approach; and investigate factors associated with these components. The sample constituted of a convenience sample of 320 university students. Participants completed a compilation of self-report questionnaire forms. Six themes were identified from the Labeling Questionnaire data: derogatory, medical, symptom related, personal and social problem related, compassion and pity related, normalization and denial related label themes. Among these themes most frequently used labels were under the medical and derogatory label categories. Case vignette analyses revealed recognition of depression and schizophrenia as mental illnesses however a distinction was observed with regards to two Turkish terms for mental illness, “akıl hastalığı” and “ruhsal hastalık.” With regards to opinions and beliefs on etiology and treatment options emphasis on psychosocial factors was associated depression and emphasis on psychobiological factors associated with schizophrenia. Although both conditions were perceived as treatable by majority of the participants, schizophrenia was viewed more pessimistically. Mental health specialist was offered as a first choice of help-seeking option by the majority of participants. Overall more rejecting attitudes were associated with contexts involving greater intimacy, and with schizophrenia. The factors that were found to be associated with label themes, opinions, beliefs and attitudes were type of mental illness, gender, class-standing, area of study, and exposure to mental illness. These results suggest accurate knowledge with regards to recognitions, opinions and beliefs on etiology

and treatment options of depression and schizophrenia. However rejecting and negative attitudes are still present and the use of derogatory labels prevalent. The results from two major approaches, suggests the significance of approaching stigma from different methodologies.

Özet

Bu araştırmanın amacı ruhsal rahatsızlıklara ilişkin damgalamanın çeşitli katmanlarının çoklu yöntem yaklaşımı ile incelenmesidir. Bu amaç, ruhsal rahatsızlığı olan bireylerin nasıl etiketlendirildiğinin niteliksel incelemesini; iki ruhsal rahatsızlığa ilişkin (major depresyon ve paranoid-şizofreni) fikir, inanç ve tutumların vaka olgularına dayanan sorularla niceliksel incelemesini; ve aynı zamanda bu unsurlarla ilişkili etkenlerin araştırılmasını içermektedir. Bu çalışma kolaylığa dayalı bir grup üniversite öğrencisinin oluşturduğu 320 kişilik bir örneklemi kapsamaktadır. Katılımcılar, çeşitli formlardan oluşan anket setini yanıtlamışlardır. Ruhsal Rahatsızlığı Etikenlendirme Formu'na verilen yanıtlardan elde edilen verilerden altı tema ortaya çıkmıştır: aşağılayıcı/küçültücü, tıbbi, semptom odaklı, kişisel ve sosyal problem odaklı, şefkat ve acıma odaklı, normalleştirme ve inkar odaklı. En çok kullanılan etiketler tıbbi ve aşağılayıcı/küçültücü tema başlıkları altında yer almıştır. Vaka olgularına dayanan analizler depresyon ve şizofreninin ruhsal rahatsızlık olarak algılandığını ancak "ruhsal hastalık" ve "akıl hastalığı" terimlerinin kullanımında anlamlı farklılıklara rastlanmıştır. Etiyoloji ve sağaltım seçeneklerine dair fikir ve inançlar açısından depresyonun psikososyal etkenlerle, şizofreninin ise psikobiyolojik etkenlerle ilişkilendirildiği gözlemlenmiştir. Her iki olgu örneği de katılımcıların çoğu tarafından tedavi edilebilir durumlar olarak görülürken şizofreninin tedavi edilebilirliği daha karamsar görülmüştür. Katılımcıların çoğu vaka olgularına ilişkin olarak ruhsal sağlık alanında çalışanları ilk yardım kaynağı olarak adlandırmıştır. Toplamda artan yakınlık düzeylerinin ve şizofreninin daha reddedici tutumlarla ilişkili olduğu gözlemlenmiştir. Analizler ruhsal rahatsızlık tipi, cinsiyet, üniversitedeki eğitim yılı, eğitim görülen alan, ve ruhsal rahatsızlık deneyimi/öyküsü gibi etkenlerin etiket temaları, fikir, inanç ve tutumlarla

ilişkili olduğunu göstermiştir. Sonuçlar katılımcıların, tanımlama, etiyoloji, ve sağaltım seçenekleri açısından doğru bilgilere sahip olduklarını ancak tutumlar açısından olumsuz eğilimlerinin bulunduğunu göstermektedir. Aşağılayıcı/küçültücü etiketler de yaygınca kullanılmıştır. İki temel yaklaşımla elde edilen sonuçlar, ruhsal rahatsızlığa ilişkin damgalamanın çoklu yöntemlerle araştırmanın önemini vurgulamaktadır.

to Pati ...

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1. INTRODUCTION

One of my patients, whom I continuously advised to see a psychiatrist for his depressive symptoms, argued that he did not want to see a psychiatrist, not because he thought she would be unhelpful but because he had a notion that the medications and antidepressants would numb him. His family on the other hand was also trying to convince him to quit therapy because they thought he did not need such a thing and that it was only cajolery and nonsense. Another patient who sought help because of a fear of experiencing psychotic episodes, was keeping his sessions as a secret from his friends and family. During sessions he would frequently use words such as “paranoia”, “paranoid”, “psychotic” with fear and devaluation however also indirectly asking whether his condition applied to these concepts.

These individuals, considering their life quality and educational background are perhaps in relatively better conditions compared to others experiencing similar problems, in spite of all the negative influences around them. They have recognized difficulties in their own lives, considered seeking help, were fortunate enough to have mental health services provided within close proximity and took actual steps to share their difficulties. The remaining majority of people with similar problems will perhaps never recognize their difficulties, never consider seeking help, even if they did consider seeking help never be able to reach the appropriate services or even if they were able to reach the services never take that step to actually share their conditions.

The reason why I preferred starting out with these real-life situations rather than directly introducing the umbrella terms of this study “stigma” and “mental illness,” is to begin with a reflection instead of a reaction to these concepts. The reactions to these concepts might have a range from criticizing the existence of such conditions encompassed by these terms from a “politically correct” standpoint, to a total denial of their existence. Regardless of the reactions we have to these terms and what they encompass, which are mostly influenced by our social interactions, expectations and pressures, I believe it is important to reflect on how we

actually experience and react to the situations regarding mental illness and stigma.

In spite of all the work that has been done on stigma and mental illness since the 1950s, including an increasing acknowledgement on intervention studies, we still encounter many accounts of the existence of stigma of mental illness across cultures, time trends, different age groups starting from childhood, gender differences, different educational backgrounds and occupations. With this point made my aim is not to discredit the work done so far. On the contrary I suggest that perhaps we need new or a combination of methods and approaches to handle the repertoire of information we have, to add new information and to encounter the challenges inherent to this matter. New and combined approaches to this field I believe can support the purpose of aiming at as honest and intimate responses as possible for the question of reflection I have proposed, which is crucial in handling the challenges inherent to stigma of mental illness.

Having laid out these concerns, I will first try to introduce *stigma* and *mental illness* with their definitions and conceptualizations. Then I will discuss some topics with regards to research on stigma and mental illness, including methods used and some evidence that has been demonstrated so far. I will then lay out the purpose and framework of this study.

2. DEFINING AND CONCEPTUALIZING STIGMA AND MENTAL ILLNESS

2.1.Defining Stigma

As defined in *Merriam-Webster's Online Dictionary*, archaically used as a scar left by a hot iron, stigma is defined as "a mark of shame or discredit," and "an identifying mark or characteristic"; in specific use "a specific diagnostic sign of a disease". In Turkish the word "damgalama" has been used as a translation of stigma. Similarly it has been defined as, according to the *Turkish Online Dictionary - Institution of Turkish Language* (Türk Dil Kurumu – *Büyük Türkçe Sözlük*), "putting a mark or

stamp on something", figuratively as "ascribing a characteristic or quality to a person with no actual basis". A sociologist Goffman in 1963 defined the term stigma as "an attribute that is deeply discrediting" (p.3). Beyond its sole definition stigma refers to something undesirable, has impact on social interactions and marks adverse experiences such as shame, blame, secrecy, isolation, social exclusion, stereotypes, discrimination (Byrne, 2000) of the stigmatized individual or group.

2.2.Conceptualizing Stigma and Mental Illness

In relatively recent conceptualizations of stigma and mental illness, stigma is viewed as an encompassing term and more than sum of its parts.

Corrigan and Watson (2002) described stigma, from a psychological paradigm, as a concept including stereotypes, prejudice and discrimination. According to their argument, if collectively shared beliefs about a social group (disregarding the uniqueness of each member of the group), in other words stereotypes, are adopted, adverse emotional reactions, in other words prejudice takes place, which is followed by discriminative behaviors. Adding onto their psychological conceptualization, in their 2004 article Corrigan, Markowitz & Watson argued that psychological models of stigma and mental illness were limited in explaining macro-level components of stigma and discussed structural levels of stigma including institutions, economics, politics and history.

Similarly, Link and Phelan's (2001) definition of stigma reflected a broad perspective. They defined stigma as "the co-occurrence of its components–labeling, stereotyping, separation, status loss, and discrimination" (p. 363) and emphasized the dependence of stigma on power. The "stigma process" follows first a recognition and labeling of the other then linking the labeled other with popular stereotypes. Upon separation between "us" and "other" and emotional responses on both parties, status loss and different forms of discrimination as well as adverse social consequences take place. Link and Phelan, introduced three levels of discrimination: Individual discrimination, structural discrimination and self-

stigmatization. Individual discrimination involves individual behaviours toward the labeled and stereotyped other which is manifested frequently by an increased desire of social distance. Structural discrimination refers to adverse consequences related to legal, political and social structures. Self-stigmatization refers to an internalization of the labels and stereotypes by the stigmatized individual or groups. In Link and Phelan's view stigma process depends on stigmatizers to be in a position of social power over those who are stigmatized.

One of the commonalities in these conceptualizations is the linear relationship of components proposed. Hinshaw (2007) criticizes this explanation by suggesting a presence of an inherent interrelationship among multiple layers of origins and functions of stigma.

> Stigmatization is embedded in dynamic and interconnected processes that include cognitions, attitudes, and identity formation at the individual level; a host of intergroup pheneomena at the social level; and institutional and economic conditions and factors at the structural level. (p.41)

Hinshaw, expanding the context of stigma suggests that stigmatization may also be extended to the people associated with the stigmatized individuals such as family members. Overall looking at the conceptualization of stigma as Hinshaw puts it "Stigma casts a long shadow" (p.24).

Thus stigma with its origin and function on multiple-levels, cannot be understood with an emphasis on only one or few levels. It needs a multiple-level of understanding.

Throughout history stigmatization has been relevant to many minorities and outgroups including certain political, ideological groups, women, homosexuals as well as mentally ill individuals. The stigma received by individuals with mental illness according to Hinshaw (2007) is extreme and has been present since long before psychiatry (Byrne, 2000; Hinshaw, 2007). In spite of its long presence and extremity with regards to

mentally ill individuals and mental illness, Byrne (2000) points out that there are no words for prejudice against mental illness such as facism, sexism or homophobia and suggests an introduction of such word could help campaigns for the reduction of the stigmatization of individuals with mental illness.

So why do such emotional and behavioral response patterns consisting stigma exist universally across cultures, communities regarding mental illness? This is suggested to rely on deep roots in the perception of threat and fear response, in other words a "deep 'existential fear'":

> "…people with mental disorder tend to produce both real threats to perceivers' health and well-being and symbolic threats to their sense of rationality and order. … The symbolic aspects of such threat are particularly important. Specifically the out-of-control nature of the symptom patterns (or, alternatively, their passivity and despair) may well give rise to perceivers' fears regarding their own abilities to maintain behavioral and emotional control. …Overall, the deep levels of symbolic threat posed by mental illness may help to explain the pervasiveness and severity of human responses to it." (Hinshaw, 2007, p. 145)

A related question on the resisting presence of certain stigmas, is whether if this pattern of behaviors are part of human nature. The field of evolutionary psychology has handled this question and provided some important contributions, arguing that certain stigmas were adaptations for the social and physical contexts in the human history however it is also argued that within the dynamic nature of our environments it doesn't mean that these behavior patterns are adaptive for today (in Hinshaw, 2007). These explanations are important in their emphasis on the dynamic nature of stigma, suggesting that although deeply rooted stigma is not predestined, and thus should be a motivator for further efforts addressing these explanations.

2.3. Defining Mental Illness and Its Relationship with Stigma

No matter how much it might seem obvious, I believe it is important to look at the definition of *mental illness.* As Hinshaw emphasizes in his book *The Mark of Shame,* how mental illness is defined has crucial implications on how social responses are shaped:

> … it is essential to consider the ways in which our society defines and understands mental disorder. Definitions of disturbing behavior patterns may, in fact, either amplify or diminish the initial, automatic patterns of response. …Given that many … explanations coexist, a complex mixture of responses can result. (p.8)

The effect of the definitions and recognitions of mental illness on attitudes and responses has been investigated since the beginning of stigma research. These investigations produced what is called *labeling theory. Primary labeling theory* emerged from sociological and psychological views emphasizing the idea that identity is shaped by social processes including labeling in which the labeled person would adopt the roles associated with the label. In other words, labels were responsible for the behaviors and conditions. As Hinshaw (2007) discusses this view was criticized for its denial of the independent existence of mental illness and disorders with the rise of psychobiological and treatment based evidences that demonstrated the impossibility of denying the existence of mental illnesses. This perspective even suggested a possible positive outcome of labeling, in which if labeled or diagnosed accurately, appropriate interventions would be possible. From these arguments, *secondary labeling theory* or *modified labeling theory* emerged. It was suggested that labels were not the causes for mental illness, rather labeling acted as a stigmatizing component which on an individual level demoralized the labeled individual, on an interpersonal and social level constricted relationships and networks in addition to the adversities associated with the mental illness itself (Markowitz, 2005). The recent conceptualizations of stigma that I

mentioned earlier were mostly influenced by the *secondary* or *modified labeling theory.*

2.4.Self-identification and Stigma

Keeping these conceptualizations and explanations regarding stigma and mental illness in mind, I am also interested in how the origin and function of stigma, prejudice and discrimination is explained, investigated especially emphasizing on an individual level, in other related fields of study. Since stigma is defined as a "mark" inflicted on the other, what is the "mark" inflicted on the self, and what are the associations? Earlier studies have proposed a presumption that ingroup ("us") favoritism and outgroup ("other") negativity. This however is argued to be a simplistic explanation. Arguing the validity of this presumption Brewer (1999, 2000, 2001) has suggested the significance of "cross-cutting social identities," in other words multiple social identities emerging from a membership to multiple groups. Multiple group memberships are argued to reduce distinctions between ingroup and outgroup, motivational base for between group discrimination, motivational base for an emphasis on ingroup bias (Brewer, 2000). This conceptualization has been supported by some evidence discussed by Brewer (Brewer, 2000, 2001; Brewer & Pierce, 2005). Evidence suggests an association between low social identity complexity and low tolerance and low acceptance of outgroups as well as high complexity and higher acceptance and tolerance for outgroups with more positive ratings of outgroups. However research regarding this matter is still scarce:

> …one agenda for future research in the social psychology of intergroup relations would be a shift of focus from single ingroup-outgroup distinctions to a focus on understanding the psychology of multiple group identities and its implications for intergroup perception and attitudes. (Brewer, 1999, p.442)

This suggestion has been an influence on this study, laying a ground for a focus on self-identifications with regards to multiple social identities, identity dimensions and associations with stigmatizing attitudes. This I

believe can be a new and interesting channel to look at one of the multiple layers of stigma.

3. RESEARCH ON STIGMA OF MENTAL ILLNESS

Research on stigma has approximately 50 years of history, mostly being descriptive in nature. Most research has defined stigma through assessments on beliefs and opinions regarding mental illness and attitudes toward people with mental illness. Studies regarding opinions and beliefs regarding mental illness has emphasized on recognitions, perceptions, causal attributions as well as opinions and beliefs about treatment and help-seeking options regarding mental illness. Studies regarding attitudes toward people with mental illness have especially emphasized on the desired social distances. Most research so far have used mostly *mental illness* as a general term, schizophrenia (a mental illness with worst prognosis) and depression (a mental illness with most prevalence) as triggers to measure stigma. More recent studies have started investigating association between stigma of mental illness and time trends, cultural factors, anti-stigma interventions and testing theory-based models of stigmatization (Angermeyer & Dietrich, 2006).

In this section I am first going to briefly introduce the frequently used methods in stigma research. Then I will discuss how the recent theory-based models have been tested, and provide some research evidence on how mental illness is recognized, what opinions and beliefs exist about its cause, treatment and help-seeking options, what kinds of attitudes and how much social distance is desired. Then I will introduce some factors that were found to be associated with stigmatization of mental illness.

3.1.Methods in Stigma Research

3.1.1. Participants

According to Link, Phelan, Yang & Collins (2004) review of articles published between 1995-2003 most research used a segment of general population followed by people with mental illness, people from specific

professionals and family members of mentally ill individuals, as samples. Most frequent locations of interest for research were, North America, Europe, Asia and Eurasia. Research from Middle East (Israel and Turkey) consisted 3.2% of the research reviewed. In Angermeyer & Dietrich's (2006) review of research conducted with general population samples the most frequent locations were Europe, America, Asia and Ocenia/Eurasia.

The most frequently used method for collection of data were personal interviews, self-reports and phone interviews.

3.1.2. Research Designs, Methodologies, and Instruments

According to Link et al. (2004) most (about 60%) of the research uses non-experimental surveys and about 7% uses surveys including a vignette component. This percentage was higher in Angermeyer & Dietrich's (2006) review of general population studies. Qualitative research in this field is unfortunately rare (eg.Rose, Thornicroft, Pinfold, & Kassam, 2007; Timlin-Sclera, Ponterotto, Blumberg, & Jackson, 2003) and experimental or quasi-experimental methods are only a few (eg. Farina et al., 1971)

In this section first I will try to briefly discuss some of the most frequently used experimental and non-experimental survey methods and instruments. Then I will provide some information although limited due to the unfortunate low number of studies about qualitative and combined methods used in stigma research. In each section I will try to mention Turkish studies.

3.1.2.1.Instruments

A. Case vignette

First use of this approach by Shirley Star in 1955 was used in later studies as Star Vignettes. In 1990s a set of vignettes were devised according to the definitions in DSM-IV. Vignettes describing alcoholism, major depression, schizophrenia and cocaine abuse were administered as part of Mac Arthur Mental Health Module of 1996 General Social Survey in the

U.S. These vignettes have been used in a number of ways in both experimental or non-experimental designs. The experimental approaches compared:

- Responses to symptomatic descriptions with or without a label
- Responses to non-symptomatic descriptions with or without its diagnostic label or symptomatic descriptions with or without its diagnostic label (eg. Schizophrenia symptoms described versus schizophrenia symptoms described with information that the description is a case of schizophrenia)
- Responses to descriptions (non-symptomatic or symptomatic) with various treatment history labels (eg. Hospitalization, psychiatric patient, etc)
- Responses to descriptions of two or more types of symptom patterns

Responses to these vignettes were usually measured in terms of how respondents would recognize them (if the label was not given), what opinions and beliefs they had regarding the causes, treatment options, help-seeking behaviors of the condition described and what attitudes they had involving the extent of desired social distance.

Case vignette method carries an advantage in acting as a stimulus for eliciting responses as measures for stigma. It also allows experimental designs which can be used in survey research. A suggested disadvantage however is that real conditions, stimuli would elicit a stronger or perhaps different response than a response elicited by verbal or written descriptions and labels (Hinshaw, 2007).

B. Social Distance Scale

One of the first measures used in stigma research was Social Distance Scale devised by Bogardus (1925) studying desired social distances toward different racial and ethnic groups. The scale includes items that assess responses to various levels of intimacy such as being a neighbor, working with, marrying a person belonging to a group under the question of

the research. This approach was first used for attitudes toward mental illness by Cumming & Cumming (1957) and Whatley (1958). To Link et al.'s (2004) knowledge Phillips was first to use Social Distance Scale with case vignettes in 1963. In many research results of Social Distance Scale has been defined as a measure of individual level discrimination as introduced by Link & Phelan (2001) and Corrigan & Watson (2002). However, it is important to remember that the responses to the items are not actual behaviors, rather intended or expressed behaviors as Corrigan et al. (2001) puts it "proxy measures of behavioral discrimination". Another disadvantage of this method is that since has been used for decades there is a risk of social desirability bias. The advantage lies in the fact that because it is a widely used method across time and various communities, countries it allows for longitudinal and cross-cultural comparisons.

C. Other scales and questionnaires

Another widely used scale called Opinions About Mental Illness [OMI] Scale was devised by Cohen & Struening (1962). Factor analyses has produced five subscales: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, interpersonal etiology. Link et al. (2004) argues that this scale have items that provide stimulus that can elicit responses, cover a wide range of issues, and due to its use over the years allows for longitudinal comparisons. However they suggest that the scale needs to be updated with new issues regarding stigma conceptualizations. A more recent scale devised by Taylor & Dear (1981), called the Community Attitudes Toward Mental Illness [CAMI], uses some of the subscales in OMI (benevolence, authoritarianism, social restrictiveness) and adds another category called mental health ideology which is considered to be a strength in that it aims to assess attitudes toward mental health facilities (Link et al., 2004).

D. Instruments in Turkish studies

In Turkish studies Turkish versions of case vignettes, social distance scales, and OMI were frequently used. There is also a reliability and validity study for Turkish version of CAMI (Bağ & Ekinci, 2006).

In recent years there is a frequent use of questionnaires designed to rate attitudes toward depression and schizophrenia by the Psychiatric Research and Education Centre (CPRE)[1] for a project called "Searching Public Attitudes Toward Mental Diseases[2]" (Aker et al. 2002, Eşsizoğlu & Arısoy, 2008;Özmen,Özmen, Taşkın, & Demet, 2003; Özmen, Ögel, Aker, Sağduyu, Tamar, & Boratav, 2004a; Özmen et al. 2004b; Özmen, Ögel, Aker, Sağduyu, Tamar, & Boratav, 2005; Sağduyu, Aker, Özmen, Ögel, & Tamar, 2001; Sağduyu, Aker, Özmen, Uğuz, Ögel, & Tamar, 2003;Seyfe Şen, Taşkın, Özmen, Aydemir, & Demet, 2003; Taşkın, Özmen, Özmen, & Demet, 2003a; Taşkın, Seyfe Şen, Aydemir, Demet, Özmen, & İçelli, 2003b; Taşkın, Özmen, Gürlek Yüksel, & Deveci, 2005; Taşkın, Seyfe Şen, Özmen, & Aydemir, 2006; Taşkın, Gürlek Yüksel, Deveci, & Özmen, 2009; Yüce, Savaş, Ersoy, Savaş, & Sertbaş, 2005) . The questionnaires designed by the PREC researchers, included two sets of questions for both depression and schizophrenia case vignettes. One set consisted of questions that related to a case vignette in which the symptoms were described but the mental illness type was not given. The other set included questions that stated the type of mental illness regarding the case vignette. The items regarding the vignettes assessed recognition, perceptions and causal attributions, opinions and beliefs about treatment and help-seeking behavior, attitudes and desired social distance regarding the condition presented in the case vignettes. The questionnaires have been administered to samples from urban and rural areas, health school and nursing students so far.

3.1.2.2.Qualitative and Combined Methods

In the rare pool of qualitative methods used in the stigma of mental illness field those studies we found had children and adolescent samples using qualitative methods like projective drawings, storytelling, semi-structured interviews in children and adolescents (Timlin-Sclera et al., 2003; Wahl, 2002). One interesting study was Rose, Thornicroft, Pinfold & Kassam's (2007) study in which they asked middle school students what

[1] Psikiyatrik Araştırmalar ve Eğitim Merkezi (PAREM)
[2] Ruhsal Hastalıklar İle İlgili Halkın Tutumunun Araştırılması (RUTUP)

sorts of words or phrases they would use to describe someone who experiences mental health problems. Using a grounded theory approach they grouped the terms according to their connotative and denotative meanings and derived six themes. In order of frequency these themes were: popular derogatory terms, negative emotional state, physical disabilities and learning difficulties, psychiatric diagnoses, and terms related to violence. They argued that the reason why they approached stigma with such a method by the pre-structured nature of vignettes and scales that could constrain what participants can express

Another interesting study used a combination of qualitative and quantitative methods. Littlewood, Jadhav, & Ryder (2007) reviewed what they called two general research procedures, one being an anthropological approach using ethnographic methods and the other being a sociological approach using quantitative survey methods, in studying stigma of mental illness. They argue the important role of the former approach referring to the multi-layered and broad origin and function of stigma and also making a point on using a measure that takes into account the terms and understandings of the population rather than psychiatric terms which might be unknown or have different meanings. Using an ethnographically grounded approach they reviewed a repertoire of questions/propositions regarding stigma, ethnographic and historic accounts on mental illness, anthropological studies, and questions used in previous research, and devised a 26 item, Likert-type questionnaire.

Considering the arguments regarding the methodological reasoning presented in these studies, I was interested in using some of the methods in this study.

3.2.Some Evidence on Stigma Research

3.2.1. Testing Theoretical Models

3.2.1.1.Labeling Theories

Empirical studies have investigated the effects of the labeling as mentally ill or mental patient. Phillips' (1966) study indicated that

designating a behavioral description with a "ex-mental patient" label was associated with higher levels of stigmatization and desire for social distance, which was used as a demonstration for *primary labeling theory.* However, later studies showed minimal influence of labeling of mental hospitalization. These results were replicated in some recent studies on university students as well (Hill, 2005; Mann & Himelein, 2004). However studies also demonstrated that when participants believed in an association between dangerousness or violence with mental illness, the labeling predicted higher desires for social distance (in Hinshaw, 2007).

Turkish studies regarding the effect of labeling of mental illness are complicated by the fact that two terms has been widely used for mental illness both among scientific communities and in daily life: "akıl hastalığı" and "ruhsal hastalık". The word "akıl" in the former term refers to words that can be translated as mental, mind, intellect, reason whereas "ruhsal" in the latter term refers to words that can be translated as mental, spiritual, psychological, psychical, soul related. Although the latter term seems to be in more frequent use among scientific communities and mental health professionals, there is no consensus on one term. In the public domain in addition to these two terms another third term "sinir hastalığı" is also used in which the word "sinir" translates into words such as nerve, temper. On Savaşır's (1971b) accounts this term was mostly used in the rural areas. Three of the terms seem to be in use with different meaning attributed to them however no study has been conducted in this area (Özmen, Taşkın, Özmen, & Demet, 2004). Though there are study results that indicate the label "akıl hastalığı" is associated with greater desires for social distance and the belief that treatment is necessary for a case description with no symptomatic behavior however since the sample consisted of medical students the results are not generalizable (Sarı, Arkar, & Aklın, 2005). Only one study was found which compared the effects of both terms. Özmen et al.(2004) found that overall health school students who described a case description (in this study depression and schizophrenia) "akıl hastalığı" was associated with more negative attitudes, greater desire for social distance,

more severe illnesses and conditions that require more intensive treatment and a psychiatrist when compared to “ruhsal hastalık.” “Akıl hastalığı” was used more frequently to describe schizophrenia case compared to the depression case.

Empirical studies have also investigated the effects of using specific diagnostic labels. Most of the studies involve case descriptions of symptoms of depression and schizophrenia comparing the descriptions with and without the respective diagnostic label. Studies conducted in other countries as well as Turkey indicate results that when given the specific diagnostic label along with or without a non-symptomatic or symptomatic case description negative attitudes and desired social distances are higher compared to responses regarding a non-symptomatic or symptomatic case description without any labeling (Akdede et al., 2004; Angermeyer & Dietrich, 2006; Sağduyu, Aker, Özmen, Uğuz, Ögel, & Tamar, 2003) .

Interestingly however, studies that use methodologies which explore how people label mental illness and what kinds of labels they use were rare. Rose et al. (2007) study was one of the recent and rare studies that investigated labeling without using a pre-structured approach. Their results demonstrated 250 labels most frequently used by middle school students that described people with mental health problems and derived six themes from these labels (popular derogatory, negative emotional state, physical disabilities and learning difficulties, psychiatric diagnoses, violence and isolation/loneliness). In another recent study Nordt, Rössler, & Lauber (2006) provided participants with a list of words (stereotypes) and asked the participants to rate each word on a 5 point likert-scale with respect to how much the word described a mentally ill person. They were able to derive five factors : 'social disturbance', 'dangerousness', 'normal healthy', 'skills' and 'sympathy' .

3.2.1.2.Recent Conceptualizations of Stigma

Most recent empirical studies on the stigma of mental illness have started testing theory-based models of stigmatization which mostly used two

major conceptualization s by Link & Phelan (2001) and Corrigan & Watson (2002) which were discussed earlier.

In Angermeyer & Dietrich's (2006) review of stigma of mental illness studies conducted on population samples, there were studies found that investigated the association between stereotypes and discrimination. Dangerousness and unpredictability were stereotypes mostly associated with social distance for schizophrenia, individual level of discrimination. A similar result was demonstrated by Savaşır (1971b) for mental illness ("akıl hastalığı"). A research in German public also demonstrated that a stereotype blaming the person with mental illness for the cause of the condition was associated with an approval of restriction financial resources, in other words social discrimination (in Angermeyer & Dietrich, 2006). Regarding the third type of discrimination suggested by Link & Phelan (2001) self-stigmatization, Ritsher, Otilingam & Grajales (2003) devised a new measure called the Internalized stigma of mental illness scale [ISMI], which also has a Turkish version (Ersoy & Varan, 2007).

A German study demonstrated that schizophrenia elicits stereotypes of dangerousness and unpredictability, emotional reactions of fear and aggression, and increased desire for social distance, however presentation of depression did not have significant results (in Angermeyer & Dietrich, 2006). Although this study shows association between these variables suggested by Link and Phelan (2001) there is no evidence for the linear relationship. This problem was partly handled in Corrigan et al. (2001) study which supported Corrigan & Watson (2002) conceptualization of stigma. They demonstrated a relationship between personal variables (familiarity with mental illness and belongingness to an ethnic group), prejudicial attitudes (authoritariatnism and benevolence) and "proxy measure of behavioral discrimination" using path analyses. Personal variables influenced the two forms of prejudice, authoritarianism (belief that mentally ill individuals are unable to take care of themselves and that a health care system is responsible for their care) and benevolence (belief that mentally ill individuals are childlike and naïve) which were measured by the

OMI scale. If individuals were familiar with mental illness or belonged to an ethnic group there was less incidence of the two forms of prejudicial attitude. These forms of prejudice in turn a influenced social distances measured by social distance scales. The presence of these prejudicial attitudes increased the desire for social distance.

More studies are needed to support these theoretical models and to test other possible models.

3.2.2. Recognition of Mental Illness

A brief review of studies involving case vignettes both worldwide and in Turkey overall demonstrate that schizophrenia is recognized as a mental illness (Aker et al., 2002; Hill, 2005; Özyiğit et al., 2004; Sağduyu et al., 2001) and in some studies when compared to depression, schizophrenia is more likely to be recognized as a mental illness (Angermeyer & Dietrich, 2006; Eşsizoğlu & Arısoy, 2008; Hill, 2005; Link et al., 1999). Some studies in Turkey suggest that there is an under-recognition of depression especially in rural populations (Eşsizoğlu & Arısoy, 2008; Seyfe Şen, 2003; Taşkın et al. 2006) In a Turkish study there was a significant difference in recognizing a condition as "ruhsal hastalık" and "akıl hastalığı" in which schizophrenia was more likely to be recognized as "akıl hastalığı" whereas depression was more likely to be recognized as "ruhsal hastalık" (Özmen et al. 2004b). Other studies using the same questionnaire also demonstrated a recognition of depression as "ruhsal hastalık" in a sample from urban Turkey and among a sample of health school students (Özmen et al., 2003b, 2004a). In these studies accurate recognitions were not associated with lower social distance.

3.2.3. Causal Attributions of Mental Illness

In Angermeyer & Dietrich's (2006) review, vignette studies among general population samples showed a tendency for lay people to emphasize psychosocial factors compared to biological factors. The emphasis was reversed in psychiatric samples. In studies focusing on *mental illness* in

general there were no consistent results. More emphasis on psychosocial factors over biological factors was more relevant to depression than schizophrenia. In cases where diagnostic labels were given psychosocial factors were emphasized in depression whereas biological factors were emphasized in schizophrenia.

The emphasis on psychosocial factors as causes for depression is also demonstrated in Turkish studies conducted among health school students, nurses, psychiatry clinic applicants as well as urban and rural areas of Turkey (Eşsizoğlu & Arısoy, 2008; Özmen et al., 2003b, 2004a; Seyfe Şen et al., 2003; Taşkın et al., 2009). Depression was also believed to be caused by weakness of personality by health school students and by urban sample (Özmen et al., 2003b, 2004a). Contrary to Angermeyer & Dietrich's (2006) review Turkish studies demonstrated an emphasis on social problems, stressful life events and weak personality as causes for schizophrenia both in rural and urban samples (Sağduyu et al., 2001, 2003). These results are parallel with results from a German study which demonstrated only 33% of accurate causal attributions regarding schizophrenia (Gaebel et al., 2000).

An interesting argument with regards to the association between causal attributions and stigmatization is that there is no one-to-one linkage as Hinshaw (2007) argues. Speaking from both a historical and empirical standpoint both moral models and biomedical models may induce intolerance and punishment as well as compassion. Hinshaw argues that for moral models the determining factor of tolerance or stigmatiziation is the underlying assumptions and practices regarding human nature. Whereas for biomedical models, those that emphasize a qualitative difference between individuals are more inclined to distance and exclude, whereas a quantitative view of difference is more likely to elicit compassionate and tolerating responses. For positive responses he argues for a belief in the interaction of psychosocial and psychobiological factors. Reductionist views may lead to stigmatizing attitudes. Regarding the research evidence

provided on causal attributions a more reductionist view emphasizing on social problems is notable especially in Turkish samples.

3.2.4. Opinions and Beliefs on Treatment and Help-Seeking Options

Studies on general population samples overall have an optimistic view if treatment is possible but have a pessimistic prognostic view if treatment is absent. Also case vignette studies demonstrate a tendency towards psychotherapy as a preferred treatment and negative views about psychopharmacological interventions (Angermeyer & Dietrich, 2006).

In studies overall depression was believed to be treatable and psychosocial interventions were emphasized as treatment options. For depression especially if diagnostic labels are given psychosocial interventions are favored over psychopharmacological interventions (Angermeyer & Dietrich, 2006). Similarly in Turkish samples psychosocial interventions were more favorable among health student, nurse, urban and rural samples (Eşsizoğlu & Arısoy, 2008; Özmen et al., 2003b, 2004a, 2005; Seyfe Şen, 2003). In the urban sample study an overall negative view of drug treatment was observed (Özmen et al., 2004a) similar to Angermeyer & Dietrich's (2006) review results.

Schizophrenia is believed to have worse prognosis compared to depression (Angermeyer & Dietrich, 2006; Imran & Haider, 2007). In a Turkish sample, however, 60% of those who recognized schizophrenia as a mental disorder considered the condition treatable (Sağduyu et al., 2001) whereas 25% of the sample believed it cannot be completely treated. Medication is believed to be a necessary treatment option especially when the diagnostic label is given (Angermeyer & Dietrich, 2006; Gaebel et al., 2000). However in a Turkish study psychotherapy was a more favorable option compared to pharmacotherapy, with negative views on durgs (Sağduyu et al., 2001).

Overall a notable tendency of negative and inaccurate beliefs and opinions towards pharmacotherapy both for depression and schizophrenia exist, especially in Turkish samples.

With regards to opinions about help-seeking behaviors Angermeyer & Dietrich (2006) found inconsistent results among general population sample studies however also observed tendencies. If mental disorders were recognized there was more willingness to seek help from a psychiatrist.

Contrary to Angermeyer & Dietrich's (2006) review of studies on general population samples which demonstrated a tendency to seek help from a general physician for depression and psychiatrist for schizophrenia; in Turkish samples a tendency to seek help from a physician, preferably a psychiatrist was observed for both depression and schizophrenia studies (Özmen et al., 2004a, 2005; Seyfe Şen, 2003; Sağduyu et al., 2001). In a rural sample however half of the participants reported that they would not seek help for depression however would consider seeking help from a psychiatrist in a schizophrenia condition (Savaş, Yumru, Göral, & Özen, 2006).

Some results also indicate an association between opinions and beliefs on help-seeking options and stigma. Studies that used case vignettes with or without designations of a treatment history demonstrated a more negative response toward the vignettes designated with mental health treatment (Ben-Borath, 2002) .

3.2.5. Attitudes and Social Distance

In majority of the studies participants from general population samples believed that unpredictability was a frequent attribution especially regarding schizophrenia (Angermeyer & Dietrich, 2006). In Savaşır (1971b) study including rural and urban samples the most frequent description for mental illness was "unpredictable" and "aggressive." Dangerousness and violence was less frequent compared to other attributions however it was more frequent for schizophrenia compared to depression (Angermeyer & Dietrich, 2006; Imran Haider, 2007; Sağduyu et.al., 2001). These beliefs

were associated with increased desire for social distance (Phelan & Basow, 2007)

Overall desired social distance increased as level of intimacy increased (Angermeyer & Dietrich, 2006; Gaebel et al., 2000) ,if diagnostic labels were given for case vignettes (see empirical evidence for labeling effects), and if type of mental illness described as a stimulus was more severe.

Desired social distance toward schizophrenia cases were high (Taşkın et al., 2003b) and more than depression cases (Angermeyer & Dietrich, 2006, Nordt, Rössler, & Lauber, 2006). Hesitant attitudes about acceptance with regards to depression cases were observed in Turkish studies (Özmen et al., 2003b, 2004a) and this attitude was more severe in rural areas (Seyfe Şen et al., 2003; Taşkın et al., 2006).

One interesting finding was that psychiatry clinic applicants had more positive attitudes toward depression whereas those who were going through a depressive episode had more negative attitudes (Taşkın et al., 2009).

3.2.6. Factors Associated with Stigma of Mental Illness

A. *Type of Mental Illness and Treatment*

As it has been mentioned in previous sections, there is empirical evidence that responses vary according to the type of mental illness. In most studies in most communities and countries schizophrenia cases were associated with higher rates of recognition of mental illness, attributions of dangerousness and unpredictability, opinions and beliefs regarding worse prognosis, greater social distance and overall more negative attitudes. However a contrary observation was made in a study that compared attitudes of samples from Tokyo and Bali, in which Balinese people responded with more positive attitudes toward schizophrenia but less toward depression compared to people in Tokyo (Kurihara, Kato, Sakamoto, Reverger, & Kitamura, 2000). It remains that various mental disorders elicit

different responses however these responses might not be universal and vary across cultures.

A stimulus involving a various indications and types of mental health treatment history specially hospitalization or psychiatric intervention also elicit various responses, in most cases more negative attitudes and greater desire for social distance (Chung, Chen, & Liu, 2001)

B. Cultural Factors

Cross-cultural studies regarding stigma of mental illness have demonstrated commonalities as well as major variations in responses to mental illness and mentally ill individuals (Gellis, Huh, Lee, & Kim, 2003; Kurihara et al., 2003; Ng, 1997). These studies suggest that stigma is a universal and global issue however it is also culture-specific thus it should be studied in consideration to socio-cultural contexts for its different origins, functions, meanings and consequences. Küey (1995) argues the necessity for more qualitative approaches in studying cultural factors in association with stigma and mental illness which should focus on: some culture-specific mental illnesses, impact of cultural factors on universal illnesses and cultural norms that define "normality" and "abnormality".

C. Socio-demographic Factors

With the assumption that attitudes are formed throughout development, socio-demographic factors that are known to be related to development such as age, gender, socioeconomic status, ethnical background, place of residency, are investigated for a possible relationship with stigma. However studies so far show little evidence for such strong association.

D. Age

Angermeyer & Dietrich (2006) observed inconsistent results on association between age and mental illness attitudes. While some research demonstrated a tendency for more negative attitudes at older ages (see also Gaebel et al., 2000), some research results were inconclusive. Nordt et al.'s (2006) study demonstrated that young participants had more stereotypes.

Turkish studies also demonstrate inconsistent results (Aker et al., 2002; Özmen et al. 2004a; Özyiğit et al., 2004; Karancı & Kökdemir, 1995).

E. Gender

Investigations on associations between gender and attitudes toward mental illness have also provided inconsistent results. Some studies have found no association, some demonstrated association between being a male and having negative attitudes (Mann & Himelein, 2004; Wang et al., 2007) whereas some demonstrated an association for being a female (Angermeyer & Dietrich, 2006; see also Chung, Chen & Liu, 2001). Adolescent studies demonstrate more obvious results such as less tendencies for help-seeking behaviors in male adolescents (Chandra & Minkovitz, 2006; Timlin-Sclera et al., 2003). Similar inconsistent results were found in Turkish studies (Aker et al., 2002; Ay, Save, & Fidanoğlu, 2006; Berksun & Birdoğan, 2002; Savaş et al., 2006). Farina (1981) suggests that men and women have similar feelings and attitudes however behave differently toward the mentally ill; women behave in more benign and favorable ways.

F. Education levels

Higher education levels were found to be associated with less tendency to blame the individual for mental illness and more willing to advise psychosocial interventions, however with regards to attitudes no consistent outcomes were observed (Angermeyer & Dietrich, 2006). In Turkish studies higher education level was associated with more accurate help seeking opinions and opinions on treatability (Savaş et al., 2006), with an emphasis on social problems for etiology of schizophrenia (Kaya & Ünal, 2006), with more positive treatment options for depression (Özmen et al., 2005) and lower education levels were associated with more negative attitudes toward schizophrenia (Sağduyu et al., 2001).

The influence of education status within certain field of study, especially for medical, health school and nursing students were investigated. An Australian study found no difference between third year and graduate pharmacy students with regards to attitudes toward severe depression and schizophrenia (Bell, Johns, & Chen, 2006). Research on first or second year

and sixth year (senior) medical students in Turkish medical faculties demonstrated an overall more positive attitude toward schizophrenia and depression (Ay, Save & Fidanoğlu, 2006) and more positive attitudes measured by lower OMI scores (Berksun & Birdoğan, 2002). However Gürlek Yüksel & Taşkın's (2005) review of studies conducted with physicians and medical students revealed inconsistent results considering the impact of psychiatry internship between first or second and sixth year. It is suggested in this review that the improvement of attitudes in higher classes could be related to personal factors and that the improvement in knowledge after psychiatry internship is only temporary due to a biologically oriented training.

G. Different educational and professional backgrounds

A brief review of research that focus on comparisons between specific professional groups and general public attitudes also yield inconsistent results. One study found less rejecting attitudes among medical and dental students compared to social science and engineering students (Chung, Chen, & Liu, 2001). In one of the two studies conducted by same authors, mental health professionals in Switzerland had more negative stereotypes than general public but did not differ in social distance attitudes (Nordt, Rössler, & Lauber, 2006). In the other study the stereotypes did not differ (LAuber et al., 2006). In Turkish study results physicians had negative tendencies in attitudes and opinions about treatment and prognosis, were able to recognize mental illness however fail to accurately diagnose the condition and offer sufficient or appropriate treatment. Varying results were observed with regards to comparisons of social distance among physicians and public(Gürlek Yüksel & Taşkın, 2005). Üçok, Polat, Sartorius, Erkoç, & Ataklı (2004) concluded that psychiatrists in Turkey shared some of the public attitudes toward schizophrenia.

Overall in studies that compared medical residents and psychiatry residents or general nurses and psychiatry nurses, psychiatry residents and nurses were more likely to demonstrate positive attitudes (Bostancı & Aştı, 2004; Chin & Balon, 2006; Eşsizoğlu & Arısoy, 2008).

Some studies demonstrate an association of mental health related education, internship, and more positive attitudes toward mental illness whereas some studies don't. This might be considered as an inconsistency however those studies which have demonstrated a difference between specialty/education with regards to attitudes toward mental illnesses have not been able to clearly demonstrate whether if the effects were due to education or experience Studies that show no association with education and attitudes suggest that the methods of education may not be enough to improve social distance and attitudes toward people with mental illness whereas those studies that suggest an association could be influenced by experiential factors or personal factors.

H. Place of residency – Urban and rural

With regards to place of residency, urban versus rural, some associations were found inTurkish studies. In one of the earliest studies on mental illness and stigma Savaşır (1971a) compared samples from urban and rural areas. He demonstrated significant differences in causal attributions, prognosis, opinions on help-seeking options and recognition of mental illness in general. Overall people living in the rural areas had more inaccurate understanding of mental illness however people living in both urban and rural areas attributed aggression and unpredictability to mental illness and demonstrated fearful, isolating reactions.

One study compared various cities in Turkey and found significant differences with regards to opinions and beliefs about and attitudes toward schizophrenia (Aker et al., 2002). Other studies have compared samples from a rural and urban area for depression and suggested that the samples from rural areas demonstrated a tendency to under-recognize depression as an illness, emphasized social problems with regards to etiology and treatment, increased desire for social distance and more negative attitudes overall (Özmen et al., 2003b, 2004a, 2005; Seyfe Şen et al., 2003; Taşkın et al., 2006).

I. Socioeconomic status, work experience, marital status, parental education

Among Turkish studies there were only a few studies found which demonstrated significant associations between socioeconomic status (higher income level associated with causal attribution regarding social problems ;lower socioeconomic status associated with negative attitudes toward schizophrenia) (Kaya & Ünal, 2006; Sağduyu et al., 2001), work experience (working status among nurses were associated with positive attitudes toward schizophrenia) (Özyiğit et al., 2004), marital status (married participants more likely to express working with a person in depression) (Taşkın et al., 2006). There were no studies found that demonstrated an association between parental education and attitudes toward mental illness.

J. Exposure to mental illness

In half of the studies reviewed by Angermeyer & Dietrich (2006) history of or contact with mental illness was positively associated with positive attitudes, however in the other half of studies no association was found.

Turkish studies conducted with outpatient samples demonstrated greater knowledge about depression and treatment compared to public, more positive attitudes toward depression. However if patients were in a depressive episode during the study they showed more negative and pessimistic attitudes toward depression (Taşkın et al, 2005, 2009).

Among medical students and residents contact with a mentally ill person especially within the family has been associated with less rejecting attitudes (Ching & Balon, 2006; Chung, Chen, Liu, 2001). In Turkish studies contact with a mentally ill person was associated with decreased desire for social distance among primary physicians (Aker et al., 2002), more positive attitudes toward schizophrenia among medical students (İkiışık, 2008) and nurses (Özyiğit et al., 2004). However people who had schizophrenia in their family were not familiar with an accurate understanding of the terminology (Sağduyu et al., 2003).

3.3.Research Suggestions

Considering a brief review of research on stigma and mental illness it can be suggested that stigma among various age groups including children needs further investigations. There is also the need to use or devise non-vignette approaches as well as experimental methods. A wider use of qualitative methods and perhaps combined methods also seems like a necessity considering that stigma has been argued to have a multi-layered and complex conceptualization. Among the multi-layered origins and functions of stigma, the structural layer as well as the emotional aspect of the individual and social layer seems to be the understudied areas (Link,et al., 2004; see also Angermeyer & Dietrich, 2006). There is also a need for trend analyses and longitudinal studies in order to investigate the development of stigmatizing views and behaviors over time. More studies should compare various communities, regions, ethnic groups within and between countries.

4. CURRENT STUDY AND PURPOSE

In this study I wanted to investigate stigmatization among university students studying in some various universities. Considering the conceptualizations regarding stigma, evidence from previous research on stigma and mental illness and suggestions for further research which I discussed earlier I wanted to take a combined, multi-method approach in order to look at some of the multiple layers of the origins and functions of stigma.

My multi-method approach involved qualitative and quantitative methods which assessed attitudes and intended behavioral reactions toward mental illness through various channels: 1. Exploration of labeling of a person with mental illness, 2.Investigation of reactions in terms of opinions and beliefs, expressed intended behaviors toward case vignettes describing depressive and schizophrenia symptoms. By using both methods I aimed at

investigating attitudes and expressed intended behaviors as well as factors associated with stigma of mental illness.

The first channel of this study, exploration of labeling, was based on Rose et al.'s (2007) methodological approach. I wanted to explore of how university students labeled people with mental illness in words, terms or phrases and what possible key themes could be derived from these. My first aim was to explore the frequency of words, terms and phrases used in describing a person with mental illness and derive key themes. To my up to date knowledge, Rose et al. (2007) is the only study using this methodology for studying stigma and mental illness, thus I was unable to form specific hypotheses. However from previous research on labeling, stereotypes and attitudes toward mental illness I expected some tendencies involving a frequent use of: Popular derogatory terms and terms referring to violence, aggression, dangerousness and unpredictability. I also expected some use of: Psychiatric or diagnostic terms as well as words expressing sympathy.

Expanding on Rose et al.'s (2007) study I wanted to make a distinction between the labels associated in reaction to a person with mental illness and labels that are expressed to be used when describing a person with mental illness in daily social encounters. I wanted to search for any distinctions between attitudes and expressed intended behaviors in terms of labeling.

Considering the risk of a social desirability bias I used an adaptation of approaches used by Link & Cullen (1983) and Savaşır (1971a). In order to see if a social desirability bias was present I also asked the participants the labels that others use in describing a person with mental illness. If such a bias was present I expected a difference in responses to this question. The presence of such a distinction would suggest a tendency to disguise the use of stigmatizing labels and projecting the use to others.

The second level of investigation for this study involved an assessment of university students' reactions through methods that would allow comparisons with previous research. Thus I aimed to assess recognitions, perceptions, causal attributions, opinions and beliefs on

treatment and help-seeking behavior, attitudes and desired social distances through a survey method involving case vignettes describing two specific mental illnesses: major depression and paranoid-type schizophrenia. Considering results from previous research, with regards to opinions and beliefs I expected:

- The cases described in vignettes to be recognized as mental illness;
- Considering the different use of terms for mental illness in Turkish, the case describing paranoid-type schizophrenia to be recognized as "akıl hastalığı" more than the case describing major depression;
- The causal explanations of the symptoms presented in case vignettes to have an emphasis on social factors for depressive symptoms and biological factors for schizophrenia symptoms;
- Both case vignette conditions to be viewed as treatable;
- Worse prognosis for schizophrenia when compared to depression;
- Psychosocial treatment options to be more preferable for depressive symptoms and psychopharmacological options more preferable for schizophrenia;
- The opinions and beliefs about help-seeking behavior regarding the condition in the case vignettes to suggest an emphasis on going to a mental health specialist.

With regards to attitudes and desired social distances, I expected:

- Greater desire for social distance as level of intimacy increases;
- Greater desire for social distance in reaction to the case in paranoid-type schizophrenia case vignette compared to the major depression case vignette;
- An overall more stigmatizing attitude toward the paranoid-type schizophrenia condition compared to the major depression condition.

Considering the two methods I used in my investigation, I also wanted to look at and discuss the differences and similarities associated with the results obtained from both methods. A difference in results would suggest the significance of the influence of using a particular methodology.

Finally my aim was to look at factors associated with both the usage of words, terms and phrases that fall under specific themes and with perceptions, causal attributions, opinions and beliefs on treatment, attitudes and desired social distances regarding major depression and paranoid-type schizophrenia, through quantitative methods. Considering the evidence from previous research discussed I expected:

- Differences influenced by the type of mental illness, depression and schizophrenia in this study;
- With regards to education status, students attending higher grades have less stigmatizing attitudes toward the mentally ill;
- With regards to area of study, psychology students to have less stigmatizing attitudes toward mental illness;
- Those students who have a history of mental illness or treatment to be less stigmatizing
- Those students who have had a contact with a mentally ill person to be less stigmatizing

Although inconsistent results were found in previous studies regarding gender, socioeconomic status, place of residency, and no study found with regards to parental education; these variables were included in this study for investigation.

Age was not included as a variable since the age range was restricted among university students.

5. METHODS

5.1.Participants

This study was carried out with Turkish university students studying mostly in Istanbul (*n* = 305) and a few in Ankara (*n* = 15) (Bilgi University, Bahçeşehir University, Istanbul Technical University, Yeditepe University, Ufuk University, Gazi University, Ankara University). A convenient sample of 322 first, second, third and fourth year students completed the self-report questionnaires on a voluntary basis during their class hours. Two incompletely filled out questionnaires were excluded, thus the sample size for this study was 320. One of the aims of our study was to evaluate the impact of psychology undergraduate education on labeling of and attitudes toward mental illness. In order to achieve this goal we attempted to match the numbers of psychology (*n* = 143) and non-psychology (*n* = 174) (three of the participants did not report their majors) students from various fields of study (engineering, business, law, sociology, international relations, history, mathematics, political science, international trade, statistics, adverstising, archeology, economics, sports management) in our sample.

5.2.Instruments

The data for this study were collected by a nine-page compilation of five different questionnaire forms. The questionnaires assessed the participants' sociodemographic characteristics, exposure to mental illness and treatment, descriptions and ratings of self-identification on various identity dimensions, labels they associate with and use for people with mental illness,and opinions, beliefs about and attitudes toward persons with depressive and schizophrenic symptoms. I translated and used the term "mental illness" as "ruhsal rahatsızlık" since it is a more contemporary and more widely used term among scientists and mental health professionals. Also as discussed previously, this term was demonstrated to be associated with less stigmatizing denotation when compared to the other possible translation of mental illness, "akıl hastalığı" (Özmen et al., 2004).

The first page of the questionnaire included basic information about the questionnaire and principles of privacy. In order to avoid priming effects we did not give any details about the content of the questionnaire except that the study was about approaches to mental health issues.

5.2.1. Sociodemographic Questionnaire

The first questionnaire was the "Sociodemographic Questionnaire" (Appendix A) which included nine questions, assessing the sociodemograhic characteristics of the participants.

5.2.2. Labeling Questionnaire

The second section included the "Labeling Questionnaire" (Appendix B) which consisted of three open ended questions asking for at least one word, term, or phrase as a response. Writing sentences or explanations were discouraged. This questionnaire was given after the Sociodemographic Questionnaire in order to reduce possible priming effects of the other questionnaires' contents. The purpose of this questionnaire was to explore stigmatizing attitudes through labeling in terms of words, terms and phrases associated with and used regarding people with mental illness. I designed the questions based on the method used by Rose et al. (2007) which was a baseline assessment for an intervention study among middle school students. Their question was: "What sorts of words or phrases might you use to describe someone who experiences mental health problems?" and their study revealed 250 labels used by middle school students. A Turkish version of this question constituted the second item of this questionnaire (question B). This question assessed self-expressed intended behaviors regarding labeling of people with mental illness. In addition I also wanted to explore the associations in terms of labels regarding people with mental illness with the presumption that the labels associated with mental illness could be different from the labels used to describe people with mental illness. I designed a question to respond to this purpose, asking what words, terms or phrases came to mind when thinking of a person with mental illness. I

preferred to ask this question first in order to avoid any priming effects that might bias the associations. Considering the possibility of social desirability bias I included a third question asking the words or terms used by others to describe people with mental illness to investigate any tendencies to disguise stigmatizing attitudes and projecting these to others. Similar approach can also be found in Savaşır (1971a) and Link & Cullen (1983).

5.2.3. Exposure to Mental Illness Questionnaire

There were five close-ended questions in the third section, "Exposure to Mental Illness Questionnaire" (Appendix C), which was designed to assess the extent of exposure to mental illness in various forms. The first two questions asked the participants whether they had a history of mental illness and a history of treatment for their mental illness. If the answers were "yes" to these questions the participants were also asked to report the diagnoses and treatment types. The third question asked the participants whether they had contact with someone who was mentally ill. Those who reported to have had contact were asked to report the type of relationship to that person and type of diagnoses. The other two questions asked the participants to rate the extent of their knowledge on mental health issues and to report the major source of their knowledge.

5.2.4. Self-Identity Questionnaire

The fourth section, called the "Self-Identity Questionnaire" (Appendix D), included 14 identification dimensions in which participants were asked to write words or phrases they use to describe themselves for each dimension in an open-ended question format and rate each dimension on a scale of 0-6 (0 = *I do not find this dimension important, I do not even consider this condition when describing myself*; 6 = *I find this dimension very important, I always consider it when describing myself*). I designed this questionnaire in order to assess self-identification using both qualitative and quantitative methods and investigate the extent of complexity and multiplicity of self-identities with regards to various dimensions.

5.2.5. Attitudes toward Depression and Schizophrenia Questionnaires

The fifth section consisted of two questionnaires which were adapted from questionnaires designed to rate attitudes toward depression and schizophrenia by the Center for Psychiatric Research and Education (CPRE)[3] for a project called "Searching Public Attitudes Toward Mental Diseases[4]" . The questionnaires designed by the CPRE researchers, included two types of questions: 1. Questions that refer to a case vignette describing a specific mental illness condition without the diagnostic term, 2. Questions that refer to a case vignette describing a specific mental illness condition with the diagnostic term provided. In our study we included the first set of case vignettes and related items in order to assess attitudes toward depression and schizophrenia. Our aim in including these questionnaires was to investigate stigmatizing attitudes by assessing recognitions, perceptions, causal attributions, opinions and beliefs on treatment and help-seeking behavior, and desired social distance in reaction to a major depression and paranoid-type schizophrenia condition. The first part of this section included a case vignette describing a female who met DSM-IV diagnostic criteria for major depressive disorder. The second part included a case vignette describing a male who met DSM-IV diagnostic criteria for paranoid-type schizophrenia. Following each case vignette, 22 items were given (Appendices E and F). Sixteen of these 22 items were the same as it was in the original questionnaire. The original questionnaire included 18 items related to the case vignettes. These items focused on opinions and beliefs in terms of definition (one item), causal attributions (four items), treatment (four items), help-seeking (two items) and on attitudes in terms of social distance (seven items). I added five items to the original set of 18 items, including items focusing on opinions and beliefs in terms of causal attribution (items 6, 7, 8) and treatment (items 19, and 20). Items regarding genetic, biochemical and childhood development as possible causal factors

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[3] Psikiyatrik Araştırmalar ve Eğitim Merkezi (PAREM)
[4] Ruhsal Hastalıklar İle İlgili Halkın Tutumunun Araştırılması (RUTUP)

as well as drug therapy and psychotherapy as possible treatment options were absent in the original questionnaire and found necessary to be added in consideration to previous research. I eliminated one item from the original set which assessed the preferred type of doctor to consult for the individual described in the case vignette with the argument that this question would limit responses involving psychologists, psychotherapists. Referring to this problem I inserted a choice of "he/she should first see a mental health specialist" for the item assessing preferences for help-seeking (item 22). The first and 22nd items were multiple-choice type questions. Twenty items were Likert-type items which were asked to be rated as "I agree", "I slightly agree", "I slightly disagree", "I disagree", and "I have no idea".

5.3.Data Collection

5.3.1. Pilot Study Process

Fifty Bilgi University students were recruited from second year psychology students who responded to announcements during class hours. During the announcements they were told that they would receive extra credit for their participation. They filled out the forms during or at the end of their class hours. As a result of an overview of the responses two questions about the extent and source of knowledge about mental illness was slightly changed. For the question asking for the amount of knowledge on mental health problems, the choices were increased to five from four choices. For the question asking the source of knowledge gained about mental health problems an instruction directing the participants to choose only one answer was added. In spite of the addition to this instruction high frequency of responses included more than one choice of answers. For this reason only the descriptive analyses of these questions were included in this study. Since the remaining questions were not altered the data from the pilot study was included in the current study.

5.3.2. Study Process

I contacted various professors, research and teaching assistants, and students in various universities who would be willing to help with the data collection process. I distributed the questionnaires and gave the instructions to those who agreed to help on a volunteer basis. Thus the classes were decided conveniently. The students were briefly informed about on what purpose and by whom the study was being conducted by their teaching assistants or professors. They were told that they would receive extra credits for the class. The questionnaires were distributed to those who were willing to participate and were given time to fill out the forms during or at the end of their class hours. I trained a psychology student from Bilgi University who volunteered to help with the data collection process. She was responsible of overseeing proper following of instructions by the professors, assistants and students and collecting the questionnaires. The data collection process lasted us two months (April – May, 2010). Data were entered into and analyzed using SPSS for Windows Version 16.0 (SPSS Inc., 2007).

5.4. Data Analysis

After entering all the data on SPSS database I conducted the data analysis in two major phases. I first handled the data from the Labeling Questionnaire which consisted of three open-ended questions. I listed all the words, terms and phrases given as responses and looked at their frequencies. Then using a qualitative method of thematic analysis I derived key themes from these labels. I then went back to the database and recoded the responses with the themes each response belonged to. In the second major phase of analysis I conducted statistical analyses using the SPSS program.

5.4.1. Thematic Analysis

The data from the Labeling Questionnaire included a few responses that were in an explanation or sentence format but most of the data consisted of single words, terms and phrases. Responses for each question ranged between one to seven words, terms and phrases. First, I listed all the

responses used for each question. I relabeled some of the responses that were written differently but had the identical meaning. For example the words “in depression” (“depresyonda”) and “depression” (“depresyon”) were considered to be identical. After the relabeling process I tabulated the frequencies of each response for each question separately and for all three questions in total. From these tables I also looked at the total number of responses as well as total number of identical responses, in other words total number of labels produced, for each question separately and for all three questions.

Secondly, using a thematic analysis I grouped all the used words, terms and phrases in terms of their denotative meaning into key themes. On the first level of categorization 12 themes and on the second level of categorization six themes emerged (Table 1). I used the categories that emerged on the second level on my further analyses.

Table 4 Thematic categories emerging from all the words, terms and phrases used

Level 1	Level 2
General & specific psychiatric & psychological Health, ill health & disability related	MEDICAL
Associated with behavioral symptoms Associated with cognitive symptoms Associated with emotional symptoms	SYMPTOM RELATED
Personal & social problem related	PERSONAL & SOCIAL PROBLEM RELATED
Compassion & pity related	COMPASSION/PITY RELATED
Associated with normalization & denial	ASSOCIATED WITH NORMALIZATION/DENIAL
Related to deviance Related to negative personality traits Violence & aggression related Popular deragotary	DEROGATORY

I looked at the number of responses and number of labels under each second level category in total and also for each question separately.

I then returned to the database and recoded the responses according to the themes they belonged. Although some participants gave one word, term or phrase as a response for one question there were participants that gave more than one response. I handled this problem by coding the presence of any one of the six themes as “0 = no” or “1 = yes” under each thematic

category column. The presence of each one of the six categories were coded separately for each question.

5.4.2. Statistical Analysis

All statistical analysis was done by SPSS. Overall, descriptive, chi-square, logistic regression, paired sample t test, and multiple regression analyses were performed.

Descriptive analyses for responses to each questionnaire form were conducted. Paired t test analyses were conducted to compare items (items 2-21) in Attitudes toward Depression and Schizophrenia Questionnaires

In order to perform further analyses I needed to categorize and recode certain variables. I included the responses from the *Sociodemographic Questionnaire* and *Exposure to Mental Illness Questionnaire* as "demographic variables". I categorized and recoded these variables as: gender, male/female; major, non-psychology/psychology; year of study, 1/2/3/4 or more; place of birth, non-big city/big city; place of residency, non-big city/big city; socioeconomic status, low to middle/middle-high to high; work study or paid job, no/yes; mother and father's education; no education to high school degree/university to graduate and above degree; history of mental illness, no/yes; history of mental illness treatment, no/yes; contact with someone mentally ill, no/yes. For the Likert-type items on the case vignette items (items 2-21) I combined "I agree" and "I slightly agree" responses and recoded as "I agree", and combined "I disagree" and "I slightly disagree" responses and recoded as "I disagree". "I have no idea" responses remained without alterations.

Following these categorizations and recodings I conducted chi-square analyses: 1. To explain the associations between responses to three questions in the *Labeling Questionnaire*, 2. To demonstrate associations between demographic variables and each theme for each question as well as each item on depression and schizophrenia case vignettes.

In addition I performed logistic regression analyses to explain the effects of demographic variables on each thematic category of labeling as

well as on recoded Likert-type items of the depression and schizophrenia case vignettes. The demographic variables, as a set of independent variables, were entered into logistic regression analyses at the same time. Each thematic category in each question and each Likert-type item on depression and schizophrenia case vignettes were considered as separate dependent variables. Each thematic category was already coded as “0 = no” and “1 = yes”. The Likert-type items on case vignette items were recoded as “0 = I don’t agree” and “1 = I agree”. “I have no idea” responses were excluded in the logistic regression analyses. The logistic regression analysis, as described here, for the items in Attitudes toward Depression and Schizophrenia Questionnaires was an approach used by CPRE researchers, which I replicated in this study.

In addition to chi-square and logistic regression analyses, in order to explore the effects the demographic variables on social distance I also used another strategy. I performed unpaired t test and multiple regression analyses. I first recoded the seven items about attitudes and social distance on the depression and schizophrenia case vignette sections with regards to the direction of the question so that a higher score meant higher social distance. The range of possible scores on each item was 0-3. If there were more than two “I have no idea” responses within the seven items those data were excluded. Mean scores of social distance were calculated for each included data. First a paired t test was performed to see the relationship between social distance scores of depression and schizophrenia case vignettes. Unpaired t test analyses were performed to see the effects of demographic variables on social distance scores of depression and schizophrenia. Finally multiple regression analyses were conducted to explain the effects of demographic variables in combination with different thematic label categories on social distance scores of depression and schizophrenia.

6. RESULTS

6.1. Descriptive Results

6.1.1. Characteristics of Participants

6.1.1.1. Sociodemographic Characteristics of Participants

Sociodemographic characteristics of the participants which were obtained from the *Sociodemographic Questionnaire* are displayed in Table 2,3, and 4

Table 2. Sociodemographic characteristics of the participants (*N* = 320)

	n	%
Sex		
Female	222	69.4
Male	98	30.6
Major		
Non-psychology	174	54.4
Psychology	143	44.7
Missing	3	0.9
Year		
1	55	17.2
2	103	32.2
3	80	25.0
4	67	20.9
4<	3	0.9
Missing	12	3.8
Birth Place		
Village/Rural	11	3.4
Community district	1	0.3
Town	43	13.4
City	55	17.2
Metropole/big city	210	65.6
Place of Residence		
Village/Rural	3	0.9
Community district	3	0.9
Town	48	15.0
City	31	9.7
Metropole/big city	235	73.4
Socioeconomic Status		
Low	1	0.3
Middle-Low	7	2.2
Middle	133	41.6
Middle-High	149	46.6
High	28	8.8
Missing	2	0.6
Paid Job/Work Study		
Yes	48	15.0
No	272	85.0
Total	320	100.0

Table 3. Parental education levels of the participants

Level of education	Mother *n*	Mother %	Father *n*	Father %
No reading/writing	2	0.6	0	0.0
Reading/writing no formal education	3	0.9	2	0.6
Elementary school	49	15.3	28	8.8
Middle school	25	7.8	21	6.6
High school	124	38.8	71	22.2
University	106	33.1	166	51.9
Graduate/doctoral	10	3.1	31	9.7
M	1	0.3	1	0.3
Total	320	100.0	320	100.0

Table 4. Distribution of class standing among psychology students (*n* = 143)

	n	%
Study year		
1	0	0.0
2	56	39.2
3	47	32.9
4	37	25.9
4<	1	0.7
Missing	2	1.4
Total	143	100.0

The mean age of the participants was 21.5 (*SD* = 1.8) with a minimum age of 18 and maximum age of 28. The females consisted 69% and males 31% of our sample. This was an expected ratio since we aimed to match the numbers of psychology (45%) and non-psychology majors (54%) and since psychology is a major known to have a female majority. This was reflected in our sample in which females consisted 92.2 % (*n* = 130) of all the psychology students in our sample. Approximately half of our sample consisted of first and second year students (49%) whereas the other half consisted of third, fourth and repeating year students (47%). Nearly two thirds of the participants reported to have been born in (66%) or to have been living in (73%) large cities. Among the participants 44% considered themselves to have a low to middle socioeconomic status and 55% to have middle-high to high socioeconomic status. Only 15% of the participants were working at a paid job or in a work study status. According to the participant responses, fathers (62%) had more university or higher degree education than mothers (36%).

6.1.1.2.Characteristics of Exposure to Mental Illness

Information about the participants' history of mental illness and their diagnoses are displayed in Table 5. Twenty-four percent of the sample reported to have had a history of mental illness, among which 84% consisted of mood and anxiety disorder diagnoses. Fifty-five percent (*n* = 42) of the participants who have had a mental illness history were psychology students.

Table 5. Prevalence of mental illness among participants and types of diagnoses

	n	%
Mental Illness History		
Yes	76	23.8
No	244	76.3
Total	320	100.0
	n	%[b]
Diagnoses[a]		
Mood Disorder and/or Symptoms	41	53.9
Anxiety Disorder and/or Symptoms	23	30.3
Schizophrenia and/or Symptoms	0	0.0
Not specified	8	10.5
Other[c]	5	6.6

[a] Some participants have stated more than one type of diagnosis (n = 4)
[b]Percentage of those who have stated to have a mental illness (*n* = 76) [c] Hyperactivity, relational problems, neurosis, paranoia, involuntary tic

Table 6. Treatment of mental illness history among participants and types of treatment

	n	%
Treatment history		
Yes	60	18.8
No	259	80.9
Missing	1	0.3
Total	320	100.0
	n	%[a]
Treatment type		
Psychiatric/Medication	22	36.7
Psychotherapy	20	33.3
Psychotherapy and Medication	9	15.0
Not specified	9	15.0
Total	60	100.0

[a] Percentage of those who have stated to have had mental illness treatment history (n=60)

Participants who have reported to have had a history of mental illness treatment with the types of treatment are shown in Table 6. These participants constitute 19% of the sample and 71.1% (*n* = 54)[5] of those who have reported to have had a mental illness history. Fifty-eight percent (*n* =

[5] A few participants reported to have had a mental illness treatment history but not a mental illness history (*n* = 6)

35) of those who have had a mental illness treatment were psychology students.

Participant information on the extent of contact with mentally ill people are displayed in Table 7. Forty-eight percent of the participants have reported a contact with someone who has had a history of mental illness. Among these participants, 75% had a familial relationship with this person. Also, mood and anxiety disorders constituted 53%, schizophrenia constituted 14% of the diagnoses among the mentally ill people whom the participants have had contact with. Fifty-two percent (n = 77) of those who have had contact with someone mentally ill were psychology students.

Table 7. Presence of and degree of contact with people who have mental illness history and types of diagnoses

	n	%
Contact		
Yes	152	47.5
No	167	52.2
Missing	1	0.3
Total	320	100.0
	n	%[b]
Degree		
Relative	114	75.0
Non-relative/not-specified[a]	38	25.0
Total	152	100.0
	n	%[b]
Diagnoses[c]		
Mood Disorder and/or Symptoms	58	38.2
Anxiety Disorder and/or Symptoms	22	14.5
Schizophrenia and/or Symptoms	21	13.8
Not specified[d]	48	31.6
Other[e]	9	5.9

[a] Non-relative (n = 33), not specified degree of contact (n = 5) [b] Percentage of those who have reported to have had a contact with someone who was mentally ill (n = 152). [c]Some participants have reported more than one type of diagnosis (n = 6). [d] Not specified category includes responses that are not specific regarding the type of treatment (n = 23) and responses that have not reported any diagnoses (n = 25). [e]Alzheimer, addiction, borderline personality disorder, attention deficit, hypochondriasis, personality disorder, conversion, autism.

The sources of knowledge about mental health issues are displayed in Table 8.

Table 8. Sources of knowledge about mental health issues (n = 318)

	n	%
Knowledge source		
Academics	112	35.8
Educational activities	41	12.9
Books	74	23.3
Internet	63	19.8
Media	50	15.7
Social environment	90	28.3
Other[a]	19	6.0

Note. Table demonstrates a "yes" response for each source. Some participants responded to more than one source.

[a] The sources written for the other category were: hospital environment, internship at a hospital or psychiatric service, teachers, psychologists, psychoanalysts, psychiatrists.

6.1.1.3.Self-Identification Characteristics of Participants

The mean scores for the rating section of the *Self-Identity Questionnaire* are displayed in Table 9. Among this study's participants, major and occupation was rated as carrying the most importance on average, in describing oneself. A summary of the results for the section involving self-descriptions on different identity dimensions are reported in Appendix G.

Table 9. Mean rating scores for the importance of different identity dimensions in self-identification

	N	*M*	*SD*
Major/Occupation Self-Identification Rating	313	4.56	1.57
Hobbies Self-Identification Rating	296	4.28	1.56
School Self-Identification Rating	314	4.22	1.55
Gender Self-Identification Rating	314	3.99	1.77
Age Group Self-Identification Rating	314	3.94	1.60
Sexual Orientation Self-Identification Rating	299	3.71	2.05
Role in Family Self-Identification Rating	313	3.55	1.80
Religious Self-Identification Rating	314	3.34	2.24
Citizenship Self-Identification Rating	303	3.32	2.15
Political/Ideological Self-Identification Rating	292	3.29	2.08
Ethnicity Self-Identification Rating	308	3.16	2.15
Cultural Orientation Self-Identification Rating	295	2.82	1.91
Sports Fan Self-Identification Rating	303	2.80	2.37
Townsman Self-Identification Rating	280	2.28	2.01
Other Self-Identification 1 Rating	16	4.50	1.71
Other Self-Identification 2 Rating	8	5.38	0.74
Other Self-Identification 3 Rating	3	6.00	0.00

6.1.2. Labeling of People with Mental Illness

6.1.2.1. Words, Terms, and Phrases

A. Number of responses and labels.

A total of 1562 responses in terms of words, terms and phrases referring to people with mental illness were given by 320 participants for all of the questions in the *Labeling Questionnaire*. When all the identical responses were combined for all three questions, there were a total of 484 different labels (Table 10). The number of labels expressed for each question are shown in Table 10. Number of responses for question A (associated labels in reaction to a person with mental illness) and question C (labels expressed to be used by others to describe a person with mental illness) were nearly identical and higher than the responses for question B (labels expressed to be used to describe a person with mental illness in daily life). However, the number labels for question A was the highest, and question C the least. Thus the variability of labels offered were least for question C.

Table 10. Number of responses and labels for the Labeling Questionnaire

	Number of responses		Number of labels	
	n	%	*n*	%
QUESTION A[a]	549	35,2	244	50,4
QUESTION B[b]	459	29,4	214	44,2
QUESTION C	554	35,4	158	32,6
TOTAL	1562	100,0	**484**[c]	

[a] Three responses which corresponded to two non-identical responses were discarded for this question. [b] One response was discarded for this question. [c] Some words, terms or phrases were used in more than one question thus the total number indicated is not the sum of questions A, B, and C.

B. Most frequently used labels.

Most frequently used words, terms and phrases with their frequencies for all three questions combined are shown in Table 11. Among these responses, a group of labels related to mental or psychological problems, illnesses, and disturbances were used in total of 70 times.

Table 11. Overall most frequently used words, terms and phrases

Labels	*n*
deli	180
hasta	137
rahatsız	96
sorunlu	81
dengesiz/lik	61
manyak	48
psikopat	39
problemli	27
ruh hastası	23
depresyon	18
paranoya/k	18
kafayı yemiş	16
anormal/anormallik	15
sıkıntılı	15
yazık	15
mutsuz/luk	14
yardıma ihtiyaç/muhtaç	14
akıl hastası	13
depresif	13
sinirli	13
agresif	10

Note. A list of all responses can be found in Table H1.

Most frequently associated labels in reaction to a person with mental illness (question A) are shown in Table 12. A group of labels related to psychological and mental problems, illnesses, disturbances were used 17 times for this question.

Table 12. Most frequent labels associated with a person with mental illness (responses to question A)

Labels	n
deli	34
hasta	34
dengesiz/lik	29
rahatsız	20
sorunlu	20
psikopat	13
paranoya/k	11
manyak	9
mutsuz/luk	9
agresif	8
şizofren/i	8
yardıma ihtiyaç/muhtaç	8
anormal/anormallik	7
depresyon	7
sıkıntılı	7
akıl hastası	6
yazık	6
farklı	5
kafayı yemiş	5
problemli	5

Note. For all responses see Table H2..

Most frequent labels that were expressed by the participants for the use of describing a person with mental illness in daily lives (question B) are displayed in Table 13. Psychological and mental problem, illness, disturbance related group of labels were used 28 times.

Table 13. Most frequently expressed labels to be used in describing a person with mental illness (responses to question B)

Labels	n
hasta	42
rahatsız	35
deli	27
sorunlu	26
dengesiz/lik	17
problemli	11
manyak	10
psikopat	8
ruh hastası	7
depresif	6
kafayı yemiş	6
sinirli	6
normal değil/olmayan	5
psikolojik sorunları olan/var	5
yardıma ihtiyaç/muhtaç	5
yazık	5

Note. For all responses see Table H3.

Labels that were expressed most frequently by the participants which suggested to be used by others to describe a person with mental illness (question C), are presented in Table 14. Psychological and mental problem, illness, disturbance related group of labels were used 19 times in question C.

Table 14. Most frequently expressed labels to be used by others in describing a person with mental illness (responses to question C)

Labels	n
deli	119
hasta	61
rahatsız	41
sorunlu	35
manyak	29
psikopat	18
dengesiz/lik	15
ruh hastası	12
problemli	11
depresyon	9
anormal	5
kafayı yemiş	5

Note. For all responses see Table H4

6.1.2.2.Key Themes

All the responses used in the *Labeling Questionnaire* were analyzed thematically as it is discussed in the Methods section. Six key themes emerged: Medical labels, symptom related labels, personal and social problem related labels, compassion and pity related labels, labels associated with normalization and denial, derogatory labels.

A. *Number of responses and labels for each theme*

The response frequencies for each theme when all responses for three questions combined were considered (Table 15). Highest number of responses belonged to the derogatory (34%) and medical (32%) label categories. However, the categories that contained the most number of labels were the derogatory (30%) and symptom related labels (25%) followed by medical labels (20%). Thus most frequent responses and most number of labels were used under the derogatory label category. Although many responses were given that were included under the medical labels theme, the number of labels were lower than number of labels for derogatory labels category. This indicates less variability in labels among medical category compared to the derogatory category.

Table 15. Number of responses and labels for each label theme

	Number of responses		Number of labels	
Label themes	n	%	n	%
Medical	493	31.6	95	19.6
Symptom Related	268	17.2	122	25.2
Personal/Social Problem Related	143	9.2	33	6.8
Compassion/Pity Related	90	5.8	50	10.3
Associated with Normalization/Denial	40	2.6	39	8.1
Derogatory	528	33.8	145	30.0
TOTAL	**1562**	100.0	**484**	100.0

The number of responses and labels for each question in the *Labeling Questionnaire* are presented in Table 16,17, and 18.

The highest number of responses belonged to the medical (29%), derogatory (29%) and symptom related (26%) label categories for question

A. Most labels belonged to the symptom related labels category (31%), followed by derogatory labels category (28%) (Table 16).

Table 16. Response frequencies for question A according to label themes

	Number of responses		Number of labels	
Label themes	n	%	n	%
Medical	159	29.0	54	22.1
Symptom Related	144	26.2	75	30.7
Personal/Social Problem Related	36	6.6	13	5.3
Compassion/Pity Related	40	7.3	21	8.6
Associated with Normalization/Denial	13	2.4	13	5.3
Derogatory	157	28.6	68	27.9
TOTAL	**549**	100.0	**244**	100.0

Note. There were n = 13 missing responses, and three responses were discarded for question A. Discarded labels were "his name is robert paulsen" (n = 1) and labels that could not be read coded as "???" (n = 2).
[a] Some participants have responded with labels that were included also in different label categories thus the total number of participants is not N = 320. [b] The percentages have been calculated according to N=320.

In question B, the highest number of responses belonged to the medical labels (34%) category followed by the derogatory labels (25%) category. However, considering number of labels derogatory (26%), medical (23%) and symptom related (23%) label categories showed similar frequencies (Table 17).

Table 17. Response frequencies for question B according to label themes

	Number of responses		Number of labels	
Label themes	n	%	n	%
Medical	156	34,0	50	23,4
Symptom Related	80	17,4	49	22,9
Personal/Social Problem Related	54	11,8	16	7,5
Compassion/Pity Related	31	6,8	21	9,8
Associated with Normalization/Denial	23	5,0	23	10,7
Derogatory	115	25,1	55	25,7
TOTAL	**460**	100,0	**215**	100,0

Note. There were n = 15 missing responses, and one response was discarded for question B. Discarded label was "welat" (n = 1)
[a] Some participants have responded with labels that were included in different label categories thus the total number of participants is not N = 320. [b] The percentages have been calculated according to N = 320.

Highest number responses given in question C belonged to the derogatory labels category (46%) followed by medical labels category (32%). Most number of labels belonged to the derogatory labels category (42%) followed by medical labels (25%) category (Table 18).

Table 18. Response frequencies for question C according to label themes

Label themes	Number of responses n	%	Number of labels n	%
Medical	178	32.1	39	24.7
Symptom Related	44	7.9	24	15.2
Personal/Social Problem Related	53	9.6	10	6.3
Compassion/Pity Related	19	3.4	14	8.9
Associated with Normalization/Denial	4	0.7	5	3.2
Derogatory	256	46.2	66	41.8
TOTAL	**554**	100.0	**158**	100.0

Note. There were n = 18 missing responses. No response was discarded.
[a] Some participants have responded with labels that were included in different label categories thus the total number of participants is not N = 320. [b] The percentages have been calculated according to N = 320.

B. Most frequently used labels for each theme.

The most frequently used words, terms and phrases for each theme category, overall, is shown in Table 19. The total list of responses given in total and for all three questions in the Labeling Questionnaire according to the themes they belong are presented in Table H5 through H28.

Table 19. Overall most frequently used labels for each theme

Medical	Symptom	Personal/ Social	Compassion/ Pity	Normalization/ Denial	Derogatory
hasta	dengesiz/lik	sorunlu	yazık	(mutlu)	deli
rahatsız	sıkıntılı	problemli	yardıma ihtiyaç/muhtaç	(normal)	manyak
ruh hastası	mutsuz/luk		zavallı		psikopat
depresyon	sinirli		yardım		kafayı yemiş
paranoya/k	bunalım				anormal/anormallik
akıl hastası	asosyal				agresif
depresif	gergin				normal değil/olmayan
psikolojik sorunları olan/var	karışık/karmaşık				çatlak
psikolojisi bozuk/bozulmuş	yalnız/lık				farklı
şizofren/i	buhran/lı				mal
özürlü	çaresiz				garip
psikolojik rahatsız	değişken				tuhaf
ruhsal rahatsızlığı olan birey/kişi/şahıs	endişeli				kafadan kontak
akli dengesi yerinde değil/olmayan	içe/içine kapanık				kıskanç
panik atak	kararsız				saldırgan
sinir hastası	kaygı/lı				sıyırmış
engelli	takıntılı				uçuk
psikolojik rahatsızlığı olan/bulunan/var	tutarsız				arıza/lı
rahatsızlığı var/olan	umutsuz				değişik
ruhsal sağlığı bozuk olan	üzüntü/lü				kaçık
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan					spastik
zihinsel özürlü					tehlikeli
aklı yerinde değil/olmayan					
hastalıklı					
nevrotik					
obsesif					
panik					
ruhsal (olarak) sorunlu					

C. Comparisons between label themes

The comparisons of the number of responses and labels for each question for each label theme are demonstrated in Figure 1 and 2. When comparisons were made within each label category no association was found between derogatory labels in question B and question C (χ^2 (1, N = 297) = 1.7, p <.197) (for all chi-square results see Table I1). This might suggest a tendency to conceal use of derogatory labels in describing people with mental illness in daily life and to project the use to others.

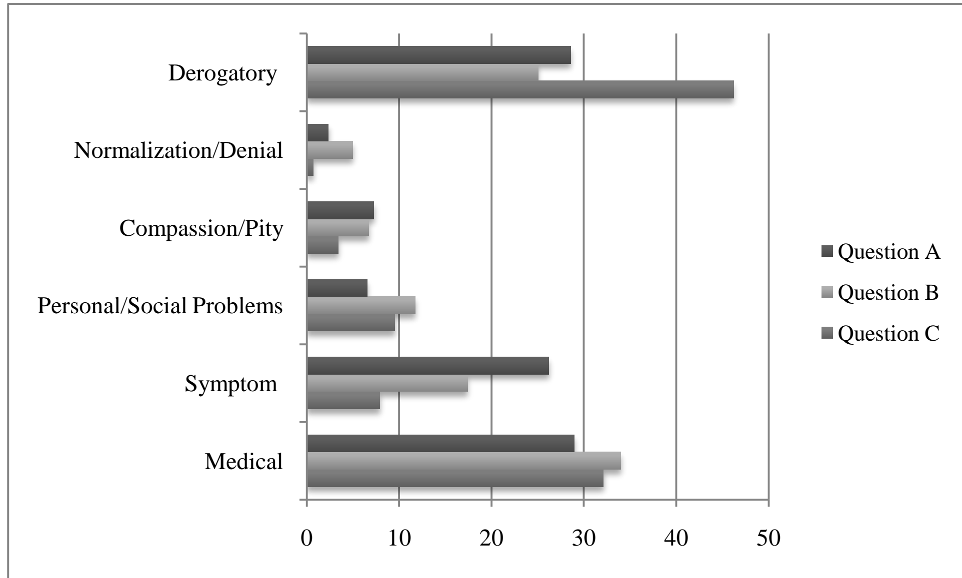

Figure 2. Percentages of responses for each label theme and each question.

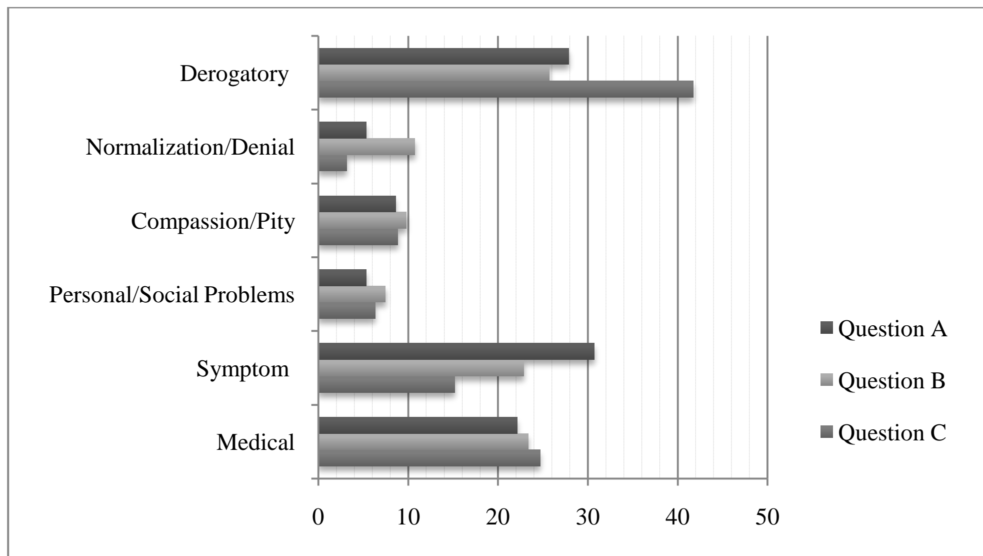

Figure 2. Percentages of labels for each label theme and each question.

6.1.3. Opinions, Beliefs, and Attitudes Regarding Mental Illness

6.1.3.1. Recognition of Depression and Schizophrenia

Majority of (84%) of the participants defined the case vignette with depressive symptoms as "ruhsal hastalık"[6] (Table 20), whereas 63% of the participants defined the paranoid-type schizophrenia condition as "akıl hastalığı" and 28% defined the condition as "ruhsal hastalık" (Table 21). Overall major depressive condition was defined as mental illness by 84% and paranoid-type schizophrenia was defined as mental illness by a total of 90% of the participants.

Table 20. Responses for recognition of depression

Question about the case vignette	*n*	*%*
Which of the following do you think describes Ms Fatma's situation?		
Mrs Fatma has a somatic disease	2	0.6
Mrs Fatma has a "ruhsal hastalık"	262	84.0
Mrs Fatma has a "akıl hastalığı"	1	0.3
Mrs Fatma has a neurological disease	20	6.4
Mrs Fatma does not have a disease	12	3.8
Other	15	4.8

Note. There were two missing responses and six discarded responses due to double responses.

Table 21. Responses for recognition of paranoid-type schizophrenia

Question about the case vignette	n	%
Which of the following do you think describes Mr Ahmet's situation?		
Mr Ahmet has a somatic disease	1	0,3
Mr Ahmet has a "ruhsal hastalık"	85	28,0
Mr Ahmet has a "akıl hastalığı"	190	62,5
Mr Ahmet has a neurological disease	21	6,9
Mr Ahmet does not have a disease	4	1,3
Other	3	1,0

Note. There were seven missing responses and nine discarded responses due to double responses.

6.1.3.2. Perceptions and Causal Attributions of Depression and Schizophrenia

Responses regarding perceptions and causal attributions for depression and paranoid-type schizophrenia are displayed on Table 22 and 23.

[6] See the discussion on these terms in the *Testing Theoretical Models – Labeling Theories* section

Among 87% (n =278) of the participants, the condition portrayed by the depression case vignette was perceived to be a condition that everyone may experience from time to time and 66% (n = 210) a state of extreme sadness. These perceptions were carried by only 13% (n = 43) and 12% (n = 39) of the participants, respectively, for the condition portrayed in the schizophrenia case vignette.

Majority of participants (82%, n = 263) indicated that the symptoms presented in the depression case vignette were due to social problems.

For the paranoid-type schizophrenia symptoms portrayed in the schizophrenia vignette, 68% (n = 216) of the participants reported that the symptoms were due to fluctuations in the biochemistry of the brain and had a biological basis. Also, 59% (n = 189) stated genetic factors, and 51% (n = 162) stated infantile and childhood problems as responsible causes.

There were significant differences between depression and schizophrenia condition for each item except the item regarding weakness of personality ($t(312) = -.34$, $p = .74$) and infantile/childhood problems ($t(316) = -1.72$, $p < 0.09$) (see Table L1 for t-test results).

Table 22. Responses on items about perception and causal attributions of depression

	I agree		I disagree		I have no idea	
Items	n	%	n	%	n	%
Ms Fatma's condition is due her social problems – ex:unemployment, poverty, family problems, etc (n = 318)	263	82.2	34	10.6	21	6.6
Ms Fatma's condition is due to the weakness of her personality (n = 316)	107	33.4	184	57.5	25	7.8
Ms Fatma's condition is a state of extreme sadness. (n = 318)	210	65.6	95	29.7	13	4.1
Ms Fatma's condition is a condition that everyone may experience from time to time (n = 317)	278	86.9	34	10.6	5	1.6
Ms Fatma's condition depends on genetic factors (n = 318)	58	18.1	209	65.3	51	15.9
Ms Fatma's condition has a biological basis, and is due to the fluctuations in the biochemistry of her brain (n = 319)	93	29.1	153	47.8	73	22.8
Ms Fatma's condition is due to her infantile/early childhood problems (n = 319)	136	42.5	125	39.1	58	18.1

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Table J2.

Table 23. Responses on items about perception and causal attributions of schizophrenia

	I agree		I disagree		I have no idea	
Items	n	%	n	%	n	%
Mr Ahmet's condition is due to social problems – ex:unemployment, poverty, family problems, etc (*n* = 318)	105	32.8	186	58.1	27	8.4
Mr Ahmet's condition is due to the weakness of his personality (*n* = 317)	123	38.4	167	52.2	27	8.4
Mr Ahmet's condition is a state of extreme sadness. (*n* = 318)	39	12.2	257	80.3	22	6.9
Mr Ahmet's condition is a condition that everyone may experience from time to time (*n* = 316)	43	13.4	263	82.2	10	3.1
Mr Ahmet's condition depends on genetic factors (*n* = 315)	189	59.1	89	27.8	37	11.6
Mr Ahmet's condition has a biological basis, and is due to the fluctuations in the biochemistry of his brain (*n* = 317)	216	67.5	54	16.9	47	14.7
Mr Ahmet's condition is due to his infantile/early childhood problems (*n* = 318)	162	50.6	93	29.1	63	19.7

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Table K2.

6.1.3.3.Opinions and Beliefs on Treatment Options for Depression and Schizophrenia

Ninety percent (*n* = 287) of the participants stated that the condition portrayed in the depression vignette was treatable. Also, 78% (*n* = 249) reported that this condition could be treated with psychotherapy and 50% (*n* = 161) with drugs; whereas 66% (*n* = 212) believed that this condition was untreatable unless social problems were solved (Table 24).

Regarding the condition portrayed in the schizophrenia vignette, 68% (*n* = 216) of the participants stated that the condition was treatable while 51% (*n* = 163) stated that the condition will never improve completely. As for treatment methods, 71% (*n* = 228) reported drugs and 61% (*n* = 194) psychotherapy. Seventy-one percent (*n* = 227) stated that hospitalization was necessary for this condition (Table 25).

Table 24. Responses to items about the treatment of depression

	I agree		I disagree		I have no idea	
Items	n	%	n	%	n	%
Ms Fatma's condition cannot be treated without solving her social problems – ex: unemployment, poverty, family problems, etc. (*n* = 318)	212	66.3	90	28.1	16	5.0
Ms Fatma's condition will never improve completely (*n* = 318)	38	11.9	258	80.6	22	6.9
Ms Fatma's condition is treatable condition (*n* = 317)	287	89.7	14	4.4	16	5.0
Ms Fatma's condition can be treated by drugs (*n* = 316)	161	50.3	100	31.3	55	17.2
Ms Fatma's condition can be treated by psychotherapy (*n* = 316)	249	77.8	26	8.1	41	12.8
People with similar complaints as Ms Fatma should be hospitalized (*n* = 319)	36	11.3	249	77.8	34	10.6

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Table J4

Table 25. Responses to items about the treatment of schizophrenia

	I agree		I disagree		I have no idea	
Items	*n*	%	*n*	%	*n*	%
Mr Ahmet's condition cannot be treated without solving his social problems – ex: unemployment, poverty, family problems, etc. (*n* = 314)	86	26.9	199	62.2	29	9.1
Mr Ahmet's condition will never improve completely (*n* = 318)	163	50.9	114	35.6	41	12.8
Mr Ahmet's condition is treatable condition (*n* = 314)	216	67.5	61	19.1	37	11.6
Mr Ahmet's condition can be treated by drugs (*n* = 318)	228	71.3	47	14.7	43	13.4
Mr Ahmet's condition can be treated by psychotherapy (*n* = 318)	194	60.6	83	25.9	41	12.8
People with similar complaints as Mr Ahmet should be hospitalized (*n* = 318)	227	70.9	59	18.4	32	10.0

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Appendix K4

6.1.3.4.Opinions and Beliefs on Help-Seeking Options for Depression and Schizophrenia

While 64% (*n* = 196) of the participants indicated that people with symptoms presented in the depression vignette should seek help first from a mental health specialist; 82% (*n* = 246) of the participants stated a mental

health specialist as the first option for help-seeking regarding the schizophrenia vignette.

Table 26. Responses on items about help-seeking options for depression

Question about the case vignette	*n*	%
What should people with similar complaints as Ms Fatma do to recover from this condition?		
They should give precedence to a physician	14	4.6
They should give precedence to a mental health specialist – psychiatrist, psychologist, psychotherapist	196	64.1
They should give precedence to being strong, if they want they can cope with this condition.	38	12.4
They should give precedence to leaving from their stressful environment – taking a vacation etc	28	9.2
The conditions of their life should be corrected in the first instance	25	8.2
They should give precedence to seeking help from traditional methods – ex: religion, hodjas, etc	2	0.7
Other	3	1.0

Note. There were three missing responses and 11 discarded responses due to double responses

Table 27. Responses on items about help-seeking options for schizophrenia

Question about the case vignette	*n*	%
What should people with similar complaints as Mr Ahmet do to recover from this condition?		
They should give precedence to a physician	40	13.3
They should give precedence to a mental health specialist – psychiatrist, psychologist, psychotherapist	246	82.0
They should give precedence to being strong, if they want they can cope with this condition.	5	1.7
They should give precedence to leaving from their stressful environment – taking a vacation etc	4	1.3
The conditions of their life should be corrected in the first instance	3	1.0
They should give precedence to seeking help from traditional methods – ex: religion, hodjas, etc	0	0.0
Other	2	0.7

Note. There were 13 missing responses and seven discarded responses due to double responses.

6.1.3.5. Attitudes and Social Distance Regarding Depression and Schizophrenia

Eighty-nine percent (n = 284) of the participants indicated disagreement to the statement that people similar to the portrayal in the depression case vignette should not be free in the community and 80% (*n* = 257) of participants did not agree that these people were aggressive. However 57 % (*n* = 183) reported agreement with the statement that people with similar symptoms presented in the vignette cannot make correct

decisions about their lives. Although majority of the participants indicated that they would rent their houses (81%, *n* = 259) to people with depressive symptoms, have them as neighbors without feeling uneasy (71%, *n* = 226), and could work with them (57%, *n* = 181); a majority (68%, *n* = 217) stated a disagreement for marrying someone in this condition (Table 28). These results indicate an increase of desire for social distance as the level of intimacy in a given context increases.

Table 28. Responses on items about attitudes and social distance regarding depression

	I agree		I disagree		I have no idea	
Items	*n*	%	*n*	%	*n*	%
People with similar complaints as Ms Fatma, shouldn't be free in the community (*n* = 318)	18	5.6	284	88.8	16	5.0
I could work with a person with similar complaints as Ms Fatma (*n* = 319)	181	56.6	110	34.4	28	8.8
I could marry a person with similar complaints as Ms Fatma (*n* = 317)	74	23.1	217	67.8	26	8.1
Having a neighbour with similar complaints as Ms Fatma does not make me uneasy (*n* = 319)	226	70.6	77	24.1	16	5.0
I would not rent my house to a person with similar complaints as Ms Fatma (*n* = 318)	48	15.0	259	80.9	11	3.4
Persons with similar complaints as Ms Fatma are aggressive (*n* = 317)	42	13.1	257	80.3	18	5.6
People with similar complaints as Ms Fatma cannot make correct decisions about their own lives (*n* = 314)	183	57.2	125	39.1	6	1.9

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Table J3

Eighty-six percent (n = 276) of the participants indicated that people similar to the condition presented in the schizophrenia case vignette cannot make correct decisions about their own lives, 64% (*n* = 204) stated that they were aggressive and 58% (*n* = 184) stated that they should not be free in the community. Majority of the participants stated that they would not rent their house to people with schizophrenic symptoms (56%, *n* =178), would feel uneasy if they had them as neighbors (73%, *n* = 234), could not work with them (78%, *n* = 249), and could not marry them (92%, *n* = 293) (Table 29). These results indicate that an increase of desire for social distance as the level of intimacy in a given context increases.

Table 29. Responses on items about attitudes and social distance regarding schizophrenia

	I agree		I disagree		I have no idea	
Items	*n*	%	*n*	%	*n*	%
People with similar complaints as Mr Ahmet, shouldn't be free in the community (*n* = 317)	184	57.5	125	39.1	8	2.5
I could work with a person with similar complaints as Mr Ahmet (*n* = 314)	50	15.6	249	77.8	15	4.7
I could marry a person with similar complaints as Mr Ahmet (*n* = 317)	11	3.4	293	91.6	13	4.1
Having a neighbour with similar complaints as Mr Ahmet does not make me uneasy (*n* = 318)	66	20.6	234	73.1	18	5.6
I would not rent my house to a person with similar complaints as Mr Ahmet (*n* = 318)	178	55.6	121	37.8	19	5.9
Persons with similar complaints as Mr Ahmet are aggressive (*n* = 316)	204	63.8	82	25.6	30	9.4
People with similar complaints as Mr Ahmet cannot make correct decisions about their own lives (*n* = 317)	276	86.3	29	9.1	12	3.8

Note. The responses "I agree" and "I slightly agree" are combined as "I agree", "I disagree" and "I slightly disagree" are combined as "I disagree". All the responses are displayed in Table K3

Responses to items regarding social distance were recoded and combined so that a mean social distance score was calculated, with higher scores indicating higher social distance (minimum mean score = 0, maximum mean score = 3). Attitude and social distance scores for the depression vignette ($M = 1.05$, $SD = 0.52$) was significantly lower than for the schizophrenia vignette ($M = 2.14$, $SD = 0.55$) (paired $t(297) = -32.36$, $p < 0.00$). This indicates an overall less rejecting attitudes toward people with depressive symptoms compared to schizophrenia.

6.2. Analytical Results

6.2.1. Relationships between Label Themes and Items on Opinions, Beliefs and Attitudes

6.2.1.1. Label Themes Associated with Perceptions and Causal Attributions

Label themes that were significantly associated with items regarding perceptions and causal attributions of depression and schizophrenia were demonstrated by logistic regression analyses and presented in Table 30 and 31.

Participants who expressed use of derogatory labels to describe a person with mental illness (question B) demonstrated a tendency to perceive symptoms of schizophrenia as a condition of extreme sadness and to perceive with less likelihood that depression was caused by infantile and childhood problems or genetic factors.

Expressed use of medical labels for description(question B) predicted agreements on the statement that symptoms of depression portrayed a condition of extreme sadness.

Participants who associated symptom related labels with a person as with mental illness (question A) showed a tendency to agree that depressive symptoms were due to genetic factors or infantile and childhood problems. However participants who expressed use of symptom related labels to describe a mentally ill person (question B) had more likelihood to disagree with the statements that depressive symptoms were due to weakness of personality, genetic factors and infantile or childhood problems and increased likelihood to agree that this was a condition that could be experienced by everyone from time to time.

Participants who associated a mentally ill person with personal and social problem related labels (question A) demonstrated less likelihood to agree that depressive symptoms were due to infantile and childhood problems. An expressed use of labels in this theme for description of a person with mental illness (question B) was associated with increased chances to disagree that schizophrenia related symptoms were due to fluctuations in brain biochemistry.

Participants who expressed use of normalization and denial related labels for question B tended to perceive a schizophrenic case as a condition of extreme sadness. However if these labels were expressed as associations regarding a person with mental illness (question A) there was less likelihood to agree that this condition was due to biochemical fluctuations in the brain.

Table 30. Results of logistic regression analyses of label themes that predict perceptions and causal attributions of depression

Items/Label Themes	p	B	OR	95% CI Lower	95% CI Upper
Ms Fatma's condition is due her social problems – ex:unemployment, poverty, family problems, etc					
			NS		
Ms Fatma's condition is due to the weakness of her personality (n = 263)					
Symptom – B (no)	0.008	1.370	3.937	1.437	10.753
Ms Fatma's condition is a state of extreme sadness (n = 278)					
Medical – B (yes)	0.011	1.103	3.013	1.290	7.034
Ms Fatma's condition is a condition that everyone may experience from time to time (n = 284)					
Symptom – B (yes)	0.037	1.797	6.032	1.113	32.690
Ms Fatma's condition depends on genetic factors (n = 243)					
Symptom – A (yes)	0.014	1.166	3.210	1.267	8.131
Symptom – B (no)	0.001	2.991	20.000	3.546	111.111
Derogatory – B (no)	0.037	1.525	4.587	1.099	19.231
Ms Fatma's condition has a biological basis. and is due to the fluctuations in the biochemistry of her brain					
			NS		
Ms Fatma's condition is due to her infantile/early childhood problems (n = 238)					
Symptom – A (yes)	0.020	0.982	2.671	1.168	6.109
Symptom – B (no)	0.008	1.288	3.623	1.401	9.346
Personal/social – B (no)	0.027	1.103	3.012	1.135	8.000
Derogatory – B (no)	0.031	1.020	2.778	1.100	6.993

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter". "NS" is abbreviation of "non-significant" results. The letters A, B, and C next to the label themes indicate the question in the Labeling Questionnaire.

Table 31. Results of logistic regression analyses of label themes that predict perceptions and causal attributions of schizophrenia

Items/Label Themes	p	B	OR	95% CI Lower	95% CI Upper
Mr Ahmet's condition is due to social problems – ex:unemployment, poverty, family problems, etc (n = 275)					
			NS		
Mr Ahmet's condition is due to the weakness of his personality					
			NS		
Mr Ahmet's condition is a state of extreme sadness (n = 270)					
Normalization/denial – B (yes)	0.007	2.326	10.241	1.892	55.419
Derogatory – B (yes)	0.046	1.207	3.344	1.024	10.920
Mr Ahmet's condition is a condition that everyone may experience from time to time (n = 290)					
			NS		
Mr Ahmet's condition depends on genetic factors (n =261)					
			NS		
Mr Ahmet's condition has a biological basis, and is due to the fluctuations in the biochemistry of his brain (n=243)					
Personal/social – C (yes)	0.009	2.156	8.640	1.699	43.937
Normalization/denial – A (no)	0.031	1.744	5.714	1.171	27.778
Personal/social – A (no)	0.039	1.188	3.279	1.060	10.204
Mr Ahmet's condition is due to his infantile/early childhood problems (n=239)					
Medical – C (yes)	0.038	0.772	2.165	1.045	4.483
Symptom – B (no)	0.037	0.934	2.545	1.058	6.135

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter". "NS" is abbreviation of "non-significant" results. The letters A, B, and C next to the label themes indicate the question in the Labeling Questionnaire.

6.2.1.2.Label Themes Associated with Opinions and Beliefs on Treatment Options

The few label themes that were found to be associated with items related to opinions and beliefs on treatment of depression and schizophrenia were demonstrated by logistic regression analyses and are presented on Table 32 and 33.

These results show that participants who have expressed a use of normalization and denial related labels for description (question B) tended to believe that depressive symptoms could never improve completely. Participants who used normalization and denial related labels, or compassion and pity related labels as their first associations with regards to

people with mental illness (question A), demonstrated increased likelihood to agree that schizophrenia cannot be treated unless social problems were solved.

Table 32. Results of logistic regression analyses of label themes that predict opinions and beliefs on treatment of depression

Items/Label Themes	p	B	OR	95% CI Lower	95% CI Upper
Ms Fatma's condition cannot be treated without solving her social problems – ex: unemployment. poverty. family problems. etc.					
			NS		
Ms Fatma's condition will never improve completely (*n* = 268)					
Normalization/denial – B (yes)	0.038	1.679	5.358	1.098	26.141
Ms Fatma's condition is treatable condition					
			NS		
Ms Fatma's condition can be treated by drugs					
			NS		
Ms Fatma's condition can be treated by psychotherapy					
			NS		
People with similar complaints as Ms Fatma should be hospitalized					
			NS		

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter".

Table 33. Results of logistic regression analyses of label themes that predict opinions and beliefs on treatment of schizophrenia

Items/Label Themes	p	B	OR	95% CI Lower	95% CI Upper
Mr Ahmet's condition cannot be treated without solving his social problems – ex: unemployment. poverty. family problems. etc. (n=259)					
Compassion/pity – A (yes)	0.046	1.038	2.823	1.019	7.820
Normalization/denial – A (yes)	0.003	2.547	12.770	2.345	69.532
Mr Ahmet's condition will never improve completely (n=251)					
Medical – C (yes)	0.041	0.685	1.984	1.029	3.825
Mr Ahmet's condition is treatable condition (n=251)					
Medical – C (no)	0.026	0.904	2.469	1.112	5.464
Mr Ahmet's condition can be treated by drugs					
			NS		
Mr Ahmet's condition can be treated by psychotherapy					
			NS		
People with similar complaints as Mr Ahmet should be hospitalized					
			NS		

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter".

6.2.1.3. Label Themes Associated with Attitudes and Social Distance

The label themes that predicted agreement items about attitudes and social distance to people with depression and schizophrenia were demonstrated by logistic regression and stepwise multiple regression analyses and displayed on Table 34, 35, and 36.

Participants who used derogatory labels in question A which asked their associations regarding people with mental illness, demonstrated a tendency that they would not rent their houses to people with depressive or schizophrenic symptoms more than those participants who did not use derogatory labels.

Participants who associated medical labels with regards to a mentally ill person (question A) with increased likelihood stated that people with schizophrenia should not be free in the community.

Associating mental illness with symptom related labels (question A) was associated with less likelihood to agree that they could have someone with depressive symptoms as their neighbor without uneasy feelings and could work with a person having symptoms of schizophrenia more than those who used these labels. Overall associating a person with mental illness with symptom related labels predicted higher social distance scores for depression (Table 36). Participants who expressed a use of symptom related labels to describe a person with mental illness (question B) on the other hand stated that they could work with depressive people and have them as neighbors without feeling uneasy, and tend to have lower social distance scores (Table 36) more than those who did not use these labels on question B.

Those participants who associated normalization and denial related labels with a person with mental illness (question A) showed a tendency to agree that people with schizophrenia should not be free in community. An expression of the use of normalization and denial related labels to describe a person with mental illness (question B) predicted lower social distance scores for schizophrenia (Table 36).

Participants who associated a person with mental illness with compassion and pity related labels (question A) tended to agree that they could marry with someone with schizophrenia. Expression of compassion and pity related labels as used to describe a person with mental illness was associated with a less chance of agreeing that people with schizophrenia cannot make correct decisions about their lives and predicted lower social distance scores for depression (Table 36).

Table 34. Results of logistic regression analyses of label themes that predict attitudes and social distance regarding depression

				95% CI	
Items/Label Themes	p	B	OR	Lower	Upper
People with similar complaints as Ms Fatma. shouldn't be free in the community					
			NS		
I could work with a person with similar complaints as Ms Fatma (n = 277)					
Symptom – B (yes)	0.014	1.144	3.138	1.263	7.797
I could marry a person with similar complaints as Ms Fatma					
			NS		
Having a neighbour with similar complaints as Ms Fatma does not make me uneasy (n = 276)					
Symptom – A (no)	0.028	0.928	2.513	1.104	5.714
Symptom – B (yes)	0.017	1.335	3.801	1.271	11.366
I would not rent my house to a person with similar complaints as Ms Fatma (n = 291)					
Derogatory – A (yes)	0.010	1.242	3.462	1.351	8.870
Symptom – B (no)	0.012	1.978	7.246	1.553	33.333
Persons with similar complaints as Ms Fatma are aggressive (n = 282)					
			NS		
People with similar complaints as Ms Fatma cannot make correct decisions about their own lives (n = 291)					
			NS		

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter".

Table 35. Results of logistic regression analyses of label themes that predict attitudes and social distance regarding schizophrenia

Items/Label Themes	p	B	OR	95% CI Lower	95% CI Upper
People with similar complaints as Mr Ahmet. shouldn't be free in the community (n=283)					
Symptom – C (no)	0.023	1.061	2.890	1.159	7.194
Normalization/denial – A (yes)	0.035	2.408	11.110	1.189	103.824
Medical – A (yes)	0.015	0.857	2.356	1.180	4.706
I could work with a person with similar complaints as Mr Ahmet (n=271)					
Symptom - A (no)	0.026	1.254	3.509	1.163	10.526
I could marry a person with similar complaints as Mr Ahmet (n=276)					
Compassion/pity – A (yes)	0.013	2.823	16.822	1.808	156.521
Having a neighbour with similar complaints as Mr Ahmet does not make me uneasy					
NS					
I would not rent my house to a person with similar complaints as Mr Ahmet (n=270)					
Derogatory – A (yes)	0.032	0.744	2.105	1.067	4.152
Medical – C (yes)	0.038	0.65	1.915	1.038	3.534
Persons with similar complaints as Mr Ahmet are aggressive (n=261)					
Personal/social – A (no)	0.015	1.296	3.650	1.289	10.417
People with similar complaints as Mr Ahmet cannot make correct decisions about their own lives (n=278)					
Compassion/pity – B (no)	0.049	1.641	5.155	1.004	26.316

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was "enter".

Table 36. Summary of stepwise multiple regression analysis for variables predicting social distance scores

Dependent/Independent Variables in the Equation	B	SE B	ß	ΔR^2
Depression [*Adj.* R^2= .221. *ps< .05*)]				
Major (0 = non-psychology; 1 = psychology)	-.205	.058	-.199	.091
Year of study (higher)	-.124	.027	-.248	.041
BBSymptom (0 = no; 1 = yes)	-.301	.073	-.229	.024
BASymptom (0 = no; 1 = yes)	.205	.063	.180	.024
Contact with MI (0 = no; 1 = yes)	-.181	.055	-.176	.025
BCMedical (0 = no; 1 = yes)	.125	.054	.121	.017
BBCompPty (0 = no; 1 = yes)	-.194	.095	-.107	.010
Socioeconomic Status (0 = low-middle; 1 = middle – high)	.105	.055	.102	.010
Schizophrenia [*Adj.* R^2= .025. *ps< .05*)]				
History of MI (0 = no; 1 = yes)	-.156	.075	-.122	.013
BBNormDenial (0 = no; 1 = yes)	-.265	.135	-.115	.012
Father's Education Status (0 = no education – high school; 1 = university and above)	.115	.065	.103	.011

6.2.2. Demographic Factors Associated with Label Themes.

The demographic variables that were demonstrated through chi-square and logistic regression analyses to be significantly associated with each label theme according to the questions in the Labeling questionnaire are provided in Table 37 through 42.

Table 37. Results of chi-square analyses of label themes for question A and demographic variables

Label Themes	**Demographic Variables**				***p***
Medical Labels	Year of study (*n* = 295)				
	1	2	3	4 and 4<	
	16.7	43.6	53.2	47.8	0.001
Symptom-related Labels	History of MI (*n* = 306)				
	No		Yes		
	25.6		37.5		0.051
	Contact with MI (*n* = 305)				
	No		Yes		
	39.5		60.5		0.009
Personal/Social Problem related labels	Work study/paid job (*n* = 306)				
	No		Yes		
	8.7		20.9		0.027[a]
	Contact with MI ((*n* = 305)				
	No		Yes		
	7.0		14.2		0.041
Compassion/Pity related labels	Gender (*n* = 306)				
	Female		Male		
	7.9		18.5		0.007
	Major (*n* = 303)				
	Non-psychology		Psychology		
	15.3		6.4		0.014
Normalization/Denial associated labels	NS				
Derogatory Labels	Major (*n* = 303)				
	Non-psychology		Psychology		
	44.2		32.9		0.044
	Psychology year of study (*n* = 139)				
	2	3	4		
	29.1	50.0	18.4		0.007
	History of MI (*n* = 306)				
	No		Yes		
	42.3		26.4		0.015

Note. A separate chi-square analysis was conducted for each label theme and each demographic variable. Only the significant results have been displayed in this table. All the results are in Appendix X. “Mental illness” is abbreviated as “MI”

[a] *p* value of Fisher’s Exact Test.

Table 38. Results of logistic regression analyses of demographic variables that predict the label categories in Question A (n=292)

				95%CI	
Label Themes/Demographic Variables	p	B	OR	Lower	Upper
Medical Labels					
Year of study (higher)	0.003	0.354	1.424	1.124	1.804
Mother's Education (higher)	0.050	0.490	1.632	1.000	2.661
Symptom-related Labels					
Contact with MI (yes)	0.011	0.676	1.966	1.168	3.308
Personal/Social Problem related labels					
Work study/paid job (yes)	0.023	1.005	2.731	1.148	6.494
Contact with MI (yes)	0.032	0.872	2.392	1.077	5.315
Compassion/Pity related labels					
Gender (male)	0.015	0.939	2.558	1.201	5.447
Normalization/Denial associated labels					
Birth Place (smaller)	0.045	1.280	3.597	1.027	12.658
Derogatory Labels					
History of MI (no)	0.012	0.751	2.119	1.178	3.817

Note. The selection method for the logistic regression analyses were forward-conditional.

Table 39. Results of chi-square analyses of label themes for question B and demographic variables

Label Themes	**Demographic Variables**				***p***
Medical Labels	NS				
Symptom-related Labels	Gender (n = 304)				
	Female	Male			
	22.4	10.0			0.011
	Major (n = 301)				
	Non-psychology	Psychology			
	14.1	23.9			0.029
	Socioeconomic status				
	Low--Middle	High-middle--High			0.029
	13.0	22.8			
Personal/Social Problem related labels	NS				
Compassion/Pity related labels	Psychology year of study (n = 136)				
	2	3	4		0.031[a]
	18.9	4.4	5.3		
Normalization/Denial associated labels	Year of study (n = 292)				
	1	2	3	4 and 4<	0.021[a]
	12.5	7.1	0.0	4.5	
	Birth place (n = 304)				
	Non-big city	Big city			0.018
	10.3	3.6			
Derogatory Labels	NS				

Note. A separate chi-square analysis was conducted for each label theme and each demographic variable. Only the significant results have been displayed in this table. All the results are in Appendix X.

[a] *p* value of Fisher's Exact Test.

Table 40. Results of logistic regression analyses of demographic variables that predict the label categories in Question B (n=288)

				95%CI	
Label Themes/Demographic Variables	p	B	OR	Lower	Upper
Medical Labels					
Year of study	0.021	0.274	1.315	1.043	1.658
Symptom related labels					
Gender (female)	0.027	0.867	2.381	1.106	5.128
Personal/social problems					
			NS		
Compassion/Pity					
			NS		
Normalization/Denial					
Birth Place (smaller)	0.046	1.082	2.950	1.019	8.547
Derogatory Labels					
			NS		

Note. The selection method for the logistic regression analyses were forward-conditional.

Table 41. Results of chi-square analyses of label themes for question C and demographic variables

Label Themes	**Demographic Variables**				***p***
Medical Labels	Contact with MI (*n* = 303)				
	No		Yes		
	41.8		56.7		0.010
Symptom-related Labels	Contact with MI (*n* = 303)				
	No		Yes		0.009
	6.5		16.0		
Personal/Social Problem related labels	Major (*n* = 300)				
	Non-psychology		Psychology		
	11.3		19.9		0.041
Compassion/Pity related labels	Gender (*n* = 303)				
	Female		Male		
	7.0		1.1		0.046[a]
	Year of study (*n* = 291)				
	1	2	3	4 and 4<	
	0.0	10.0	1.3	5.8	0.022[a]
Normalization/Denial associated labels	Gender (*n* = 303)				
	Female		Male		
	0.5		3.4		0.075[a]
Derogatory Labels	NS				

Note. A separate chi-square analysis was conducted for each label theme and each demographic variable. Only the significant results have been displayed in this table. All the results are in Appendix X. "Mental illness" is abbreviated as "MI"
[a] *p* value of Fisher's Exact Test.

Table 42. Results of logistic regression analyses of demographic variables that predict the label categories in Question C (n=287)

Label Themes/Demographic Variables	p	B	OR	95%CI Lower	Upper
Medical Labels					
Contact with MI (yes)	0.011	0.604	1.829	1.145	2.921
Symptom related labels					
Contact with MI (yes)	0.008	1.091	2.978	1.332	6.658
Personal/Social problems					
			NS		
Compassion/Pity					
Birth Place (bigger)	0.053	2.017	7.514	0.973	58.021
Normalization/Denial					
			NS		
Derogatory Labels					
			NS		

Note. The selection method for the logistic regression analyses were forward-conditional

A. Gender

Among the demographic variables gender was significantly associated with the use of compassion and pity related labels in question A and symptom related labels in question B, in both chi-square and logistic regression analyses. For question A, male participants used more words, terms and phrases associated with compassion and pity than females. Female participants, on the other hand, used more symptom related labels in question B, than males.

B. Area of Study - Psychology vs Non-Psychology Majors

Area of study was found to be associated with label themes only in chi-square analyses. Non-psychology students demonstrated a higher use of compassion and pity related labels as well as derogatory labels in question A, compared to psychology students. Psychology students used more symptom related labels in question A than non-psychology students and more personal and social problem associated labels in question C.

C. Year of Study

Chi-square and logistic analyses demonstrated that participants in higher classes tended to use more medical labels in question A but tended to use less of normalization and denial related labels in question B.

When the effect of study year among only psychology students was explored in chi-square analyses; 3rd year students used more derogatory labels than 2nd and 4th year students, and 2nd year students used more of these labels than 4th year students, for question A. Second year students used more compassion and pity related labels than 3rd and 4th year students.

D. Place of Residency and Birth

Those participants who reported to have been born in areas other than metropolitan cities, tended to use of normalization and denial related labels both as associations for and as used to describe a mentally ill person.

E. Socioeconomic Status

Socioeconomic status variable was only significant in one chi-square analysis which demonstrated that those participants who considered themselves to belong to high-middle to high status demonstrated increased likelihood to express use of symptom related labels for description (question B).

F. Other Sociodemographic Factors

Chi-square and logistic regression analyses showed that working participants used more personal and social problem related labels to associate a person with mental illness.

Regarding parental education, only mother's education level was shown through logistic regression analysis to be significantly associated with medical label use in question A. Participants who reported their mothers' education level as university or above, used more medical labels than those who reported an education level below university degree.

G. Exposure to Mental Illness

With regards to variables assessing exposure to mental illness, history of mental illness and contact with someone mentally ill were significant variables associated with label categories. Both chi-square and logistic regression analyses for question A demonstrated increased likelihood of the use of symptom related labels and decreased likelihood of the use of derogatory labels by participants who reported to have had a history of mental illness. Also, participants who reported to have had a

contact with mental illness demonstrated increased likelihood to use symptom related and personal, social related labels with regards to associations in reaction to a person with mental illness (question A).

6.2.3. Demographic Factors Associated with Perceptions and Causal Attributions

The results of chi-square and logistic regression analyses between demographic variables and items related to perceptions and causal attributions of depression are displayed in Table 43 and 44. The results of chi-square and logistic regression analyses between demographic variables and items related to perceptions and causal attributions of schizophrenia are displayed in Table 45 and 46.

Table 43. Results of logistic regression analyses of demographic variables that predict perceptions and causal attributions of depression

				95% CI	
Items/Demographic variables	p	B	OR	Lower	Upper
Ms Fatma's condition is due her social problems – ex:unemployment, poverty, family problems, etc (n = 280)					
			NS		
Ms Fatma's condition is due to the weakness of her personality (n = 274)					
Major (non-psychology)	0.000	1.177	3.247	1.835	5.747
Year of study (higher)	0.017	0.322	1.380	1.058	1.798
Contact with MI (no)	0.001	0.911	2.488	1.456	4.237
Ms Fatma's condition is a state of extreme sadness (n = 289)					
History of MI (no)	0.010	0.724	2.062	1.190	3.571
Ms Fatma's condition is a condition that everyone may experience from time to time (n = 295)					
			NS		
Ms Fatma's condition depends on genetic factors (n = 251)					
Year of study (higher)	0.000	0.587	1.799	1.315	2.462
Ms Fatma's condition has a biological basis. and is due to the fluctuations in the biochemistry of her brain (n = 229)					
Contact with MI (yes)	0.012	0.706	2.025	1.171	3.500
Ms Fatma's condition is due to her infantile/early childhood problems (n = 245)					
Major (psychology)	0.011	0.665	1.944	1.162	3.253
Father's education (lower)	0.021	0.633	1.883	1.100	3.226

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

Table 44. Results of chi-square analyses of demographic variables and items on perception and causal attributions of depression

Items/Demographic variables	**I agree**	**I disagree**	**I have no idea**	**p**
Ms Fatma's condition is due her social problems – ex:unemployment, poverty, family problems, etc				
Major				
Non-psychology	84.4	12.1	3.5	0.035
Psychology	80.3	9.2	10.6	
Father's education				
No education-high school	76.0	14.0	9.9	0.044
University and above	86.7	8.7	4.5	
Ms Fatma's condition is due to the weakness of her personality				
Major				
Non-psychology	43.9	49.7	6.4	0.000
Psychology	22.5	67.6	9.9	
Contact with MI				
No	44.2	50.3	5.5	0.000
Yes	22.7	66.7	10.7	
Ms Fatma's condition is a state of extreme sadness				
Psychology year of study				
2	52.7	38.2	9.1	0.016
3	76.6	23.4	0	
4	60.5	39.5	0	
Mother's education				
No education-high school	68.7	29.4	2.0	0.036
University and above	61.2	31.0	7.8	
History of MI				
No	69.0	26	5.0	0.016
Yes	56.6	42.1	1.3	
Ms Fatma's condition is a condition that everyone may experience from time to time				
			NS	
Ms Fatma's condition depends on genetic factors				
Major				
Non-psychology	12.1	70.1	17.8	0.006
Psychology	26.1	59.9	14.1	
Year of study				
1	7.3	81.8	10.9	0.014
2	15.7	67.6	16.7	
3	17.7	64.6	17.7	
4	30.0	50.0	20.0	
Birth place				
Non-big city	20.9	70.0	9.1	0.045
Big city	16.8	63.5	19.7	
Ms Fatma's condition has a biological basis. and is due to the fluctuations in the biochemistry of her brain				
History of MI				
No	25.5	50.2	24.3	0.037
Yes	40.8	40.8	18.4	
Contact with MI				
No	21.1	51.2	27.7	0.002
Yes	38.2	44.1	17.8	
Ms Fatma's condition is due to her infantile/early childhood problems				
Major				
Non-psychology	34.7	43.9	21.4	0.006
Psychology	52.4	32.9	14.7	
Year of study				
1	43.6	47.3	9.1	0.028
2	37.9	45.6	16.5	
3	50.0	23.8	26.2	
4	42.0	37.7	20.3	

Note. Separate chi-square analyses were done for each demographic variable and each item pair. This table only displays the significant associations. "Mental illness" is abbreviated as MI. The "NS" abbreviation is for no significant associations found.

Table 45. Results of chi-square analyses of demographic variables and items on perception and causal attributions of schizophrenia

Items/Demographic variables	**I agree**	**I disagree**	**I have no idea**	**p**
Mr Ahmet's condition is due to social problems – ex:unemployment, poverty, family problems, etc				
			NS	
Mr Ahmet's condition is due to the weakness of his personality				
Major				
Non-psychology	47.4	44.4	8.2	0.004
Psychology	29.4	61.5	9.1	
Mr Ahmet's condition is a state of extreme sadness.				
			NS	
Mr Ahmet's condition is a condition that everyone may experience from time to time				
Gender				
Female	10.0	87.7	2.3	0.005
Male	21.9	72.9	5.2	
Major				
Non-psychology	17.6	77.6	4.7	0.007
Psychology	9.1	90.2	0.7	
Year of study				
1	29.6	68.5	1.9	0.017
2	9.9	87.1	3.0	
3	13.8	82.5	3.8	
4	7.2	89.9	2.9	
Birth place				
Non-big city	20.9	76.4	2.7	0.022
Big city	9.7	86.9	3.4	
Mr Ahmet's condition depends on genetic factors				
Gender				
Female	67.4	21.1	11.5	0.000
Male	43.3	44.3	12.4	
Major				
Non-psychology	44.2	41.3	14.5	0.000
Psychology	78.6	12.9	8.6	
Year of study				
1	29.6	59.3	11.1	0.000
2	59.4	25.7	14.9	
3	65.8	21.5	12.7	
4	75.4	15.9	8.7	
Birth place				
Non-big city	54.1	38.5	7.3	0.007
Big city	63.1	22.8	14.1	
Father's education				
No education-high school	50.0	37.7	12.3	0.009
University and above	66.1	22.4	11.5	
Contact with MI				
No	53.3	32.7	13.9	0.033
Yes	67.8	22.8	9.4	
Mr Ahmet's condition has a biological basis, and is due to the fluctuations in the biochemistry of his brain				
Major				
Non-psychology	57.0	23.3	19.8	0.000
Psychology	81.0	9.9	9.2	
Year of study				
1	55.6	29.6	14.8	0.015
2	72.3	13.9	13.9	
3	61.2	15.0	23.8	
4	78.6	12.9	8.6	
Contact with MI				
No	59.6	20.5	19.9	0.003
Yes	77.3	13.3	9.3	
Mr Ahmet's condition is due to his infantile/early childhood problems				
Gender				
Female	45.7	32.6	21.7	0.018
Male	62.9	21.6	15.5	

Table 46. Results of logistic regression analyses of demographic variables that predict perceptions and causal attributions of schizophrenia

Items/Demographic Variables	p	B	OR	95% CI Lower	Upper
Mr Ahmet's condition is due to social problems – ex:unemployment, poverty, family problems, etc (n = 275)					
			NS		
Mr Ahmet's condition is due to the weakness of his personality (n = 274)					
Major (non-psychology)	0.001	0.835	2.304	1.406	3.774
Mr Ahmet's condition is a state of extreme sadness (n = 279)					
Gender (male)	0.023	0.825	2.283	1.122	4.651
Father's education (lower)	0.019	0.837	2.309	1.147	4.651
Mr Ahmet's condition is a condition that everyone may experience from time to time (n = 290)					
Gender (male)	0.015	0.851	2.342	1.178	4.651
Year of study (lower)	0.015	0.417	1.517	1.085	2.123
Mr Ahmet's condition depends on genetic factors (n =261)					
Gender (female)	0.035	0.705	2.024	1.050	3.903
Major (psychology)	0.000	1.310	3.708	1.846	7.446
Year of study (higher)	0.002	0.474	1.606	1.194	2.160
Father's education (higher)	0.005	0.866	2.379	1.291	4.381
Mr Ahmet's condition has a biological basis, and is due to the fluctuations in the biochemistry of his brain (n=253)					
Major (psychology)	0.001	1.172	3.229	1.641	6.351
Mr Ahmet's condition is due to his infantile/early childhood problems (n=239)					
Gender (male)	0.024	0.688	1.988	1.093	3.623

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

A. Gender

Considering gender, male participants indicated that they perceived the condition portrayed in the schizophrenia case vignette as a condition of extreme sadness and a condition that can be experienced by everyone time to time, more than female participants. With regards to causal attributions, more male participants agreed that the condition was due to infantile or childhood problems, whereas more females agreed that it was due to genetic factors.

B. Area of Study – Psychology vs Non-Psychology Majors

Area of study was found to be associated with item responses regarding causal attributions of depression. There were more non-psychology students who stated that symptoms presented in the depression case vignette were due to social problems and weakness of personality than

psychology students. Psychology students on the other hand, indicated that symptoms presented were due to genetic factors and infantile or childhood problems, more than non-psychology students.

Non-psychology students perceived the schizophrenia condition as a condition that can be experienced by everyone from time to time and agreed that the condition was due to personal weakness, more than psychology students. Psychology students on the other hand agreed that the condition was due to genetic factors and fluctuations of the brain biochemistry, more than non-psychology students.

C. Year of Study

Chi-square and logistic regression analyses showed that participants who were in higher grades indicated genetic factors and weakness of personality as causes for depressive symptoms. Chi-square analysis also showed that 3rd year students agreed more than 1st, 4th, and 2nd year students that the symptoms were due to infantile or childhood problems.

Students who were in first year of their study agreed that the symptoms presented in the schizophrenia case vignette could be experienced by everyone more than students in 3rd, 2nd, and 4th year students (in order). Students in higher classes indicated agreements that the condition presented was due to genetic factors. The association between participant year of study and agreement on fluctuations in the brain biochemistry as a cause was shown only in a chi-square analysis.

D. Places of Residency and Birth

Only one chi-square analysis showed that birth place was associated with the responses regarding genetic factors as a cause. Participants who reported to have been born in areas other than big cities agreed more to this item than participants who were born in big-cities.

Chi-square analyses showed associations regarding the birth place of participants. Participants who stated to have been born in big cities indicated that schizophrenic symptoms were due to genetic factors more than those who reported to have been born in non-big cities. Those who stated to have been born in non-big cities tended to perceive the condition that could be

experienced by everyone from time to time more than those born in big cities.

E. Parental Education Levels

Regarding parental education levels, logistic regression analysis showed that participants who reported a below university degree for their fathers, had increased likelihood to agree the item that depressive symptoms were due to infantile or childhood problems. According to chi-square analysis results, responses from participants with higher education levels of their fathers were associated with higher agreements on social problems as causes for depressive symptoms. Another chi-square analysis demonstrated that those participants who had mothers with lower than university degree education perceived the condition presented in the case vignette as extreme sadness more than participants whose mothers had higher levels of education.

Participants whose fathers' education level was below university degree perceived the schizophrenic condition as a condition of extreme sadness more than those whose fathers' who had university or higher degrees. Those participants who had fathers with university or higher degrees agreed more that the condition was due to genetic factors.

F. Exposure to Mental Illness

Chi-square and logistic regression analyses demonstrated that participants who have reported a history of mental illness disagreed more with the perception that the condition presented in the depression case vignette was a condition of extreme sadness. Also, participants with this experience stated that the depressive symptoms were due to fluctuations in the biochemistry of the brain more than participants who did not have such a history. Both chi-square and logistic regression analyses showed that contact with someone mentally ill was an experience among participants which was associated with agreements on biochemical changes in the brain and disagreements on personal weakness as causes for depressive symptoms.

Chi-square analyses also demonstrated that participants who reported contact with someone mentally ill agreed more that the condition presented was due to genetic factors and biochemical fluctuations in the brain.

6.2.4. Demographic Factors Associated with Opinions and Beliefs on Treatment Options

The results of chi-square and logistic regression analyses between demographic variables and items related to opinions and beliefs on treatments of depression are displayed in Table 47 and 48. The results of chi-square and logistic regression analyses between demographic variables and items related to opinions and beliefs on treatments of schizophrenia are displayed in Table 49 and 50.

Table 47. Results of logistic regression analyses of demographic variables that predict opinions and beliefs on treatment of depression

				95% CI	
Items/Demographic Variables	p	B	OR	Lower	Upper
Ms Fatma's condition cannot be treated without solving her social problems – ex: unemployment. poverty. family problems. etc. (n = 285)					
Major (non psychology)	0.01	0.681	1.976	1.179	3.311
Ms Fatma's condition will never improve completely (n = 279)					
Gender (male)	0.013	0.922	2.513	1.211	5.236
Ms Fatma's condition is treatable condition (n = 284)					
Gender (female)	0.003	2.366	10.653	2.254	50.356
Place of residence (smaller)	0.029	2.048	7.752	1.230	50.000
Father's education (higher)	0.007	2.153	8.614	1.823	40.700
Year of study	0.005	1.463	4.319	1.571	11.870
Ms Fatma's condition can be treated by drugs (n = 247)					
Major (psychology)	0.000	1.003	2.727	1.602	4.643
Ms Fatma's condition can be treated by psychotherapy (n = 261)					
Major (psychology)	0.004	1.627	5.088	1.662	15.571
Birth place (bigger)	0.023	1.037	2.821	1.154	6.897
People with similar complaints as Ms Fatma should be hospitalized (n = 270)					
Gender (male)	0.052	0.805	2.237	0.993	5.051
History of MI (no)	0.047	1.269	3.559	1.016	12.500
Year of study (lower)	0.001	0.750	2.119	1.374	3.268

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

Table 48. Results of chi-square analyses of demographic variables and items on opinions and beliefs on treatment of depression (*continued on next page)*

Items/Demographic variables	I agree	I disagree	I have no idea	p
Ms Fatma's condition cannot be treated without solving her social problems – ex: unemployment, poverty, family problems, etc.				
Major				
Non-psychology	75.1	22.0	2.9	0.002
Psychology	57.0	35.2	7.7	
Father's education				
No education-high school	61.2	29.8	9.1	0.026
University and above	69.9	27.6	2.6	
Contact with MI				
No	73.1	24.0	3.0	0.029
Yes	60.0	32.7	7.3	
Ms Fatma's condition will never improve completely				
Major				
Non-psychology	16.2	74.0	9.8	0.002
Psychology	7.0	89.4	3.5	
Gender				
Female	9.0	85.1	5.9	0.022
Male	18.6	72.2	9.3	
Contact with MI				
No	15.0	74.9	10.2	0.005
Yes	8.0	88.7	3.3	
Ms Fatma's condition is treatable condition				
Major				
Non-psychology	83.7	7.6	8.7	0.000
Psychology	98.6	0.7	0.7	
Gender				
Female	93.6	1.8	4.5	0.002
Male	83.5	10.3	6.2	
Year of study				
1	80.0	16.4	3.6	0.000
2	92.1	3.0	5.0	
3	88.6	2.5	8.9	
4	97.1	0.	2.9	
Father's education				
No education-high school	84.3	8.3	7.4	0.009
University and above	94.4	2.1	3.6	
Ms Fatma's condition can be treated by drugs				
Major				
Non-psychology	38.6	39.2	22.2	0.000
Psychology	64.8	23.2	12.0	
Year of study				
1	38.9	48.1	13.0	0.017
2	48.5	25.7	25.7	
3	52.5	33.8	13.8	
4	60.9	26.1	13.0	
Psychology year of study				
2	54.5	21.8	23.6	0.015
3	70.2	27.7	2.1	
4	71.1	21.1	7.9	
Contact with MI				
No	42.4	34.5	23.0	0.003
Yes	60.0	28.7	11.3	

Table 48 (*continued*). Results of chi-square analyses of demographic variables and items on opinions and beliefs on treatment of depression

Items/Demographic variables	I agree	I disagree	I have no idea	p
Ms Fatma's condition can be treated by psychotherapy				
Major				
Non-psychology	66.7	12.9	20.5	0.000
Psychology	93.0	2.8	4.2	
Gender				
Female	84.5	5.0	10.5	0.000
Male	65.6	15.6	18.8	
Year of study				
1	65.5	21.8	12.7	0.002
2	77.5	4.9	17.6	
3	82.3	6.3	11.4	
4	88.2	4.4	7.4	
Psychology year of study				
2	85.7	3.6	10.7	0.046
3	97.8	2.2	0	
4	97.4	2.6	0	
Birth place				
Non-big city	70.9	15.5	13.6	0.002
Big city	83.0	4.4	12.6	
History of MI				
No	75.6	8.7	15.7	0.023
Yes	89.2	6.8	4.1	
History of MI treatment				
No	75.9	9.3	14.8	0.033
Yes	91.4	3.4	5.2	
Contact with MI				
No	72.5	9.6	18.0	0.007
Yes	86.5	6.1	7.4	
People with similar complaints as Ms Fatma should be hospitalized				
Major				
Non-psychology	14.5	70.5	15.0	0.002
Psychology	7.7	86.7	5.6	
Gender				
Female	7.7	84.7	7.7	0.000
Male	19.6	62.9	17.5	
Year of study				
1	30.9	58.2	10.9	0.000
2	6.9	79.4	13.7	
3	5.0	88.8	6.2	
4	5.7	84.3	10.0	
History of MI				
No	13.6	74.9	11.5	0.034
Yes	3.9	88.2	7.9	
History of MI treatment				
No	13.2	74.8	12.0	0.017
Yes	3.3	91.7	5.0	

Note. Separate chi-square analyses were done for each demographic variable and each item pair. This table only displays the significant associations. "Mental illness" is abbreviated as MI. The "NS" abbreviation is for no significant associations found.

Table 49. Results of chi-square analyses of demographic variables and items on opinions and beliefs on treatment of schizophrenia

Items/Demographic variables	I agree	I disagree	I have no idea	p
Mr Ahmet's condition cannot be treated without solving his social problems – ex: unemployment, poverty, family problems, etc.				
Year of study				
1	41.5	50.9	7.5	0.022
2	29.3	59.6	11.1	
3	21.2	65.0	13.8	
4	18.6	77.1	4.3	
Psychology year of study				
2	27.3	60.0	12.7	0.026
3	23.4	63.8	12.8	
4	10.5	89.5	0	
Mr Ahmet's condition will never improve completely				
	NS			
Mr Ahmet's condition is treatable condition				
Major				
Non-psychology	59.6	23.4	17.0	0.000
Psychology	79.3	15.0	5.7	
Father's education				
No education-high school	73.1	12.6	14.3	0.045
University and above	66.0	23.7	10.3	
Mr Ahmet's condition can be treated by drugs				
Gender				
Female	76.9	10.4	12.7	0.002
Male	59.8	24.7	15.5	
Major				
Non-psychology	57.0	22.7	20.3	0.000
Psychology	88.8	5.6	5.6	
Year of study				
1	53.7	35.2	11.1	0.000
2	70.6	13.7	15.7	
3	73.8	12.5	13.8	
4	84.3	4.3	11.4	
Birth place				
Non-big city	64.5	22.7	12.7	0.015
Big city	75.5	10.6	13.9	
Socioeconomic status				
Low-middle	77.3	10.8	11.9	0.043
High-middle--High	65.0	19.3	15.7	
Mr Ahmet's condition can be treated by psychotherapy				
Major				
Non-psychology	56.4	23.8	19.8	0.000
Psychology	66.4	28.7	4.9	
Psychology year of study				
2	69.6	19.6	10.7	0.039
3	59.6	38.3	2.1	
4	71.1	28.9	0	
People with similar complaints as Mr Ahmet should be hospitalized				
Major				
Non-psychology	64.0	21.5	14.5	0.003
Psychology	79.7	15.4	4.9	
Birth place				
Non-big city	62.7	22.7	14.5	0.035
Big city	76.0	16.3	7.7	
History of MI				
No	68.2	19.8	12.0	0.048
Yes	81.6	14.5	3.9	

Note. Separate chi-square analyses were done for each demographic variable and each item pair. This table only displays the significant associations. "Mental illness" is abbreviated as MI. The "NS" abbreviation is for no significant associations found.

Table 50. Results of logistic regression analyses of demographic variables that predict opinions and beliefs on treatment of schizophrenia

Items/Demographic Variables	p	B	OR	95% CI Lower	Upper
Mr Ahmet's condition cannot be treated without solving his social problems – ex: unemployment, poverty, family problems, etc. (n=268)					
Year of study (lower)	0.003	0.401	1.493	1.151	1.938
Mr Ahmet's condition will never improve completely (n=264)					
Year of study (higher)	0.005	0.354	1.424	1.115	1.820
Mr Ahmet's condition is treatable condition (n=262)					
Major (psychology)	0.013	0.783	2.187	1.180	4.053
Place of residence (bigger)	0.047	0.664	1.943	1.009	3.743
Father's education (lower)	0.019	0.809	2.247	1.145	4.405
Mr Ahmet's condition can be treated by drugs (n=260)					
Major (psychology)	0.001	1.413	4.110	1.731	9.759
Year of study (higher)	0.002	0.574	1.776	1.226	2.572
Mr Ahmet's condition can be treated by psychotherapy (n=262)					
			NS		
People with similar complaints as Mr Ahmet should be hospitalized (n=272)					
Socioeconomic status (higher)	0.036	0.638	1.893	1.041	3.443

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

A. Gender

According to the results from chi-square and logistic regression analyses, females tend to see the condition presented in the depression case vignette as treatable compared to males. Males on the other hand tend to see the condition as never treatable completely and indicate that people in this condition should be hospitalized.

According to chi-square analysis gender is significantly associated with responses on whether the condition presented in the schizophrenia case vignette could be treated with drugs. Female participants agreed on this item more than males.

B. Area of Study – Psychology vs Non-Psychology Majors

Participants studying psychology have indicated that the condition presented in the depression case vignette can be treated with drugs and psychotherapy more than non-psychology students. More participants studying an area other than psychology have stated that the condition cannot be treated unless the social problems are removed.

Logistic regression and chi-square analyses demonstrate that psychology students state that the condition is treatable and can be treated with drugs more than non-psychology students. Chi-square analyses also show associations in which more psychology students indicate psychotherapy as a treatment option for this condition as well as hospitalization.

C. *Year of Study*

Participants who are in higher classes tend to view the condition as treatable whereas participants who belong to lower classes agree that the people who are in the condition presented in the depression case vignette should be hospitalized more than participants in higher classes do.

Chi-square analyses have also shown that among psychology students, as the year of study increases the number of people agreeing that depressive symptoms could be treated with drugs and psychotherapy also increases.

Participants who belong to lower classes indicated that the condition cannot be treated unless the social problems were removed more than higher class students. Higher class students have stated that this condition will never improve completely and that this condition can be treated with drugs more than lower class students.

Among psychology students, those who belong to lower classes agreed that this condition cannot be treated unless social problems were removed more than those belonging to higher classes. Fourth year students indicated psychotherapy as a treatment option more than second year and then third year students.

D. *Places of Residency and Birth*

Participants who have reported to have been born in big cities have also indicated that depressive symptoms could be treated with psychotherapy.

Logistic regression analysis demonstrated that participants who have reported to reside in a big-city agree that this condition is treatable more than those participants who reported to live in areas other than big-cities.

Chi-square analyses also suggested that participants who reported to have been born in big cities compared to areas other than big cities, stated more agreements on drugs and hospitalization as treatment options.

E. Other Sociodemographic Factors

Participants who considered themselves in a high-middle to high socioeconomic status have agreed on the necessity of hospitalization more than those who consider themselves belonging to low-middle socioeconomic status.

Participants who have fathers with university and above degree seem to have considered the condition treatable less than those participants whose fathers have a below university degree.

F. Exposure to Mental Illness

According to the results from chi-square and logistic regression analyses, participants without a reported history of mental illness indicated the necessity of hospitalization for the depressive condition more than participants with such a history. Chi-square analyses have suggested other significant associations regarding exposure to mental illness and opinions about treatment, such as, history of mental illness and treatment, and contact with someone mentally ill were associated with psychotherapy as a treatment option.

According to a chi-square analysis participants who reported a history of mental illness agreed on the necessity of hospitalization for this case more than participants who have not reported such a history.

6.2.5. Demographic Factors Associated with Attitudes and Social Distance

Demographic variables that were demonstrated to have an association with attitudes and social distance related items regarding the depression and schizophrenia case vignettes are displayed on Table 51 through 54 . Stepwise multiple regression analyses for demographic variables predicting overall social distance scores are displayed on Table 36.

Table 51. Results of chi-square analyses of demographic variables and items on attitudes and social distance regarding depression (*continued on next page)*

Items/Demographic variables	I agree	I disagree	I have no idea	p
People with similar complaints as Ms Fatma, shouldn't be free in the community				
Gender				
Female	4.5	93.2	2.3	0.001
Male	8.2	80.6	11.2	
Major				
Non-psychology	9.2	84.4	6.4	0.005
Psychology	1.4	95.1	3.5	
Year of study				
1	16.7	77.8	5.6	0.023
2	3.9	90.2	5.9	
3	2.5	93.8	3.8	
4	4.3	3.8	5.7	
I could work with a person with similar complaints as Ms Fatma				
Major				
Non-psychology	46.2	45.1	8.7	0.000
Psychology	69.2	21.7	9.1	
Year of study				
1	34.5	56.4	9.1	0.001
2	53.9	32.4	13.7	
3	67.5	27.5	5.0	
4	68.6	25.7	5.7	
Contact with MI				
No	50.0	38.6	11.4	0.023
Yes	64.5	29.6	5.9	
I could marry a person with similar complaints as Ms Fatma				
History of MI				
No	19.8	71.5	8.7	0.029
YEs	34.7	58.7	6.7	
History of MI treatment				
No	20.6	70.8	8.6	0.05
Yes	35.6	57.6	6.8	
Contact with MI				
No	18.1	71.1	10.8	0.023
Yes	29.3	65.3	5.3	
Having a neighbour with similar complaints as Ms Fatma does not make me uneasy				
Major				
Non-psychology	64.7	29.5	5.8	0.029
Psychology	78.3	17.5	4.2	
Year of study				
1	54.5	3.6	0.019	
2	72.5	6.9		
3	75.0	6.2		
4	78.6	1.4		
Contact with MI				
No	64.7	27.5	7.8	0.013
Yes	77.5	20.5	2.0	

Table 51(*continued*). Results of chi-square analyses of demographic variables and items on attitudes and social distance regarding depression

Items/Demographic variables	I agree	I disagree	I have no idea	p
I would not rent my house to a person with similar complaints as Ms Fatma				
Gender				
Female	10.9	86.0	3.2	0.005
Male	24.7	71.1	4.1	
Persons with similar complaints as Ms Fatma are aggressive				
Gender				
Female	10.0	85.1	5.0	0.018
Male	20.8	71.9	7.3	
Major				
Non-psychology	18.6	75.0	6.4	0.008
Psychology	7.0	88.0	4.9	
Year of study				
1	27.3	72.7	0.0	0.002
2	14.0	80.0	6.0	
3	7.5	85.0	7.5	
4	4.3	87.1	8.6	
Place of residence				
Non-big city	22.9	71.1	6.0	0.010
Big city	9.8	84.6	5.6	
Contact with MI				
No	16.3	75.9	7.8	0.030
Yes	9.3	87.3	3.3	
People with similar complaints as Ms Fatma cannot make correct decisions about their own lives			NS	

Note. Separate chi-square analyses were done for each demographic variable and each item pair. This table only displays the significant associations. "Mental illness" is abbreviated as MI. The "NS" abbreviation is for no significant associations found.

Table 52. Results of logistic regression analyses of demographic variables that predict attitudes and social distance regarding depression

				95% CI	
Items/Demographic variables	p	B	OR	Lower	Upper
People with similar complaints as Ms Fatma. shouldn't be free in the community (n=285)					
Major (non psychology)	0.006	2.072	7.937	1.792	35.714
I could work with a person with similar complaints as Ms Fatma (n = 277)					
Major (psychology)	0.002	0.885	2.424	1.403	4.188
Year of study (higher)	0.013	0.327	1.386	1.070	1.796
I could marry a person with similar complaints as Ms Fatma (n = 278)					
Year of study (higher)	0.034	0.290	1.336	1.023	1.746
History of MI (yes)	0.017	0.722	2.058	1.140	3.714
Having a neighbour with similar complaints as Ms Fatma does not make me uneasy (n = 288)					
Year of study (higher)	0.011	0.344	1.410	1.083	1.837
I would not rent my house to a person with similar complaints as Ms Fatma (n = 291)					
Gender (male)	0.004	0.960	2.611	1.355	5.025
Persons with similar complaints as Ms Fatma are aggressive (n = 282)					
Place of residence (smaller)	0.035	0.804	2.232	1.060	4.717
Year of study (lower)	0.002	0.604	1.828	1.248	2.681
People with similar complaints as Ms Fatma cannot make correct decisions about their own lives (n=291)			NS		

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

Table 53. Results of chi-square analyses of demographic variables and items on attitudes and social distance regarding schizophrenia

Items/Demographic variables	I agree	I disagree	I have no idea	p
People with similar complaints as Mr Ahmet, shouldn't be free in the community				
			NS	
I could work with a person with similar complaints as Mr Ahmet				
History of MI				
No	12.9	82.5	4.6	0.028
Yes	25.7	68.9	5.4	
I could marry a person with similar complaints as Mr Ahmet				
			NS	
Having a neighbour with similar complaints as Mr Ahmet does not make me uneasy				
Contact with MI				
No	16.8	74.9	8.4	0.030
Yes	24.7	72.7	2.7	
I would not rent my house to a person with similar complaints as Mr Ahmet				
			NS	
Persons with similar complaints as Mr Ahmet are aggressive				
Gender				
Female	67.7	19.5	12.7	0.000
Male	57.3	40.6	2.1	
Birth place				
Non-big city	73.4	21.1	5.5	0.043
Big city	59.9	28.5	11.6	
Socioeconomic status				
Low-middle	57.1	32.9	10.0	0.034
High-middle--High	70.7	20.7	8.6	
People with similar complaints as Mr Ahmet cannot make correct decisions about their own lives				
Gender				
Female	89.1	6.4	4.5	0.023
Male	82.5	15.5	2.1	

Note. Separate chi-square analyses were done for each demographic variable and each item pair. This table only displays the significant associations. "Mental illness" is abbreviated as MI. The "NS" abbreviation is for no significant associations found.

Table 54. Results of logistic regression analyses of demographic variables that predict attitudes and social distance regarding schizophrenia

Items/Demographic variables	p	B	OR	95% CI Lower	Upper
People with similar complaints as Mr Ahmet. shouldn't be free in the community (n=292)					
Father's Education (higher)	0.047	0.487	1.628	1.007	2.632
I could work with a person with similar complaints as Mr Ahmet (n=283)					
History of MI (yes)	0.017	0.812	2.252	1.158	4.377
I could marry a person with similar complaints as Mr Ahmet (n=288)					
Work (yes)	0.048	1.309	3.704	1.010	13.581
Contact with MI (yes)	0.035	1.681	5.368	1.128	25.544
Having a neighbour with similar complaints as Mr Ahmet does not make me uneasy (n=285)					
			NS		
I would not rent my house to a person with similar complaints as Mr Ahmet (n=283)					
Major (psychology)	0.045	0.523	1.688	1.013	2.813
Year of study (lower)	0.007	0.337	1.401	1.095	1.792
Persons with similar complaints as Mr Ahmet are aggressive (n=272)					
Gender (female)	0.001	0.983	2.673	1.502	4.757
Birth place (smaller)	0.015	0.771	2.160	1.159	4.032
Socioeconomic status (higher)	0.013	0.721	2.056	1.165	3.628
People with similar complaints as Mr Ahmet cannot make correct decisions about their own lives (n=289)					
Gender (female)	0.012	1.025	2.788	1.251	6.216

Note. Discarded responses were coded as missing variables and were excluded from analysis. "I have no idea" responses were also excluded. Selection method for the logistic regression was forward-conditional.

A. Gender

Male participants stated more than female participants that they would not rent their house to someone in a similar condition presented in the depression case vignette. Chi-square analyses also demonstrated that males agreed that people with similar complaints as in the depression case vignette should not be fee in the community and that they are aggressive, more than female participants. These results suggest a more restricting attitude by males compared to females with regards to presentations of depression.

According to both chi-square and logistic regression analyses, females perceived people in the condition portrayed in the schizophrenia case vignette as aggressive and people who cannot make correct decisions about their lives more than males. According to these results it may be

suggested that females demonstrate a more fearful and devaluing response toward presentations of schizophrenia compared to males.

B. Area of Study – Psychology vs Non-Psychology

Regarding area of study, psychology students indicated that they could work with someone with depressive symptoms and have them as neigbours without feeling uneasy more than non-psychology students. Participants who were not psychology majors, indicated that these people should not be free in the community and that they were aggressive more than psychology students. According to these results it may be suggested that non-psychology students tend to give more fearful and restrictive responses to depressive symptoms compared to psychology students. Whereas being a psychology student as also demonstrated by multiple regression analysis (Table 36) predict lower social distance scores, in other words less rejecting attitudes toward depression.

Participants who were psychology majors indicated that they would not rent their houses to people with schizophrenic symptoms more than non-psychology students.

C. Year of Study

Participants who had higher class standings more likely agreed that they could have people with depressive symptoms as neighbors without uneasy feelings, could work with them and could marry them . They also tended to perceive people with depressive symptoms aggressive less than those in lower classes.

Participants who had lower class standings demonstrated increased likelihood to agree that they would not rent their houses to people with schizophrenia.

Multiple regression analyses demonstrated that being a higher class student was associated with increased chance for lower social distance scores for depression (Table 36).

D. Places of Residency and Birth

Participants who reported to live in areas other than big cities stated that people with depressive symptoms were aggressive more than those who reported to live in bigger cities.

People with symptoms of schizophrenia were perceived as aggressive more by participants who reported to live in areas other than big cities compared to participants reported to live in big cities.

E. Socioeconomic Status

People with symptoms of schizophrenia were perceived as aggressive more by participants who belonged to middle-high to high socioeconomic status compared to participants who belonged to low to middle socioeconomic status.

Multiple regression analyses demonstrated that belonging to high-middle to high socioeconomic status was associated to increased chance for higher social distance scores for depression (Table 36).

F. Other Demographic Factors

Participants who were working showed increased likelihood to agree that they could marry someone who had symptoms similar to the schizophrenia case vignette.

Having a father with university or above degree predicted agreement on the statement that people with schizophrenia should not be free in the community

Multiple regression analyses showed that having a father with below university degree predicted lower social distance scores for schizophrenia (Table 36).

G. Exposure to Mental Illness

Exposure to mental illness among participants also was shown to have associations with attitudes and social distance. History of mental illness, history of mental illness treatment and contact with someone mentally ill among participants increased the chance of stating that they could marry a person with depressive symptoms. Chi-square analyses also demonstrated that participants who reported a contact with mental illness

stated that they could work with someone with depressive symptoms and have them as neighbours without feeling uneasy more than participants with no contact. Participants who did not have a contact indicated that people with depressive symptoms were aggressive more than participants with such contact

Participants who reported a history of mental illness stated that they could work with people who presented symptoms of schizophrenia more than participants with no history. Participants who had a contact with someone mentally ill also agreed more to the statements that they could marry someone with symptoms of schizophrenia or have them as a neighbor without feeling uneasy more than participants who did not have such a contact.

Multiple regression analyses indicated that having a contact with mental illness predicted lower social distance scores for depression and having a history of mental illness predicted lower social distance scores for schizophrenia (Table 36).

7. DISCUSSION

7.1.Labeling of Mental Illness: Labels Associated with and Expressed to be Used to Describe a Person with Mental Illness

The most frequent labels that were associated with mental illness were “deli” (crazy, insane), “hasta” (ill, sick), “dengesiz” (unstable, disturbed), “ rahatsız” (uncomfortable, unwell, ill), “sorunlu” (with problems, troubled) in order of frequency. Most of the responses belonged to the medical (29%) and derogatory (29%) labels category followed by symptom related labels (26%). This suggests that the when asked to think about a person with mental illness participants mostly make associations with medical and derogatory labels. The medical labels associated however refer to more general terms rather than psychological or mental health related terms.

“Hasta” (ill, sick), “rahatsız” (uncomfortable, unwell, ill), “deli”(crazy, insane), “sorunlu” (with problems, troubled) and total of labels refering to psychological and mental problems, disturbances were labels most frequently expressed to be used to describe a person with mental illness. Most of these responses belonged to the medical labels category (34%) followed by derogatory labels category (25%). These results demonstrate an emphasis on medical labels compared to other label categories when participants are asked to express what labels they would use to describe a person with mental illness. These findings also suggest that psychological and mental health related terms are expressed frequently as well as more general health related terms within the medical labels category.

The most frequent label that was expressed to be used by others to describe a mentally ill individual was “deli” with a frequency twice the frequency of the second ranking label “hasta” (ill, sick). Labels referring to psychological and mental problems or disturbances were much less. Nearly half of the responses belonged to the derogatory labels category (46%) followed by medical labels category (32%). This suggests that there is an emphasis on expressing derogatory labels when participants are asked to provide labels used by others to describe a person with mental illness.

When participants were asked to think of a person with mental illness they made medical or derogatory related associations. Although use of derogatory labels might easily indicate negative attitudes, the same argument is not easy to make for the use of medical labels. Considering the *secondary labeling theory* the use of medical labels could implicate negative attitudes. This may carry relevance considering that the majority of the medical labels consisted of more general health or ill-health related terms such as “hasta” and “rahatsız.” These terms were included under the medical labels category with their denotative meanings. However, there are instances where their connotative meanings refer to derogatory meanings.

When participants were asked to express terms that they would use in daily life to describe a person with mental illness, there was more emphasis on medical labels compared to derogatory labels. This time the medical labels also consisted of specifically psychological and mental health or ill-health related terms. This may suggest that although there is an observable negative attitude on an intended behavior level, by the expressed use of derogatory labels, there is also emphasis on describing people with mental illness by recognizing and acknowledging their problem. The high frequency of derogatory labels which were expressed to be used by others around the participants compared to the frequency of derogatory labels expressed to be used by the participants. This may suggests that participants have a tendency to describe people with mental illness with less negative labels compared to others. However as discussed earlier social desirability bias may also explain this trend. Participants may have a tendency to conceal their negative labeling attitudes and projecting these attitudes to others.

Overall, among the six themes that emerged from the responses (medical, symptom related, personal and social problem, compassion and pity related, normalization and denial related, derogatory) there was more emphasis on medical and derogatory labels followed by symptom related labels. With regards to the number of labels, derogatory labels category involved more variability compared to medical labels category.

The expectation for the emphasized use of derogatory labels both associated with and expressed to be used to describe people with mental illness was supported. The frequent use of derogatory labels was also demonstrated in Rose et al. (2007) study. On the contrary to my expectations on frequent use of violence, aggression, dangerousness related terms there were only 29 responses, 21 of them expressed as labels that were associated with a person with mental illness. This surprising finding was also evident in Rose et al. (2007) study. The terms referring to "unpredictability" in Turkish were grouped under different label categories because of their denotative meaning thus further analyses would be required in order to demonstrate any tendencies. As expected, labels referring to sympathy were demonstrated and referred to feelings of compassion and pity.

7.2.Opinions, Beliefs and Attitudes Regarding Mental Illness

7.2.1. Recognition

Overall both the conditions described in the major depression and paranoid-type schizophrenia case vignettes were recognized as mental illness ("ruhsal hastalık" and "akıl hastalığı" added together) by majority of participants. The recognition of mental illness was slightly higher for the schizophrenia condition (%90) compared to the major depressive condition (%84) which confirms previous evidence (Angermeyer & Dietrich, 2006; Eşsizoğlu & Arısoy, 2008; Hill, 2005; Link et al. 1999). Depressive condition was recognized as "ruhsal hastalık" (84%) by the majority of participants (also Özmen et al., 2003b, 2004a; Seyfe Şen et al., 2003)whereas paranoid-type schizophrenia condition was described more as "akıl hastalığı" (63%) and less as "ruhsal hastalık"(28%) which are results that support Özmen et al.'s (2004b) study. Taşkın et al. (2003a, 2003b) and studies showed a greater frequency of "ruhsal hastalık" than "akıl hastalığı" for recognizing the schizophrenia case vignette.

7.2.2. Perception and Causal Attribution

The condition presented in the major depression case vignette was perceived as a condition that may be experienced by anyone from time to time and a state of extreme sadness by a majority of participants (87% and 66% respectively). Similar results were demontrated in some Turkish studies (Özmen et al., 2003b; Seyfe Şen et al., 2003)Very few participants perceived the paranoid-type schizophrenia condition this way (13% and 12%) however these findings are contrary to some Turkish studies which have demonstrated greater frequency of these perceptions among their samples (Taşkın et al., 2003b)

The most prominent causal explanation for depressive symptoms was social problems (82%) however the causal explanations for paranoid-type schizophrenia symptoms emphasized on biological factors (68%), genetic factors (59%). These results parallel Angermeyer & Dietrich's review of general population studies (2006).

With regards to previous Turkish studies emphasis on social factors as causal explanation for depression was confirmed by these results (Eşsizoğlu & Arısoy, 2008; Özmen et al., 2003b, 2004a; Seyfe Şen et al., 2003; Taşkın et al., 2005, 2006, 2009). Contrary to some Turkish studies which suggested weakness of personality as causal factor for depression (Özmen et al., 2003b, 2004a; Seyfe Şen et al., 2003), in this study only 33% of participants agreed to this causal factor.

Some Turkish studies have demonstrated emphasis on social problems as causal explanations for schizophrenia symptoms (Sağduyu et al., 2001, 2003; Taşkın et al., 2003b) and some on weakness of personality (a range of 40-65% of participants) (Aker et al., 2002; Özyiğit et al., 2004; Sağduyu et al., 2001, 2003; Taşkın et al., 2003a, 2003b,). However in this study 33% of participants agreed on social problems and 38% on weakness of personality as causal explanation for schizophrenia.

7.2.3. Opinions and Beliefs on Treatment Options

With regards to treatability although majority of participants believed that both case vignette conditions were treatable however depressive symptoms were believed to be treatable more than schizophrenia symtpoms (90% and 68%). For depression (Özmen et al., 2003b, 2005; Seyfe Şen et al., 2003; Taşkın et al., 2005) for schizophrenia (Taşkın et al., 2003a) Worse prognosis was associated with schizophrenia case compared to the depression case.

Mostly preferred treatment options for depressive symptoms were psychotherapy (78%), removal of social problems (66%) and drug treatment (50%) and for schizophrenia symptoms were drug treatment (71%), hospitalization (71%) and psychotherapy (61%).

An emphasis on psychosocial interventions for depression demonstrated in various studies (Angermeyer & Dietrich, 2006;Eşsizoğlu & Arısoy, 2008; Özmen et al., 2003b, 2004a, 2005) has been supported.

An emphasis on drug treatment for schizophrenia in various studies (Aker et al., 2002; Angermeyer & Dietrich, 2006; Gaebel et al., 2000) has been confirmed in this study. The percentage of participants who suggest psychotherapy as a treatment option for schizophrenia in this study was similar to that in some Turkish studies (Aker et al., 2002; Sağduyu, et al., 2001) however in these studies psychotherapy was less preferred than drug treatment in Aker et al. study and the reverse in Sağduyu et al. study.

7.2.4. Opinions and Beliefs about Help-Seeking Options

Majority of participants agreed that the person presented in the case vignettes should first prefer going to a mental health specialist with a greater tendency regarding schizophrenia case (82%) compared to the depression case (64%). Secondly suggested help-seeking options were personal and social related solutions for depression and going to a physician for schizophrenia. Thus an emphasis on psychosocial interventions for depression and psychobiological interventions for schizophrenia is also reflected in these results. In some Turkish studies majority of participants

gave precedence to going to a physician especially psychiatrist or psychologist (Aker et al., 2002; Özmen et al., 2003b, 2005; Seyfe Şen et al., 2003; Taşkın et al., 2003a). In studies investigating attitudes toward depression suggested options for help-seeking were also similar to this study's findings (Özmen et al., 2003b, 2005; Seyfe Şen et al., 2003) .

7.2.5. Attitudes and Social Distance

Considering previous research evidence on attributions regarding dangerousness and violence, this study's results supported the notion that violence and dangerousness was more frequently associated with schizophrenia compared to depression (Angermeyer & Dietrich, 2006; Imran &Haider, 2007; Sağduyu et al., 2001). People with symptoms presented in the schizophrenia case vignette was reported by participants to be aggressive (64%) (similar in Aker et al, 2002; Taşkın et al., 2003a, 2003b) more than the depression case vignette (13%) (similar in Özmen et al., 2004a).

Majority of participants thought that people with both symptoms of depression and schizophrenia could not make correct decisions about their own lives, however this attitude was more frequent in reaction to the schizophrenia case (86%) (similar in Aker et al., 2002; Taşkın et al., 2003a, 2003b) compared to depression case (52%) (similar in Özmen et al. 2004a).

Looking at the results from the social distance items for both depression and schizophrenia case vignettes as the level of intimacy increased from a tenant, to a neigbour, colleague and spouse the desired social distance also increased. This result confirmed previous studies and review results (Aker et al., 2002; Angermeyer & Dietrich, 2006; Gaebel et al., 2000;Özmen et al., 2004a; Özyiğit et al., 2002; Taşkın et al., 2003a, 2003b). Comparison of social distance scores of items regarding the depression and schizophrenia case vignettes revealed significantly higher scores for schizophrenia, in other words greater desire for social distance for people having symptoms of schizophrenia. There are various studies that

confirm this finding as well (Angermeyer & Dietrich, 2006; Nordt, Rössler, & Lauber, 2006)

7.3.Some Associations Between Results from Two Different Methods: Label Themes and Opinions, Beliefs and Attitudes

When analyses were conducted to explore predictive characteristics of label themes with regards to agreements on case vignette items, some associations were found.

Medical and derogatory labels were associated with some items on case vignettes however these associations did not reflect any clear tendencies. This may be explained by the consideration that both label themes were widely used by the majority of participants and for this reason may not have predicted the tendencies demonstrated by the case vignette items. It may be suggested that the results from two different methods are not clearly correlated. This argument however needs further investigation. As discussed earlier certain labels included in the medical labels category had some negative connotations in daily usage. A different categorization of themes may demonstrate different results.

An interesting trend was found with regards to sympotom related labels and depression case vignette items. When a person with mental illness was associated with a symptom related label, there was an increased chance for participants to agree on genetic factors and infantile/childhood problems as causes for depression and to have higher overall social distance scores. However when symptom related labels were expressed as labels used to describe a person with mental illness in daily life, there was a decreased chance to agree on genetic factors and infantile/childhood problems, and weak personality as causes for depression and to have lower overall social distance scores. This suggests that similar labels included under the same symptom related labels category are associated with certain beliefs and attitudes differently under different contexts. If symptom related labels are associated with a person with mental illness participants tend to have more rejecting attitudes however when these labels are expressed to be

used to describe a person with mental illness participants tend to have less rejecting attitudes. This trend however needs further demonstrations with the specific labels included in this category.

Other label themes were associated with some items regarding case vignettes however due to high confidence interval ranges they were considered to be less reliable. Further analyses and demonstrations are again needed in this matter.

7.4.Factors Associated with Labeling, Opinions, Beliefs and Attitudes

7.4.1. Type of Mental Illness

Overall significant differences with regards to recognition, causal attribution, opinions and beliefs on treatment, and desired social distance were found in reaction to presentations of two different mental illnesses. Schizophrenia was recognized as “akıl hastalığı”, believed to be caused by biologically related factors, thought to be treatable with drugs and hospitalization, more than depression. Depression on the other hand was recognized as “ruhsal hastalık”, believed to be caused by social factors, thought to be treatable by psychosocial interventions, more than schizophrenia. Both conditions were recognized as mental illnesses in general, regardded as treatable and for both conditions mental health specialists were suggested as sources for help by the majority of participants. However participants expressed greater desires for social distance in reaction to symptoms of schizophrenia than depressive symptoms. Although both types of mental illnesses were recognized rather accurately by this study’s sample with regards to recognition of mental illness and opinions and beliefs about etiology, treatment and help-seeking options; schizophrenia was associated with higher stigmatizing attitudes with regards to expressed intended behaviors and labeling.

7.4.2. Gender

More males than females provided labels related to compassion and pity when asked for associations regarding a person with mental illness. Females more than males expressed to be using symptom related labels in describing a person with mental illness.

In reaction to the case vignettes males more than females viewed depression with bad prognosis, thought hospitalization as a treatment option, believed people with depressive symptoms to be aggressive and restricted in the community, and were unwilling to rent their house to these people. This suggests an more incaccurate knowledge regarding depression by males compared to females. Females on the other hand believed more than males depression as a treatable condition.

Males perceived schizophrenia as a condition of extreme sadness and condition that can be experienced by everyone from time to time, and believed that the condition was due to infantile/childhood problems

Females on the other hand believed more than males that schizophrenia was due to genetic factors and can be treated with drugs. Females also viewed people with schizophrenia symptoms to be aggressive and unable to make correct decisions.

Considering females' greater focus on using symptom related labels in describing a person with mental illness, these results from case vignette responses may suggest an greater emphasis on medical and biological factors by females. Males on the other hand seem to demonstrate a denying tendency with regards to medical and biological factors and rather have greater emphasis on social factors, especially with regards to schizophrenia. Also with regards to depression males seem to have more inaccurate knowledge and have greater desire for social distance and restriction than females. Females demonstrated a more fearful response toward people with schizophrenia than males. This gender differences regarding depression and schizophrenia may be explained by high prevalence rates of depression among females. However these arguments require further research since my

results were limited by the uneven distribution of female male ratio in my sample.

7.4.3. Area of study – Psychology vs Non-psychology Majors

Psychology students more than non-psychology students associated a person with mental illness with symptom related labels whereas non-psychology students demonstrated associations with compassion and pity related and derogatory labels.

Non-psychology students more than psychology students emphasized social problems and weakness of personality as causes for, and social interventions for treatment of depression whereas psychology students emphasized on genetic factors and childhood problems as etiology for and drug and psychotherapy as treatment options for depression. Non-psychology students demonstrated more restrictive and fearful responses with regards to depressive symptoms wheras psychology students showed greater acceptance than non-psychology students on relatively less close level of intimacy (such as neighbour and colleague). Overall psychology students demonstrated lower social distance scores, in other words less rejecting attitudes toward people with depression.

Non-psychology students more than psychology students perceived schizophrenia as a condition that can be experienced from time to time and believed personality weakness to be a cause for schizophrenia. Psychology students on the other hand emphasized on genetic and biological factors for the etiology of schizophrenia. They also believed schizophrenia symptoms to be treatable, and can be treated with drughs, psychotherapy and hospitalization more than non-psychology students. Psychology students more than non-psychology students expressed hesitant attitude about renting a house to a aperson with schizophrenia.

Overall, non-psychology students emphasize more on psychosocial factors whereas psychology students emphasize psychobiological factors with regards to depression. Psychology students demonstrate less rejecting attitudes and non-psychology students demonstrate more restrictive and

fearful responses toward people with depression. There is a tendency to emphasize psychosocial factors among non-psychology students more than psychology students and emphasize psychobiological factors among psychology students. Psychology students also demonstrate a greater emphasis on treatment options for schizophrenia however they also seem to be hesistant in accepting people with schizophrenia. Thus it can be argued that psychology students put more emphasis on psychobiological factors and have more accurate knowledge regarding treatment options and this seems to be associated with less rejecting attitudes toward depression however the same cannot be said for schizophrenia. Although there seems to be an association with regards to area of study and opinions, beliefs and attitudes; whether this association is an implication of the psychology education or an influence by experiential or personal factors remains to be studied.

7.4.4. Year of study

Students attending higher classes associated a person with mental illness with medical labels more than associated with normalization or denial related labels less than students attending lower classes, indicating increasing acknowledgement of ill-health mental or general with increasing years of study.

Students in higher grades emphasized genetic factors and weakness of personality as causes for depressive symptoms and thought of the condition as treatable more than; believed for the necessity of hosptilaziton less than students attending lower grades. Although causational attributions regarding depression do not demonstrate a clear tendency, there seems to be a tendency for more positive treatment options with increasing grades. The association between more positive treatment options and higher grades was also demonstrated in Özmen et al. (2005) for depression. Students attending higher grades overall had lower social distance scores indicating more accepting attitudes for depression.

Students in first year of study demonstrated a belief that schizophrenai was a condition that could be experienced by everyone from

time to time and emphasized social interventions as for treatment more than students in higher grades. Students attending higher grades emphasized genetic factors as a causational factor and drug treatment as a treatment option for schizophrenia more than lower grade students. These findings seem to contradict with Kaya & Ünal (2006) study in which higher education levels were associated with greater emphasis on social problems as causational factors for schizophrenia. Students attending higher grades however also believed that schizophrenia had bad prognosis more than students attending lower grades. No significant associations were found regarding social distance attitudes regarding schizophrenia, which was demonstrated by Sağduyu et al. (2001).

Overall a some indications for more positive treatment options and tendencies for less rejecting attitudes for depression, more accurate causational and more positive treatment beliefs regarding schizophrenia in students attending higher grades were demonstrated.

When only psychology students were considered derogatory labels were associated with a person with mental illness most among third year psychology students. This finding is interesting considering the fact that third year psychology students have been taking a course on abnormal psychology for a semester during the time they filled out the questionnaires.

Among psychology students a more emphasis on pscyhotherapy and psychopharmacological treatment for depression as year of study increases. Psychotherapy was an emphasized treatment option among fourht year psychology students regardign schizophrenia, and for students attending lower grades social interventions were emphasized.

Although these results need further evidence, it might be suggested that within the psychology students in this sample, an increase in year of study is mostly associated with more accurate and positive opinions on treatment. However year of study among psychology does not seem to have a positive influence with regards to labeling of the mentally ill. The findings from some previous studies which have demonstrated more positive attitudes toward mental illness with increasing years of study among

medical students (Ay, Save & Fidanoğlu, 2006; Berksun & Birdoğan, 2002) were not replicated in this study however should be aimed for in future studies.

7.4.5. Places of Residency and Birth – Urban vs Rural

With regards to place of birth and residency some indications of association were found.

There were some indications that those participants who reported to have been born in areas other than big cities associated and described people with mental illnes with normalization and denial related labels.

With regards to birth place, when big cities and areas other than big cities were compared, those participants who were born in big cities tended to believe depressive symptoms could be treated with psychotherapy. They also regarded genetic factors responsible for schizophrenia, believed drug treatment and hospitalization as treatment options for schizophrenia. People born in other areas than big cities believed genetic factors to be responsible for depression. This may suggest a slightly more accurate understanding of causation and treatment options for depression and schizophrenia among people who were born in big cities. Contrary to earlier and recent research in Turkish samples that showed some associations between residency in rural areas and higher social distance scores, less accurate knowledge about causation and treatment (Özmen et al., 2003b, 2004a, 2005; Savaşır, 1971b, 1971c; Seyfe Şen et al., 2003; Taşkın et al., 2006) no associations were found with regards to social distance attitudes in this study. Only those who lived in non big city areas demonstrated a belief that people with depressive and schizophrenia symptoms were aggressive, suggesting a fearful response. In Savaşır's (1971b) study people residing both in urban and rural areas had attributed aggression to people with mental illness. In this study this was not supported which may suggest that after about forty years, aggressive behaviors are less attributed to mental illness in urban areas.

7.4.6. Socioeconomic Status

Those participants who considered themselves to have a high-middle to high socioeconomic status expressed a use of symptom related labels when describing a person with mental illness.

These participants also viewed hospitalization necessary for treatment of schizophrenia, attributed aggression to people with schizophrenia and demonstrated higher social distance scores for depression, in other words more rejecting attitudes toward depression. This finding is interesting possibly suggesting an association between high socioeconomic status and more fearful, rejecting and restricting tendencies toward depression and schizophrenia. There were no studies found that support these finding except for a study that demonstrated an association between high socioeconomic status with social problems as causational factors for schizophrenia (Kaya & Ünal, 2006). Sağduyu et al. (2001) studies association between lower socioeconomic status and negative attitudes toward schizophrenia was not supported in this study.

7.4.7. Parental Education

There were some associations found between parental education levels and labeling, opinions, beliefs and attitudes. However further studies focusing on these associations are thought to be necessary in order to explain these relationships.

7.4.8. Exposure to Mental Illness

Participants who had history of mental illness associated a person with mental illness with symptom related labels and less with derogatory labels compared to others who did not have a history. Those who had a contact with mental illness on the other hand associated a mentally ill person with more personal and social problem related labels.

History of mental illness among participants was associated with greater agreement on biological basis for the cause of and psychotherapy as a treatment option for depression. No history of mental illness on the other

hand was associated with perception of depression as a condition of extreme sadness and necessity for hospitalization as a treatment option for depression. History of mental illness was associated with opinions regarding a necessity for hospitalization in the schizophrenia case. It was also associated with overall lower social distances scores for schizophrenia. Thus it is suggested that history of mental illness is especially influential in more accurate opinions on treatment options and less rejecting attitudes toward schizophrenia.

Participants who had contact with mental illness believed biological factors as responsible for depression and schizophrenia, emphasized psychotherapy as a treatment option for depression. Whereas, participants without a contact with mental illness tended to believe that personal weakness was a cause for depression. Contact with mental illness was also associated with overall lower social distance scores in other words less rejecting attitudes toward people with depressive symptoms. No contact with mental illness increased the tendency to view people with depressive symptoms to be aggressive. Thus contact with mental illness is demonstrated to be associated with more accurate opinions and beliefs regarding causation and treatment as well as more accepting attitudes toward depression.

Overall it can be suggested that history of mental illness and contact with mental illness has positive influences with regards to opinions and beliefs regarding mental illness as well as accepting attitudes toward mentally ill individuals. However further research is necessary to explore the implications of history of, contact with mental illness as well as the types of mental illnesses in history and contact.

7.4.9. Summary of Factors Associated with Label Themes, Opinions, Beliefs and Attitudes

As hypothesized type of mental illness, area and year of study, and exposure to mental illness were found to be associated with opinions, beliefs and attitudes.

Among variables that were aimed for investigation, there were some tendencies found with regards to gender differences, places of residency and birth, socioeconomic status, parental education levels. However these variables are needed to be investigated specifically in further research.

7.5.Limitations and Suggestions for Further Research

My aim in this study was to explore stigma of mental illness among university students. However one limitation of this study is that the convenience sample results cannot be generalized to university student population. Thus this research study should be expanded to a greater sample.

The qualitative method used to investigate labels used in different contexts should be applied to different age groups as well as different socioeconomic and cultural contexts in order to make comparisons for different samples.

Case vignette items could be adapted to other specific mental illnesses since it is difficult to make generalizations about opinions, beliefs and attitudes toward mental illness in general from reactions to two different mental illnesses.

A brief comparison between results from two methods showed no clearly defined tendencies or correlations. This may be explained by actual differences in what two methods assess. However it may also be due to the influences of the themes derived. Different categorizations may reveal different results, thus further research may focus on influences of different categorizations.

With regards to factors associated with labeling of and opinions, beliefs and attitudes regarding mental illness, further studies are needed to especially investigate influences of gender differences, urban and rural areas, socioeconomic status, types of mental illnesses other than depression and schizophrenia, influences of education compared to personal and experiential differences, and different forms of history of and contact with mental illnesses. The results from a self-identity measure constructed for

this study was analyzed only descriptively. Further analyses should look for associations between these results and labels, opinions, beliefs and attitudes regarding mental illness. This measure could also be used for other areas involving stigmatizing attitudes.

8. CONCLUSION

Labeling analyses revealed six themes: derogatory labels, medical labels, symptom related labels, personal and social problem related labels, compassion and pity related labels, normalization and denial related labels. Among these themes medical and derogatory labels were the frequently used labels. Labels that were associated with a person with mental illness belonged to the medical and derogatory label themes. Medical labels however were more frequent with regards to describing a person with mental illness in daily life when compared to derogatory labels. A check for social desirability bias revealed a tendency to disguise use of derogatory labels and project this tendency to others. With regards to the variability of labels derogatory labels category included the most variability. The analyses were conducted by taking the denotative meanings of the responses into account, however different themes and associations may emerge if connotative meanings are also taken into account.

Case vignette analyses revealed a majority of recognition of depression and schizophrenia as mental illnesses however when the distinctness between the two Turkish terms for mental illness is taken into consideration, schizophrenia was recognized as “akıl hastalığı” more than depression and depression was recognized as “ruhsal hastalık” more than schizophrenia. With regards to causal attributions, an emphasis on psychosocial factors were observant for depression and psychobiological factors for schizophrenia. A similar trend of emphases were observed for the opinions and beliefs regarding treatment options for depression and schizophrenia. Hospitalization was a more frequent option for schizophrenia. Majority of participants offered seeking help from a mental health specialist as a first option both for depression and schizophrenia,

however a this option was considered more frequently for schizophrenia. Schizophrenia condition was associated with aggression more than depression. Overall social distance scores for schizophrenia was significantly higher than depression, indicating more rejecting attitudes. For both conditions high social distance scores were associated with inreased level of intimacy in presented contexts.

When predictive characteristics of label themes for opinions, beliefs and attitudes regarding depression and schizophrenia were analyzed although some tendencies were demonstrated no clear associations were drawn. This may be explained by a prevalent use of derogatory and medical labels as well as by the influence of the particular categorizations derived in this study.

With regards to factors associated with label themes, opinions, beliefs and attitudes, type of mental illness has been demonstrated to have an influence. Some tendencies were also observed with regards to gender differences, class standing (year of study), area of study (psychology vs non-psychology), palce of residency and birth, socioeconomic status, parental education levels and exposure to mental illness.

These results suggest a well recognition of depression and schizophrenia with rather accurate emphases regarding opinions and beliefs on causational factors and treatment options. However rejecting and negative attitudes are still present and the use of derogatory labels is very prevalent. These results from two major approaches demonstrate some similarities and some differences. Thus it can be suggested that considering a multi-method approach is important in revealing the different layers of the origins and functions of stigma. For this reason, metaphorically speaking we need to consider ways that allow the blind people touching one part of the elephant to communicate with eachother so that they can form a more holistic picture of the elephant. A multi-layered understanding of stigma is important in efforts to tackle the challenges associated with it because as Corrigan, Markowitz and Watson (2004) nicely put it:

> Mental illness strikes with a two-edged sword. On one side, people must struggle with the symptoms and disabilities that prevent them from achieving many of their life goals. On the other, the stigma of mental illness further hampers their opportunities and aspirations. (p. 489)

This is not only a concern for people like my patients which I have introduced in the beginning, but entails and concerns all of us.

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Appendix A: Sociodemographic Form

Genel Bilgiler:

---

1. **Yaşınız:** _____

2. **Cinsiyetiniz**: Kadın ☐ Erkek ☐

3. **Okuduğunuz**

   Üniversite: ______________________________

   Bölüm: ______________________________

   Sınıf: ________

4. **Aşağıdakilerden hangisi doğduğunuz yeri en iyi şekilde tanımlar?**

   Köy ☐ Bucak ☐ İlçe Merkezi ☐ İl merkezi ☐

   Büyükşehir ☐

5. **Aşağıdakilerden hangisi ikamet ettiğiniz yeri en iyi şekilde tanımlar?**

   Köy ☐ Bucak ☐ İlçe Merkezi ☐ İl merkezi ☐

   Büyükşehir ☐

6. **Aşağıdakilerden hangisi sosyoekonomik statünüzü en iyi şekilde tanımlar?**

   Alt ☐ Alt-orta ☐ Orta ☐ Üst-orta ☐ Üst ☐

7. **Ücret veya burs karşılığı bir işte çalışıyor musunuz?**
   Evet ☐ Hayır ☐

8. **Aşağıdakilerden hangisi annenizin eğitim düzeyini en iyi şekilde tanımlar?**
   ☐ Okuryazar değil
   ☐ Okuryazar ama okul bitirmedi
   ☐ İlkokul
   ☐ Ortaokul
   ☐ Lise
   ☐ Üniversite
   ☐ Yüksek lisans/doktora

9. **Aşağıdakilerden hangisi babanızın eğitim düzeyini en iyi şekilde tanımlar?**
   ☐ Okuryazar değil
   ☐ Okuryazar ama okul bitirmedi
   ☐ İlkokul
   ☐ Ortaokul
   ☐ Lise
   ☐ Üniversite
   ☐ Yüksek lisans/doktora

Appendix B: Labeling Questionnaire

Aşağıda açık uçlu, doğru/yanlış cevabı olmayan üç soru yer almaktadır. Lütfen soruları dikkatlice okuyup her bir soruya en az bir kelime veya terim veya deyiş veya deyim yazınız. Lütfen cümle veya açıklama yazmaktan kaçınınız.

A. Ruhsal rahatsızlığı olduğunu düşündüğünüz veya bildiğiniz bir bireyi veya karakteri aklınıza getirin. Ne tür kelime / terim / deyiş / deyimler aklınıza geliyor? Lütfen olabildiğince düşünmeden aklınıza ilk geldiği şekliyle yazınız.

B. Ruhsal rahatsızlığı olduğunu düşündüğünüz veya bildiğiniz bir bireyi veya karakteri aklınıza getirin. Günlük hayatınızda bu bireyi veya karakteri tanımlarken, anlatırken, bu birey veya karakter hakkında konuşurken en çok hangi kelime / terim / deyiş / deyimler kullanırsınız?

C. Çevrenizdeki kişiler ruhsal rahatsızlığı olduğunu düşündükleri veya bildikleri bir bireyi veya karakteri tanımlarken en çok hangi kelime / terim / deyiş / deyimleri kullanırlar?

Appendix C: Exposure to Mental Illness Questionnaire

Lütfen aşağıdaki sorularda durumunuzu en iyi tanımlayan seçeneği işaretleyiniz. Seçtiğiniz seçenekle ilgili daha detaylı bilgi isteniyorsa lütfen verilen boşluklara bu bilgileri bildiğiniz şekli ile yazınız.

1. **Hayatınızın herhangi bir döneminde ruhsal rahatsızlığınız oldu mu?**

   Hayır ☐
   Evet ☐
   "Evet" ise, ruhsal rahatsızlığınızın adını veya tanısını yazınız:
   ____.

2. **Hayatınızın herhangi bir döneminde ruhsal rahatsızlığınız için tedavi gördünüz mü?**

   Hayır ☐
   Evet ☐
   "Evet" ise, ruhsal rahatsızlığınız için görmüş/görmekte olduğunuz tedaviyi belirtiniz:
   ____.

3. **Ruhsal rahatsızlığı olan bir yakınınız, var mı veya geçmişte oldu mu?**

   Hayır ☐
   Evet ☐
   "Evet" ise, yakınlık derecesini belirtiniz: _________________________.
   "Evet" ise, biliyorsanız bu ruhsal rahatsızlığın adını veya tanısını belirtiniz:
   ____.

4. **Ruhsal sağlık sorunları hakkındaki bilgi seviyenizi en iyi hangisi tanımlar?**

   ☐ Hiç bilgim yok
   ☐ Az bilgiliyim
   ☐ Orta düzeyde bilgiliyim
   ☐ Oldukça bilgiliyim
   ☐ Çok fazla bilgiliyim

5. **Ruhsal sağlık sorunları hakkında bilginiz var ise bu bilgileri <u>en çok</u> nereden edindiniz? (Lütfen tek bir kutuyu işaretleyiniz.)**

   ☐ Akademik ortam
   ☐ Eğitim amaçlı faaliyet (Örn: konferans, seminer, kurs)
   ☐ Kitap
   ☐ İnternet
   ☐ Medya
   ☐ Sosyal çevrem
   ☐ Diğer (Belirtiniz: ________________)

Appendix D: Self-Identity Questionnaire

Aşağıdaki tablonun A sütununda bazı kimlik boyutları verilmiştir.

Tablonun B. sütununda bu boyutlara göre kendinizi tanımlarken hangi kelime/terimleri kullandığınızı belirtmeniz istenmektedir.

C. sütununda ise kendinizi tanımlarken bu kimlik boyutlarından hangilerini ne derecede önemsediğiniz ve kullandığınıza göre "0" ile "6" arasında bir sayıya karşılık gelen kutuyu işaretlemeniz istenmektedir.

0 = Kendimi tanımlarken bu boyuta hiç önem vermem, dikkate bile almam

6 = Kendimi tanımlarken bu boyuta çok önem veririm, her zaman dikkate alırım

A.	B.	C.						
	Bu boyutta kendimi tanımlarken şu kelimeleri/terimleri kullanırım:	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Cinsiyet		☐	☐	☐	☐	☐	☐	☐
Yaş grubu		☐	☐	☐	☐	☐	☐	☐
Öğrenim görülen okul		☐	☐	☐	☐	☐	☐	☐
Öğrenim görülen bölüm / Meslek		☐	☐	☐	☐	☐	☐	☐
Aile içi rol (Örn. Anne, baba, kardeş, çocuk, vb.)		☐	☐	☐	☐	☐	☐	☐
İlgi alanları/hobiler/sosyal faaliyet alanları		☐	☐	☐	☐	☐	☐	☐
Cinsel tercih		☐	☐	☐	☐	☐	☐	☐
Din/dinsel inanç sistemi		☐	☐	☐	☐	☐	☐	☐
Milliyet/etnik köken		☐	☐	☐	☐	☐	☐	☐
Politik/ideolojik görüş		☐	☐	☐	☐	☐	☐	☐
Hemşehrilik		☐	☐	☐	☐	☐	☐	☐
Yurttaşı olduğunuz ülke		☐	☐	☐	☐	☐	☐	☐
Kültürel coğrafya (Örn. Akdenizli, Avrupalı, Asyalı, Ortadoğulu, vb.)		☐	☐	☐	☐	☐	☐	☐
Spor kulübü taraftarlığı		☐	☐	☐	☐	☐	☐	☐
Diğer (Belirtiniz: ___________________)		☐	☐	☐	☐	☐	☐	☐
Diğer (Belirtiniz: ___________________)		☐	☐	☐	☐	☐	☐	☐
Diğer (Belirtiniz: ___________________)		☐	☐	☐	☐	☐	☐	☐

Appendix E: Attitudes Toward Depression Questionnaire

Aşağıda bazı sorunları olan bir kişinin kısa öyküsü anlatılmaktadır. Bu kısa öyküyü dikkatlice okuduktan sonra lütfen sırasıyla 1.'den 22.'ye kadar olan soruları cevaplayınız.

Fatma Hanım, 38 yaşında, evli, 3 çocuklu bir ev kadını. Eşi memur. Fatma Hanım kendisini sürekli üzüntülü, neşesiz hissettiğini, sık sık ağladığını, eskiden severek yaptığı işleri artık yapmak istemediğini, geceleri uyuyamadığını, halsiz, iştahsız olduğunu, giderek zayıfladığını belirtmektedir. Birkaç aydır var olan bu durumunun son zamanlarda hemen hemen her gün olduğunu ve gün boyu sürdüğünü söylemektedir.

1. Size göre Fatma hanımın durumu aşağıdakilerden hangisine uymaktadır? (lütfen tek bir kutuyu işaretleyiniz)	
Fatma hanımda bedensel bir hastalık bulunmaktadır	☐
Fatma hanımda ruhsal bir hastalık bulunmaktadır	☐
Fatma hanımda bir akıl hastalığı bulunmaktadır	☐
Fatma hanımda bir sinir hastalığı bulunmaktadır	☐
Fatma hanımda herhangi bir hastalık bulunmamaktadır	☐
Diğer:_________________________	☐

Lütfen aşağıdaki tablonun ilk sütununda yer alan ifadelere katılıp katılmadığınızı belirtiniz. Her bir ifade için "katılıyorum", "kısmen katılıyorum", "pek katılmıyorum", "katılmıyorum", "fikrim yok" seçenekleri verilmiştir. Her bir ifade için tek bir seçeneği, yani tek bir kutuyu işaretleyiniz.

	Katılıyorum	**Kısmen katılıyorum**	**Pek katılmıyorum**	**Katılmıyorum**	**Fikrim yok**
2. Fatma hanımın bu durumu yaşadığı sosyal sorunlardan (işsizlik, yoksulluk, ailevi sorunlar, vb.) kaynaklanmaktadır.	☐	☐	☐	☐	☐
3. Fatma hanımın bu durumu kişilik yapısının zayıflığından kaynaklanmaktadır.	☐	☐	☐	☐	☐
4. Fatma hanımın bu durumu aşırı üzüntü halidir.	☐	☐	☐	☐	☐
5. Fatma hanımın bu durumu zaman zaman herkesin yaşayabileceği bir durumdur.	☐	☐	☐	☐	☐
6. Fatma hanımın bu durumu genetik faktörlere dayanmaktadır.	☐	☐	☐	☐	☐

7. Fatma hanımın bu durumunun biyolojik bir temeli vardır, beynin biyokimyasındaki değişikliklerden kaynaklanmaktadır.	☐	☐	☐	☐	☐
8. Fatma hanımın bu durumu bebeklik / erken çocukluk dönemindeki sorunlardan kaynaklanmaktadır.	☐	☐	☐	☐	☐
9. Fatma hanımınkine benzer şikayetleri olan kişiler toplum içinde serbest dolaşmamalıdır.	☐	☐	☐	☐	☐
10. Fatma hanımınkine benzer şikayetleri olan bir kişi ile birlikte çalışabilirim.	☐	☐	☐	☐	☐
11. Fatma hanımınkine benzer şikayetleri olan bir kişi ile evlenebilirim.	☐	☐	☐	☐	☐
12. Fatma hanımınkine benzer şikayetleri olan bir komşum olması beni rahatsız etmez.	☐	☐	☐	☐	☐
13. Fatma hanımınkine benzer şikayetleri olan bir kişiye evimi kiraya vermem.	☐	☐	☐	☐	☐
14. Fatma hanımınkine benzer şikayetleri olan kişiler saldırgan olur.	☐	☐	☐	☐	☐
15. Fatma hanımınkine benzer şikayetleri olan kişiler kendi hayatları ile ilgili doğru kararlar alamaz.	☐	☐	☐	☐	☐
16. Fatma hanımın bu durumu yaşadığı sosyal sorunlar (işsizlik, yoksulluk, ailevi sorunlar, vb.) çözülmeden geçmez.	☐	☐	☐	☐	☐

17. Fatma hanımın bu durumu tam olarak düzelmez.	☐	☐	☐	☐	☐
18. Fatma hanımın durumu tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐
19. Fatma hanımın durumu ilaçla tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐
20. Fatma hanımın durumu psikoterapi ile tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐
21. Fatma hanımınkine benzer şikayetleri olanlar mutlaka hastaneye yatırılarak tedavi edilmelidir.	☐	☐	☐	☐	☐

22.	**Fatma hanımınkine benzer şikayetleri olanların bu durumdan kurtulmak için aşağıdakilerden hangisini öncelikle yapması gerekmektedir? (lütfen tek bir kutuyu işaretleyiniz)**	
	Öncelikle bir doktora gitmesi gerekmektedir	☐
	Öncelikle bir ruh sağlığı uzmanına (psikiyatr, psikolog, psikoterapist) gitmesi gerekmektedir	☐
	Öncelikle güçlü olması gerekmektedir, isterse bu durumu aşabilir	☐
	Öncelikle bir tatile çıkması, bulunduğu ortamdan uzaklaşması gerekmektedir	☐
	Öncelikle yaşadığı şartların düzeltilmesi gerekmektedir	☐
	Öncelikle geleneksel (dinsel, yatır, hoca, vb. dahil) yardım aranmalıdır	☐
	Diğer:______________________________	☐

Appendix F: Attitudes Toward Schizophrenia Questionnaire

Aşağıda bazı sorunları olan bir kişinin kısa öyküsü anlatılmaktadır. Bu kısa öyküyü dikkatlice okuduktan sonra lütfen sırasıyla 1.'den 22.'ye kadar olan soruları cevaplayınız.

Ahmet Bey, 27 yaşında evli, memur. Yaklaşık 8 aydır çevresinden şüphelenmeye, yaptığı buluşlar nedeniyle mafyanın peşinde olduğunu düşünmeye başlamış. Kulağına kendisine emir veren sesler geliyor, zaman zaman bu seslerle konuşuyor, onlara tepki gösteriyormuş. Giderek işyerindeki arkadaşlarından da şüphelenmeye ve işe gidememeye başlamış. Evden çıkmıyor, kimseyle görüşmüyor ve sabaha kadar sıkıntılı bir şekilde dolaşıyormuş.

1. Ahmet beyin durumu aşağıdakilerden hangisine uymaktadır? (lütfen tek bir kutuyu işaretleyiniz)	
Ahmet beyde bedensel bir hastalık bulunmaktadır	☐
Ahmet beyde ruhsal bir hastalık bulunmaktadır	☐
Ahmet beyde bir akıl hastalığı bulunmaktadır	☐
Ahmet beyde bir sinir hastalığı bulunmaktadır	☐
Ahmet beyde herhangi bir hastalık bulunmamaktadır	☐
Diğer:________________________________	☐

Lütfen aşağıdaki tablonun ilk sütununda yer alan ifadelere katılıp katılmadığınızı belirtiniz. Her bir ifade için "katılıyorum", "kısmen katılıyorum", "pek katılmıyorum", "katılmıyorum", "fikrim yok" seçenekleri verilmiştir. Her bir ifade için tek bir seçeneği, yani tek bir kutuyu işaretleyiniz.

	Katılıyorum	**Kısmen katılıyorum**	**Pek katılmıyorum**	**Katılmıyorum**	**Fikrim yok**
2. Ahmet beyin bu durumu yaşadığı sosyal sorunlardan (işsizlik, yoksulluk, ailevi sorunlar, vb.) kaynaklanmaktadır	☐	☐	☐	☐	☐
3. Ahmet beyin bu durumu kişilik yapısının zayıflığından kaynaklanmaktadır.	☐	☐	☐	☐	☐
4. Ahmet beyin bu durumu aşırı üzüntü halidir.	☐	☐	☐	☐	☐
5. Ahmet beyin bu durumu zaman zaman herkesin yaşayabileceği bir durumdur.	☐	☐	☐	☐	☐
6. Ahmet beyin bu durumu genetik faktörlere dayanmaktadır.	☐	☐	☐	☐	☐
7. Ahmet beyin bu durumunun biyolojik bir temeli vardır, beynin	☐	☐	☐	☐	☐

biyokimyasındaki değişikliklerden kaynaklanmaktadır.					
8. Ahmet beyin bu durumu bebeklik / erken çocukluk dönemindeki sorunlardan kaynaklanmaktadır.	☐	☐	☐	☐	☐
9. Ahmet beyinkine benzer şikayetleri olan kişiler toplum içinde serbest dolaşmamalıdır.	☐	☐	☐	☐	☐
10. Ahmet beyinkine benzer şikayetleri olan bir kişi ile birlikte çalışabilirim.	☐	☐	☐	☐	☐
11. Ahmet beyinkine benzer şikayetleri olan bir kişi ile evlenebilirim.	☐	☐	☐	☐	☐
12. Ahmet beyinkine benzer şikayetleri olan bir komşum olması beni rahatsız etmez.	☐	☐	☐	☐	☐
13. Ahmet beyinkine benzer şikayetleri olan bir kişiye evimi kiraya vermem.	☐	☐	☐	☐	☐
14. Ahmet beyinkine benzer şikayetleri olan kişiler saldırgan olur.	☐	☐	☐	☐	☐
15. Ahmet beyinkine benzer şikayetleri olan kişiler kendi hayatları ile ilgili doğru kararlar alamaz.	☐	☐	☐	☐	☐
16. Ahmet beyin bu durumu yaşadığı sosyal sorunlar (işsizlik, yoksulluk, ailevi sorunlar, vb.) çözülmeden geçmez.	☐	☐	☐	☐	☐
17. Ahmet beyin bu durumu tam olarak düzelmez.	☐	☐	☐	☐	☐
18. Ahmet beyin durumu tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐
19. Ahmet beyin durumu ilaçla tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐

20. Ahmet beyin durumu psikoterapi ile tedavi edilebilen bir durumdur.	☐	☐	☐	☐	☐
21. Ahmet beyinkine benzer şikayetleri olanlar mutlaka hastaneye yatırılarak tedavi edilmelidir.	☐	☐	☐	☐	☐

22.	**Ahmet beyinkine benzer şikayetleri olanların bu durumdan kurtulmak için aşağıdakilerden hangisini öncelikle yapması gerekmektedir? (lütfen tek bir kutuyu işaretleyiniz)**	
	Öncelikle bir doktora gitmesi gerekmektedir	☐
	Öncelikle bir ruh sağlığı uzmanına (psikiyatr, psikolog, psikoterapist) gitmesi gerekmektedir	☐
	Öncelikle güçlü olması gerekmektedir, isterse bu durumu aşabilir	☐
	Öncelikle bir tatile çıkması, bulunduğu ortamdan uzaklaşması gerekmektedir	☐
	Öncelikle yaşadığı şartların düzeltilmesi gerekmektedir	☐
	Öncelikle geleneksel (dinsel, yatır, hoca, vb. dahil) yardım aranmalıdır	☐
	Diğer:____	☐

Appendix G: A Summary of Results for the Description Section of the Self-Identity Questionnaire

Age Group

Among *n* = 295 responses descriptions referring to "youth" constituted 57.6% (*n* = 170) of the responses. Other descriptions involved descriptions of age and age ranges (13.6%, *n* = 40) and descriptions referring to adulthood or young adulthood (4.4%, *n* = 13).

Gender

Among *n* = 288 responses words that referred to being a female such as woman, lady, miss or Mrs., girl, female, young woman/girl consisted of 68.4% (*n* = 197) and words that referred to being a male included words such as man, son, guy, male consisted of 29.2% (*n* = 84). There were less variation in words referring to being a male.

School Attended

Among *n* = 294 responses, 43.2% (*n* = 127) of the words consisted of specific university names, 38.4% (*n* = 113) referred to the word university in general and 13.6% (*n* = 40) of the words referred to the quality and meaning of university.

Occupation and Major

Among 289 responses, 94.8% (*n* = 274) of the words described the participants' own major or future occupation and 5.5% (*n* = 16) of the words referred to the meanings attributed to occupation or major.

Role in the Family

Among a total of *n* = 305 responses, 41.6 % of the words described being a child/daughter/son (*n* = 127, including *n* = 12 single child), 36.7% being a sibling (*n* = 112), and 13.4% of the responses described a specific role or position attributed in the family (*n* = 41).

Hobbies and Activities of Interest

Among a total of 398 responses, there were *n* = 87 (21.9%) responses related to sports, *n* = 59 (14.8%) related to music and musical instruments, *n* = 55 (13.8%) related to books, literature, philosophy, poetry, history, *n* = 31

(7.8%) related to cinema and television, n = 26 (6.5%) related to theatre and dance, n = 21 (5.3%) related to computer and science, n = 20 (5.0%) socializing with friends and shopping, n = 15 (3.8%) related to travelling, n = 15 (3.8%) related to photography, n = 6 (1.5%) social responsibilities and n = 6 (1.5%) fine arts.

Sexual Orientation

Among a total of 252 responses 33.7% (n = 85) responses described heterosexuality and 11.1% (n = 28) an interest in the opposite sex, and 1.2% (n = 3) bisexuality. Seventeen responses (6.7%) were related to being normal or mainstream and 1.6% (n = 4) of the responses indicated confusion or uncertainty. The remaining responses included words referring to male or female. These responses demonstrated that some participants described their sex of interest whereas some described their own sex.

Religion or Belief Systems

Among a total of n = 274 responses, 65.7% (n = 180) responses described being a Muslim, 11.3% (n = 31) being an atheist or denying a belief system, 6.9% (n = 19) being a deist, 2.6 % (n = 7) being Jewish and 2.2% (n = 6) being a Christian.

Ethnical Background

Among a total of 266 responses 75.9% (n = 202) responses described being a “Turk”, 1.9% (n = 5) being a “Kurd”, 1.5% (n = 4) being an “Armenian”, 1.5% (n = 4) being a “Cerkez”, 1.1% (n = 3) being an “Albenian”. 4.5% of the responses include words describing being an “Arab”, a “Bulgarian migrant”, “Alaoite”, “Azerbaijani”, “Bosnian”, “Eastern”, “Croatian”, from the Black Sea (Karadenizli), “Thracian”, and “Greek”. Three percent of the responses (n = 8) were related to being a world citizen or referring to humanity, equality and respect; while another 3.0% of the responses described no ethnic background and denial of such identity, and 1.9% (n = 5) of the responses indicated a mixed or uncertain background.

Political and Ideological Stand

Among a total of 234 responses, 15.4 % (n = 36) liberalism,15.0% (n = 35) no interest in politics, negative attitudes toward it or uncertain, 10.7% (n =

25) left, 8.6% (*n* = 20) "Ataturkculuk" and "Kemalism", 7.7% (*n* = 18) socialism, 7.3% (*n* = 17) democracy.

Townsmanship

Among 199 responses, most of the responses were related to being from Istanbul (*n* = 31, 15.6%) and 9.1% (*n* = 18) indicated words describing no interest and in this dimension.

Citizenship

Among 249 responses a total of 88.0 % (*n* = 219) words were used to describe citizenship with "Turkiye (Turkey)", "Turk", "Turkiye Cumhuriyeti (Republic of Turkey)".

Cultural Geography

Among 243 responses 22.6% (*n* = 55) consisted of words "Europe" and "European", 12.8 % (*n* = 31) "Black Sea" and belonging to the 'Black Sea', 10.7% "Asia" and "Asian", 8.6% (*n* = 21) "Mediterranean" .

Supporting a Sports Team

Among 240 responses the supported teams included Galatasaray (*n*=85, 35.4%), Fenerbahce (*n* = 65, 27.1%), Besiktas (*n* = 41, 17.1%), other (*n* = 7, 2.9%) while other definitions include definitions regarding fanaticism, sympathy and interest.

Other

A total of 29 responses were given for the 'other' category which allowed the participants to suggest alternatives for identity dimensions. The words used referred to marital status, physical attributes, success/ambition, scholarship status, cognitive abilities, positivism and negativism, cleanliness, humanism, environmentalism/animal rights, hobbies.

Appendix H: Results of the *Labeling Questionnaire*: Labels and Label Themes

Table H1. List of all the words, terms and phrases used in the Labeling Questionnaire

Labels	*n*
deli	180
hasta	137
rahatsız	96
sorunlu	81
dengesiz/lik	61
manyak	48
psikopat	39
problemli	27
ruh hastası	23
depresyon	18
paranoya/k	18
kafayı yemiş	16
anormal/anormallik	15
sıkıntılı	15
yazık	15
mutsuz/luk	14
yardıma ihtiyaç/muhtaç	14
akıl hastası	13
depresif	13
sinirli	13
agresif	10
psikolojik sorunları olan/var	9
psikolojisi bozuk/bozulmuş	9
bunalım	8
normal değil/olmayan	8
şizofren/i	8
çatlak	7
farklı	7
mal	7
özürlü	7
garip	6
psikolojik rahatsız	6
ruhsal rahatsızlığı olan birey/kişi/şahıs	6
tuhaf	6
akli dengesi yerinde değil/olmayan	5
panik atak	5
sinir hastası	5
asosyal	4
engelli	4
gergin	4
kafadan kontak	4
karışık/karmaşık	4
kıskanç	4
psikolojik rahatsızlığı olan/bulunan/var	4
rahatsızlığı var/olan	4
ruhsal sağlığı bozuk olan	4
saldırgan	4
sıyırmış	4
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	4
uçuk	4
yalnız/lık	4
zavallı	4
zihinsel özürlü	4
aklı yerinde değil/olmayan	3
arıza/lı	3
buhran/lı	3
çaresiz	3
değişik	3
değişken	3
endişeli	3
hastalıklı	3
içe/içine kapanık	3
kaçık	3
kararsız	3
kaygı/lı	3
nevrotik	3
obsesif	3
panik	3
ruhsal (olarak) sorunlu	3
spastik	3
takıntılı	3
tehlikeli	3
tutarsız	3
umutsuz	3
üzüntü/lü	3
yardım	3
46/46'lı	2
acıma/k	2
aciz	2
akıl sağlığı yerinde değil/olmayan	2
allah acil şifalar versin/şifa versin	2
anlamak/anlayış	2
balatayı sıyırmış	2
beyni yanmış	2
borderline	2
çok kötü	2
danışan	2
davranış bozukluğu	2
delidir ne yapsa yeridir	2
destek	2
düşünceli	2
fütursuz	2
gariban	2
geçmiş olsun	2
gereksiz	2
gerizekalı	2
güçsüz	2
huzursuz	2
iki yüzlü	2
inatçı	2
kafadan sakat	2
kafası bozuk	2
kendi halinde	2
keyifsiz	2
kontrolsüz	2
kötü	2
mantıksız	2
meczub	2
mutlu	2
obsesif kompülsif	2
patoloji/k	2
psikolojik deli	2
sağlıksız	2
sakat	2
salak	2
sevgi	2
sorunları olan/var	2
stresli	2
şuursuz	2
uykusuzluk/uyuyamama	2
üzgün	2
zor	2
abuk subuk konuşma	1
acaba neden kaynaklandı	1
acayip	1
acı	1
acı çeken	1

acımasızca kişilere fiziksel zarar verebilen	1
agresif (aşırı)	1
agresif (çok)	1
ağlama nöbeti	1
ağlamak	1
aile	1
akıl fikir versin	1
akıl sağlığı bozuk	1
akıldan rahatsız	1
akılsız	1
aklı başında olmayan	1
aklı gelip gidiyor	1
aklı gidik	1
aklı salim değil	1
aklı salim düşünemiyor	1
aklından zoru var	1
aklını peynir ekmekle yemek	1
aklını yemiş	1
akli dengesi bozuk	1
alkol	1
alkolik	1
allah akıl fikir versin	1
allah akıl versin	1
allah başa vermesin	1
allah çene vermiş gerisini koyvermiş	1
allah düşmanına göstermesin	1
allah korusun ama	1
allah kurtarsın	1
allahı yerinde değil	1
allahın garibi	1
anksiyetesi olan	1
anksiyöz	1
aptal	1
arkadaş	1
asabi	1
asalak	1
aşırı derecede kararsız	1
azıcık noksan	1
bağımlı	1
bahtsız	1
baskın	1
başa çıkamama	1
başarı	1
bazı problemler yaşıyor	1
bazı sorunları var	1
ben elimden geleni yaptım	1
bencil	1
bıkkın	1
bıkkınlık veren	1
bilmiyorum	1
bipolar	1
bir problemi var	1
bir sakin ol	1
bir sorunu var herhalde yazık	1
biraz enteresan	1
birçok zorlukla karşılaşmak	1
birkaç tahtası eksik	1
bizim de başımıza gelebilirdi	1
boş bakıyor	1
bu ne perhiz bu ne lahana turşusu	1
buldumcuk	1
bulunduğu durumdan rahatsız	1
bunaldım	1
canı sıkkın	1
cinayet	1
çaba harcıyor	1
çabalarının karşılığını alamamış	1
çatışmalı	1
çevresinde mutlu olan insanları gördükçe dahada mutsuzluğa itiliyor	1
çıkmazda	1
çocuk	1
çok acıyorum ona	1
çok fazla konuşuyor	1
çok garip ya	1
çok konuşur	1
çok kötü durumda	1
çok yoğun strese maruz kalmış	1
çok zor bir şey	1
çözümsüzlükler	1
dağlanmış	1
dalgınlık	1
daraldım	1
deli deliyi görünce sopasını bırakırmış	1
deli deliyi görünce sopasını saklarmış diye düşünür yoldan çekilirim	1
deli deliyi görünce sopasını saklarmış. sakla ve yanaşma	1
deli dolu	1
delirmiş gibi davranıyor	1
deliye her gün bayram	1
dengesiz hareketleri var	1
derin	1
dertli	1
dışarı çıkmak istemiyor	1
diken üstünde	1
dikkatli	1
dini takıntıları var	1
doktor	1
doktorluk	1
donuk	1
durmak bilmeyen	1
durumu çok kötü	1
duyarlı	1
duygusal	1
düşüncesiz	1
düşünmeden davranan	1
düzenli ilaç ve terapi	1
eğitim düzeyi düşük	1
embesil	1
empati kurmaktan yoksun	1
en yakın arkadaşım manik depresif ve kişilik bozukluğu tanısıyla Lape'de yatmıştı sürekli yalan söylüyordu ama aldırmıyordum dışlamamalı derken çok sağlam kazık yedim	1
enteresan	1
esirekli	1
extacy	1
farkında olmadan böyle davranıyor	1
farkındalığı olan	1
fazla haseti olan	1
hassas (fazla)	1
kırılgan (fazla)	1
fevri hareketleri bulunan	1
gel!	1
gel-git akıllı	1
genelde konuşmam	1
engelli (genellikle engelli diye hitap ederim)	1
gerçeğini kabul etmeme	1
gerçek dışında kendi ütopyalarında yaşamak	1
gerçekten durumu çok zor	1
gerçekten sorunları var	1
gıcık	1
güçlü ol	1
güçlük	1
gülme	1

gülme komşuna gelir başına	1
güvensizlik yaşayan	1
haddini bil	1
hafif deli	1
halüsinasyon	1
hareketlerini kontrol edemeyen	1
hareketli	1
hassas	1
hasta olduğu konusunda	1
hastalığı ne ise ismini söylerim şizofreni gibi	1
hastalık hastası	1
hastanelik	1
hayat boş eğlen coş	1
hayata bakış açısı	1
hayata küsmüş	1
hayata nasıl bakıyor acaba	1
hayatı güzel	1
hep aşırı	1
hepimizde bir parça var	1
hepten sıyırdı	1
her şey kötü gidiyor	1
her şeyin bir çözümü vardır	1
herhangi bir kelime veya terim kullanmam normal biri gibi davranırım	1
herhangi farklı bir kelime/terim/deyiş kullanmazlar. normal insan için kullandıkları kelimeleri kullanırlar.	1
herşeye rağmen yaşam çabası var	1
herşeyi kafaya takan	1
herşeyin aşırı	1
hiperaktivite	1
huylu	1
huzur bozucu	1
huzurlu	1
hüzünlü	1
idiot	1
ilaç	1
ilaç almazsa ne yapacağı belli olmaz	1
ilaç kullanıyormuş	1
ilgi	1
ilgi arsızı	1
ilgisiz	1
incitecek söz kullanmam	1
insanı yoruyor	1
insanlardan nefret ediyorum	1
intihar deneyimi yaşamış	1
iradesiz	1
ismini kullanırım	1
istemsiz ağlamalar	1
itici	1
iyice uçtu	1
kabul edilemez	1
kafa gitmiş	1
kafada bir şeyler eksik	1
kafadan çatlak	1
kafası yerinde değil	1
kafasında çok şey var	1
kafayı temizlemiş	1
kaotik	1
karamsar	1
karmaşık yapısı var	1
karşındakini kesinlikle dinlemiyor	1
katil ruhlu	1
kayık	1
keder	1
kendinden memnun değil	1
kendine güven	1
kendini savunan	1
kendini topluma adapte edemeyen bir insan	1
kendiyle ilişkisi olmayan	1
keşke yardım edebilsem	1
kırılgan	1
kızgın	1
kimi zaman çok sessiz kimi zaman çok neşeli	1
kinci	1
kişilik bozukluğu var	1
kollarına kesikler atan	1
kompleksli	1
konsantrasyon eksikliği	1
konuşma akışında bozukluk	1
konuşmamayı terich ederim	1
korkuları var	1
korumasız	1
kötümserlik	1
kuruntulu	1
kuşkucu	1
manik depresyon	1
melankolik	1
menfaat	1
mental bozukluğu var	1
mental hasta	1
mükemmeliyetçi	1
narsist	1
ne ekersen onu biçersin	1
ne kötüymüş	1
ne sorunu var?	1
nefret ediyorum	1
negatif	1
neşesiz	1
nevroz	1
normal	1
normal kişi	1
o birey hakkında konuşurken ruhsal rahatsızlığına yönelik kelimeler kullanmam	1
o derim	1
o iyi değil	1
olduğun gibi yaşa	1
onun gibi olmak istemem	1
onun problemleri var	1
onun yerinde olmama	1
otistik	1
öfkeli	1
ölçüsüz	1
önemsiz konuların probleme dönüşmesi	1
özdeşleşmek	1
özünde iyi biri	1
paranoid şizofren	1
pasif	1
paylaşmaya ihtiyaç duyan	1
pek fazla özel kelime kullanmam	1
psiko	1
psiko deli	1
psikoloji	1
psikolojik açıdan sorunlu	1
psikolojik durumu iyi değil	1
psikolojik hasta	1
psikolojik hastalığı var	1
psikolojik rahatsızlıkları var	1
psikolojik sorunlu	1
psikolojik vaka	1
psycho	1
rahatsız (biraz)	1
rahatsız edici	1
rahatsızlığı yüzünden	1
rahatsızlık verici	1
raporlu	1
ruh sağlığı bozuk	1

ruh sağlığı iyi değil	1
ruhsal açıdan sorunları olan	1
ruhsal bozukluğu olan (biri var ya hani)	1
ruhsal bozukluğu olan hasta	1
ruhsal bozukluk	1
ruhsal dengesi bozuk	1
ruhsal hasta	1
ruhsal problemleri var	1
saçma sapan konuşan	1
saçmalıyor	1
sadece o kişi ile konuşurum	1
sahip olduklarının farkında değil	1
sakin	1
sakin ol	1
samimiyetsiz	1
sana öyle geliyor	1
sapık	1
saplantılı	1
sessiz	1
sevgisiz	1
sıkıldım	1
sıkıntıları olan	1
sıkıntılı bir dönemde	1
sıra dışı	1
sigara	1
sinir	1
sinir bozucu	1
sinir krizleri geçiren	1
sinirleri bozulmuş	1
sinirlerine çoğunlukla hakim olamayan	1
sinirli (aşırı)	1
sorumsuz	1
sorun	1
sorunları ile baş edememe ve derinleşememe hali	1
sorunları olup yardıma ihtiyacı olan birisi	1
sorunları var herhalde	1
sorunlu aile düzeni	1
sosyal ortamlardan kaçınan	1
sosyopat	1
suskun	1
şefkat	1
şey biraz	1
şımarık	1
şirin	1
şizo	1
şizofren	1
şizofren (bu çocuk)	1
şu çok konuşan	1
şüpheci	1
şüpheyle bakma	1
tahmin edilemeyen	1
tahtası eksik	1
takıntı	1
takmıyorum	1
tamam	1
tedavi olması gerek	1
tedavisi var mıdır	1
tedavisi yok mu	1
tedirgin	1
telaşlı	1
terapiye gitmeli	1
terelelli	1
tırlatmış	1
titiz	1
topluma aykırı birey	1
uçmuş	1
uçurum kenarında bile olsan sırf hayata gıcıklık olsun diye gülümse dostum	1
umarım benim başıma gelmez	1
umarım düzelir	1
umursayamamak	1
unutkanlık	1
üstün IQ	1
üşütük	1
üzücü	1
üzüldük	1
üzülürüm	1
vah vah yazık garibim	1
vahşi	1
yarım akıllı	1
yaşadıkları kolay değil	1
yedisinde neyse yetmişinde o olur, değişmez	1
yorgun	1
yüzü gülüyor	1
zaman paylaşılmayacak insanlar	1
zararlı	1
zayıf	1
zayıf algı	1
zeka	1
zekayı tam kullanamayan	1
zihinsel engelli	1
zor biri	1
zor yaşam	1
zorlanmak	1
zorluk	1
Total (*n* = 484)	**1562**

Note Discarded responses were “his name is robert paulsen” (*n* = 1), “welat” (*n* = 1) and responses that could not be read and coded as “???”(*n* = 2).

Table H2. List of all the words, terms and phrases used for question A in the Labeling Questionnaire

Labels	*n*
deli	34
hasta	34
dengesiz/lik	29
rahatsız	20
sorunlu	20
psikopat	13
paranoya/k	11
manyak	9
mutsuz/luk	9
agresif	8
şizofren/i	8
yardıma ihtiyaç/muhtaç	8
anormal/anormallik	7
depresyon	7
sıkıntılı	7
akıl hastası	6
yazık	6
farklı	5
kafayı yemiş	5
problemli	5
bunalım	4
depresif	4
karışık/karmaşık	4
psikolojik sorunları olan/var	4
ruh hastası	4
saldırgan	4
sinirli	4
buhran/lı	3
çaresiz	3
değişken	3
garip	3
içe/içine kapanık	3
obsesif	3
panik	3
psikolojisi bozuk/bozulmuş	3
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	3
umutsuz	3
acıma/k	2
aciz	2
aklı yerinde değil/olmayan	2
allah acil şifalar versin/şifa versin	2
arıza/lı	2
borderline	2
çatlak	2
danışan	2
delidir ne yapsa yeridir	2
destek	2
düşünceli	2
engelli	2
geçmiş olsun	2
gergin	2
kaygı/lı	2
mal	2
mantıksız	2
nevrotik	2
obsesif kompulsif	2
özürlü	2
panik atak	2
patoloji/k	2
psikolojik deli	2
psikolojik rahatsız	2
sağlıksız	2
sevgi	2
tehlikeli	2
tutarsız	2
uçuk	2
uykusuzluk/uyuyamama	2
üzüntü/lü	2
yalnız/lık	2
46/46'lı	1
abuk subuk konuşma	1
acaba neden kaynaklandı	1
acı	1
acı çeken	1
acımasızca kişilere fiziksel zarar verebilen	1
agresif (aşırı)	1
ağlama nöbeti	1
aile	1
akıl sağlığı yerinde olmayan	1
aklı başında olmayan	1
aklından zoru var	1
aklını peynir ekmekle yemek	1
akli dengesi yerinde olmayan	1
alkol	1
allah çene vermiş gerisini koyvermiş	1
allah düşmanına göstermesin	1
allahı yerinde değil	1
anksiyetesi olan	1
arkadaş	1
bağımlı	1
bahtsız	1
baskın	1
başarı	1
bazı sorunları var	1
bıkkınlık veren	1
bipolar	1
bu ne perhiz bu ne lahana turşusu	1
buldumcuk	1
bunaldım	1
çabalarının karşılığını alamamış	1
çevresinde mutlu olan insanları gördükçe dahada mutsuzluğa itiliyor	1
çıkmazda	1
çok yoğun strese maruz kalmış	1
dağlanmış	1
dalgınlık	1
daraldım	1
davranış bozukluğu	1
değişik	1
deli deliyi görünce sopasını bırakırmış	1
deli deliyi görünce sopasını saklarmış diye düşünür	1

yoldan çekilirim	
deliye her gün bayram	1
derin	1
diken üstünde	1
dikkatli	1
doktor	1
durmak bilmeyen	1
duyarlı	1
duygusal	1
düşüncesiz	1
düşünmeden davranan	1
empati kurmaktan yoksun	1
en yakın arkadaşım manik depresif ve kişilik bozukluğu tanısıyla Lape'de yatmıştı sürekli yalan söylüyordu ama aldırmıyordum dışlamamalı derken çok sağlam kazık yedim	1
endişeli	1
farkındalığı olan	1
fevri hareketleri bulunan	1
fütursuz	1
gel!	1
gerçeğini kabul etmeme	1
gerçek dışında kendi ütopyalarında yaşamak	1
güçlük	1
gülme	1
gülme komşuna gelir başına	1
güvensizlik yaşayan	1
haddini bil	1
halüsinasyon	1
hareketlerini kontrol edemeyen	1
hareketli	1
hassas	1
hayat boş eğlen coş	1
her şey kötü gidiyor	1
her şeyin bir çözümü vardır	1
herşeyin aşırı	1
hiperaktivite	1
huzursuz	1
hüzünlü	1
iki yüzlü	1
ilaç	1
ilaç almazsa ne yapacağı belli olmaz	1
ilgi arsızı	1
ilgisiz	1
inatçı	1
insanlardan nefret ediyorum	1
intihar deneyimi yaşamış	1
istemsiz ağlamalar	1
itici	1
kaçık	1
kafadan çatlak	1
kaotik	1
karamsar	1
kararsız	1
karşındakini kesinlikle dinlemiyor	1
katil ruhlu	1
keder	1

kendini savunan	1
kendiyle ilişkisi olmayan	1
kırılgan	1
kıskanç	1
kimi zaman çok sessiz kimi zaman çok neşeli	1
kinci	1
kollarına kesikler atan	1
kompleksli	1
konsantrasyon eksikliği	1
kontrolsüz	1
konuşma akışında bozukluk	1
korumasız	1
kötü	1
kötümserlik	1
kuruntulu	1
kuşkucu	1
manik depresyon	1
meczub	1
melankolik	1
mutlu	1
narsist	1
ne ekersen onu biçersin	1
ne sorunu var?	1
nefret ediyorum	1
negatif	1
normal değil	1
normal kişi	1
onun yerinde olmama	1
otistik	1
özdeşleşmek	1
paranoid şizofren	1
pasif	1
psikoloji	1
psikolojik rahatsızlığı olan/bulunan/var	1
psikolojik vaka	1
rahatsız edici	1
rahatsızlığı var/olan	1
raporlu	1
ruhsal bozukluğu olan hasta	1
ruhsal dengesi bozuk	1
ruhsal olarak sorunlu	1
ruhsal problemleri var	1
ruhsal sağlığı bozuk olan	1
saçma sapan konuşan	1
samimiyetsiz	1
sapık	1
sıkıldım	1
sıkıntıları olan	1
sıra dışı	1
sigara	1
sinir hastası	1
sorumsuz	1
sorun	1
sorunları ile baş edememe ve derinleşememe hali	1
sorunlu aile düzeni	1
sosyal ortamlardan kaçınan	1
sosyopat	1
spastik	1
şefkat	1
şüpheci	1
takıntı	1

tedavisi var mıdır	1
tedirgin	1
telaşlı	1
tuhaf	1
uçurum kenarında bile olsan sırf hayata gıcıklık olsun diye gülümse dostum	1
umarım benim başıma gelmez	1
umarım düzelir	1
umursayamamak	1
unutkanlık	1
üstün IQ	1
üşütük	1
üzücü	1
yardım	1
zaman paylaşılmayacak insanlar	1
zararlı	1
zavallı	1
zayıf algı	1
zekayı tam kullanamayan	1
zihinsel özürlü	1
zorluk	1
Total (n=244)	**549**

Note Discarded labels were “his name is robert paulsen”(n=1) and responses that could not be read which were coded as “???” (n=2).

Table H3. List of all the words, terms and phrases used for question B in the Labeling Questionnaire

Labels	n
hasta	42
rahatsız	35
deli	27
sorunlu	26
dengesiz/lik	17
problemli	11
manyak	10
psikopat	8
ruh hastası	7
depresif	6
kafayı yemiş	6
sinirli	6
normal değil/olmayan	5
psikolojik sorunları olan/var	5
yardıma ihtiyaç/muhtaç	5
yazık	5
akıl hastası	4
mutsuz	4
ruhsal rahatsızlığı olan birey/kişi/şahıs	4
sıkıntılı	4
anormal	3
asosyal	3
bunalım	3
paranoya/k	3
psikolojisi bozuk/bozulmuş	3
agresif	2
anlamak/anlayış	2
depresyon	2
endişeli	2
gergin	2
kararsız	2
kıskanç	2
mal	2
panik atak	2
psikolojik rahatsızlığı olan/bulunan/var	2
rahatsızlığı var/olan	2
sıyırmış	2
sinir hastası	2
sorunları olan/var	2
tuhaf	2
yardım	2
zihinsel özürlü	2
ağlamak	1
akıl sağlığı yerinde değil	1
akıldan rahatsız	1
aklı salim değil	1
akli dengesi yerinde olmayan	1
alkolik	1
allah başa vermesin	1
allah korusun ama	1
anksiyöz	1
asabi	1
asalak	1
balatayı sıyırmış	1
başa çıkamama	1
bazı problemler yaşıyor	1
ben elimden geleni yaptım	1
bencil	1
beyni yanmış	1
bıkkın	1
bir problemi var	1
bir sakin ol	1
biraz enteresan	1
biraz rahatsız	1
birçok zorlukla karşılaşmak	1
biri var ya hani ruhsal bozukluğu olan	1
boş bakıyor	1
bu çocuk şizofren	1
bulunduğu durumdan rahatsız	1
cinayet	1
çaba harcıyor	1
çatışmalı	1
çatlak	1
çocuk	1
çok acıyorum ona	1
çok garip ya	1
çok konuşur	1
çözümsüzlükler	1
değişik	1
dini takıntıları var	1
donuk	1
düzenli ilaç ve terapi	1
eğitim düzeyi düşük	1
engelli	1
enteresan	1
extacy	1
farkında olmadan böyle davranıyor	1
farklı	1
fazla haseti olan	1
fütursuz	1
gariban	1
garip	1
genelde konuşmam	1
genellikle engelli diye hitap ederim	1
gerçekten durumu çok zor	1
gerçekten sorunları var	1
güçlü ol	1
güçsüz	1
hafif deli	1
hasta olduğu konusunda	1
hastalığı ne ise ismini söylerim şizofreni gibi	1
hastalık hastası	1
hastalıklı	1
hayata bakış açısı	1
hayata küsmüş	1
hayata nasıl bakıyor acaba	1
hayatı güzel	1
hep aşırı	1
hepimizde bir parça var	1
herhangi bir kelime veya terim kullanmam normal biri gibi davranırım	1
herşeye rağmen yaşam çabası var	1
herşeyi kafaya takan	1

huylu	1
huzurlu	1
huzursuz	1
inatçı	1
incitecek söz kullanmam	1
ismini kullanırım	1
iyice uçtu	1
kaçık	1
kafada bir şeyler eksik	1
kafadan kontak	1
kafasında çok şey var	1
kaygılı	1
kayık	1
kendi halinde	1
kendinden memnun değil	1
kendine güven	1
kendini topluma adapte edemeyen bir insan	1
keşke yardım edebilsem	1
keyifsiz	1
kızgın	1
kişilik bozukluğu var	1
kontrolsüz	1
konuşmamayı terich ederim	1
korkuları var	1
kötü	1
meczub	1
menfaat	1
mental bozukluğu var	1
mental hasta	1
mutlu	1
neşesiz	1
nevroz	1
normal	1
o birey hakkında konuşurken ruhsal rahatsızlığına yönelik kelimeler kullanmam	1
o derim	1
o iyi değil	1
olduğun gibi yaşa	1
onun gibi olmak istemem	1
öfkeli	1
ölçüsüz	1
önemsiz konuların probleme dönüşmesi	1
özünde iyi biri	1
özürlü	1
paylaşmaya ihtiyaç duyan	1
pek fazla özel kelime kullanmam	1
psiko	1
psikolojik açıdan sorunlu	1
psikolojik hasta	1
psikolojik hastalığı var	1
psikolojik rahatsız	1
psikolojik rahatsızlıkları var	1
rahatsızlık verici	1
ruh sağlığı bozuk	1
ruh sağlığı iyi değil	1
ruhsal açıdan sorunları olan	1
ruhsal bozukluk	1
ruhsal hasta	1
ruhsal sağlığı bozuk	1
ruhsal sorunlu	1
saçmalıyor	1
sahip olduklarının farkında değil	1
sakat	1
sakin	1
sakin ol	1
salak	1
sana öyle geliyor	1
saplantılı	1
sessiz	1
sıkıntılı bir dönemde	1
sinir	1
sinir bozucu	1
sinir krizleri geçiren	1
sinirlerine çoğunlukla hakim olamayan	1
spastik	1
sorunları olup yardıma ihtiyacı olan birisi	1
stresli	1
suskun	1
şirin	1
şu çok konuşan	1
şuursuz	1
şüpheyle bakma	1
tahmin edilemeyen	1
takıntılı	1
takmıyorum	1
tamam	1
tehlikeli	1
titiz	1
üzgün	1
üzülürüm	1
üzüntülü	1
vahşi	1
yalnız	1
yarım akıllı	1
yorgun	1
yüzü gülüyor	1
zavallı	1
zayıf	1
zeka	1
zor	1
zor biri	1
zor yaşam	1
zorlanmak	1
Total (n=214)	**459**

Note Discarded response was “welat” (n=1).

Table H4. List of all the words, terms and phrases used for question C in the Labeling Questionnaire

Labels	*n*
deli	119
hasta	61
rahatsız	41
sorunlu	35
manyak	29
psikopat	18
dengesiz/lik	15
ruh hastası	12
problemli	11
depresyon	9
anormal	5
kafayı yemiş	5
çatlak	4
özürlü	4
paranoya/k	4
sıkıntılı	4
yazık	4
akıl hastası	3
akli dengesi yerinde değil/olmayan	3
depresif	3
kafadan kontak	3
mal	3
psikolojik rahatsız	3
psikolojisi bozuk/bozulmuş	3
sinirli	3
tuhaf	3
çok kötü	2
garip	2
gereksiz	2
gerizekalı	2
hastalıklı	2
kafadan sakat	2
kafası bozuk	2
normal değil/olmayan	2
ruhsal rahatsızlığı olan birey/kişi/şahıs	2
ruhsal sağlığı bozuk	2
sıyırmış	2
sinir hastası	2
takıntılı	2
uçuk	2
zavallı	2
46/46'lı	1
acayip	1
agresif (çok)	1
akıl fikir versin	1
akıl sağlığı bozuk	1
akılsız	1
aklı gelip gidiyor	1
aklı gidik	1
aklı salim düşünemiyor	1
aklı yerinde olmayan	1
aklını yemiş	1
akli dengesi bozuk	1
allah akıl fikir versin	1
allah akıl versin	1
allah kurtarsın	1
allahın garibi	1
aptal	1
arıza	1
asosyal	1
aşırı derecede kararsız	1
azıcık noksan	1
balatayı sıyırmış	1
beyni yanmış	1
bilmiyorum	1
bir sorunu var herhalde yazık	1
birkaç tahtası eksik	1
bizim de başımıza gelebilirdi	1
bunalım	1
canı sıkkın	1
çok fazla konuşuyor	1
çok kötü durumda	1
çok zor bir şey	1
davranış bozukluğu	1
değişik	1
deli deliyi görünce sopasını saklarmış. sakla ve yanaşma	1
deli dolu	1
delirmiş gibi davranıyor	1
dengesiz hareketleri var	1
dertli	1
dışarı çıkmak istemiyor	1
doktorluk	1
durumu çok kötü	1
embesil	1
engelli	1
esirekli	1
farklı	1
fazla hassas	1
fazla kırılgan	1
gariban	1
gel-git akıllı	1
gıcık	1
güçsüz	1
hastanelik	1
hepten sıyırdı	1
herhangi farklı bir kelime/terim/deyiş kullanmazlar. normal insan için kullandıkları kelimeleri kullanırlar.	1
huzur bozucu	1
idiot	1
iki yüzlü	1
ilaç kullanıyormuş	1
ilgi	1
insanı yoruyor	1
iradesiz	1
kabul edilemez	1
kaçık	1
kafa gitmiş	1
kafası yerinde değil	1
kafayı temizlemiş	1
karmaşık yapısı var	1
kendi halinde	1
keyifsiz	1
mükemmeliyetçi	1
ne kötüymüş	1
nevrotik	1

onun problemleri var	1
panik atak	1
psiko deli	1
psikolojik durumu iyi değil	1
psikolojik rahatsızlığı olan/bulunan/var	1
psikolojik sorunlu	1
psycho	1
rahatsızlığı var/olan	1
rahatsızlığı yüzünden	1
ruhsal sorunlu	1
sadece o kişi ile konuşurum	1
sakat	1
salak	1
sevgisiz	1
sinirleri bozulmuş	1
sinirli (aşırı)	1
sorunları var herhalde	1
spastik	1
stresli	1
şey biraz	1
şımarık	1
şizo	1
şizofren	1
şuursuz	1
tahtası eksik	1
tedavi olması gerek	1
tedavisi yok mu	1
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	1
terapiye gitmeli	1
terelelli	1
tırlatmış	1
topluma aykırı birey	1
tutarsız	1
uçmuş	1
üzgün	1
üzüldük	1
vah vah yazık garibim	1
yalnız/lık	1
yardıma ihtiyaç/muhtaç	1
yaşadıkları kolay değil	1
yedisinde neyse yetmişinde o olur, değişmez	1
zihinsel engelli	1
zihinsel özürlü	1
zor	1
Total (n=158)	**554**

Table H5. List of all the words, terms and phrases that are included in the medical label category

Labels	n
hasta	137
rahatsız	96
ruh hastası	23
depresyon	18
paranoya/k	18
akıl hastası	13
depresif	13
psikolojik sorunları olan/var	9
psikolojisi bozuk/bozulmuş	9
şizofren/i	8
özürlü	7
psikolojik rahatsız	6
ruhsal rahatsızlığı olan birey/kişi/şahıs	6
akli dengesi yerinde değil/olmayan	5
panik atak	5
sinir hastası	5
engelli	4
psikolojik rahatsızlığı olan/bulunan/var	4
rahatsızlığı var/olan	4
ruhsal sağlığı bozuk olan	4
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	4
zihinsel özürlü	4
aklı yerinde değil/olmayan	3
hastalıklı	3
nevrotik	3
obsesif	3
panik	3
ruhsal (olarak) sorunlu	3
akıl sağlığı yerinde değil/olmayan	2
borderline	2
danışan	2
davranış bozukluğu	2
obsesif kompülsif	2
patoloji/k	2
sağlıksız	2
sakat	2
akıl sağlığı bozuk	1
akıldan rahatsız	1
aklı salim değil	1
aklı salim düşünemiyor	1
akli dengesi bozuk	1
alkol	1
alkolik	1
anksiyetesi olan	1
anksiyöz	1
bağımlı	1
bipolar	1
doktor	1
doktorluk	1
düzenli ilaç ve terapi	1
extacy	1
engelli (genellikle engelli diye hitap ederim)	1
halüsinasyon	1
hasta olduğu konusunda	1
hastalığı ne ise ismini söylerim şizofreni gibi	1
hastalık hastası	1
hastanelik	1
hiperaktivite	1
ilaç	1
ilaç kullanıyormuş	1
kişilik bozukluğu var	1
manik depresyon	1
melankolik	1
mental bozukluğu var	1
mental hasta	1
narsist	1
nevroz	1
otistik	1
paranoid şizofren	1
psikoloji	1
psikolojik açıdan sorunlu	1
psikolojik durumu iyi değil	1
psikolojik hasta	1
psikolojik hastalığı var	1
psikolojik rahatsızlıkları var	1
psikolojik sorunlu	1
psikolojik vaka	1
rahatsız (biraz)	1
rahatsızlığı yüzünden	1
ruh sağlığı bozuk	1
ruh sağlığı iyi değil	1
ruhsal açıdan sorunları olan	1
ruhsal bozukluğu olan (biri var ya hani)	1
ruhsal bozukluğu olan hasta	1
ruhsal bozukluk	1
ruhsal dengesi bozuk	1
ruhsal hasta	1
ruhsal problemleri var	1
sigara	1
şizofren	1
şizofren (bu çocuk)	1
tedavi olması gerek	1
tedavisi var mıdır	1
terapiye gitmeli	1
zihinsel engelli	1
Total (n=95)	493

Table H6. List of all the words, terms and phrases that are included in the symptom related labels category

Labels	n
dengesiz/lik	61
sıkıntılı	15
mutsuz/luk	14
sinirli	13
bunalım	8
asosyal	4
gergin	4
karışık/karmaşık	4
yalnız/lık	4
buhran/lı	3
çaresiz	3
değişken	3
endişeli	3
içe/içine kapanık	3
kararsız	3
kaygı/lı	3
takıntılı	3
tutarsız	3
umutsuz	3
üzüntü/lü	3
düşünceli	2
huzursuz	2
kendi halinde	2
keyifsiz	2
kontrolsüz	2
meczub	2
stresli	2
uykusuzluk/uyuyamama	2
üzgün	2
acı	1
acı çeken	1
ağlama nöbeti	1
ağlamak	1
aşırı derecede kararsız	1
bıkkın	1
boş bakıyor	1
bulunduğu durumdan rahatsız	1
bunaldım	1
canı sıkkın	1
çatışmalı	1
çevresinde mutlu olan insanları gördükçe dahada mutsuzluğa itiliyor	1
çıkmazda	1
çok yoğun strese maruz kalmış	1
dalgınlık	1
daraldım	1
dengesiz hareketleri var	1
derin	1
dertli	1
dışarı çıkmak istemiyor	1
diken üstünde	1
dikkatli	1
dini takıntıları var	1
donuk	1
durmak bilmeyen	1
duyarlı	1
duygusal	1
düşünmeden davranan	1
empati kurmaktan yoksun	1
esirekli	1
farkında olmadan böyle davranıyor	1
hassas (fazla)	1
kırılgan (fazla)	1
fevri hareketleri bulunan	1
gerçeğini kabul etmeme	1
gerçek dışında kendi ütopyalarında yaşamak	1
güvensizlik yaşayan	1
hareketlerini kontrol edemeyen	1
hareketli	1
hassas	1
hayata küsmüş	1
herşeyi kafaya takan	1
huylu	1
hüzünlü	1
ilgisiz	1
intihar deneyimi yaşamış	1
istemsiz ağlamalar	1
kafasında çok şey var	1
kaotik	1
karamsar	1
karmaşık yapısı var	1
keder	1
kendinden memnun değil	1
kendiyle ilişkisi olmayan	1
kırılgan	1
kızgın	1
kimi zaman çok sessiz kimi zaman çok neşeli	1
kollarına kesikler atan	1
konsantrasyon eksikliği	1
konuşma akışında bozukluk	1
korkuları var	1
kötümserlik	1
kuruntulu	1
kuşkucu	1
mükemmeliyetçi	1
neşesiz	1
öfkeli	1
pasif	1
sahip olduklarının farkında değil	1
sakin	1
saplantılı	1
sessiz	1
sıkıldım	1
sıkıntıları olan	1
sinir krizleri geçiren	1
sinirleri bozulmuş	1
sinirlerine çoğunlukla hakim olamayan	1
sinirli (aşırı)	1
sosyal ortamlardan kaçınan	1
suskun	1
şüpheci	1
şüpheyle bakma	1
tahmin edilemeyen	1
takıntı	1
tedirgin	1
telaşlı	1
titiz	1
umursayamamak	1
unutkanlık	1
yorgun	1
zayıf algı	1
zeka	1
zekayı tam kullanamayan	1
Total (n=122)	268

Table H7. List of all the words, terms and phrases that are included in the labels related to personal/social problems category

Labels	n
sorunlu	81
problemli	27
sorunları olan/var	2
zor	2
aile	1
arkadaş	1
başa çıkamama	1
bazı problemler yaşıyor	1
bazı sorunları var	1
bir problemi var	1
birçok zorlukla karşılaşmak	1
çabalarının karşılığını alamamış	1
çok kötü durumda	1
çok zor bir şey	1
çözümsüzlükler	1
dağlanmış	1
durumu çok kötü	1
gerçekten durumu çok zor	1
gerçekten sorunları var	1
güçlük	1
her şey kötü gidiyor	1
o iyi değil	1
onun problemleri var	1
önemsiz konuların probleme dönüşmesi	1
sıkıntılı bir dönemde	1
sorun	1
sorunları ile baş edememe ve derinleşememe hali	1
sorunları var herhalde	1
sorunlu aile düzeni	1
yaşadıkları kolay değil	1
zor yaşam	1
zorlanmak	1
zorluk	1
Total (n=33)	143

Table H8. List of all the words, terms and phrases s that are included in the compassion/pity related lables category

Labels	n
yazık	15
yardıma ihtiyaç/muhtaç	14
zavallı	4
yardım	3
acıma/k	2
aciz	2
allah acil şifalar versin/şifa versin	2
anlamak/anlayış	2
destek	2
gariban	2
geçmiş olsun	2
sevgi	2
acaba neden kaynaklandı	1
akıl fikir versin	1
allah akıl fikir versin	1
allah akıl versin	1
allah başa vermesin	1
allah düşmanına göstermesin	1
allah korusun ama	1
allah kurtarsın	1
allahın garibi	1
bahtsız	1
ben elimden geleni yaptım	1
bir sakin ol	1
bir sorunu var herhalde yazık	1
bizim de başımıza gelebilirdi	1
çaba harcıyor	1
çocuk	1
çok acıyorum ona	1
gel!	1
gülme	1
gülme komşuna gelir başına	1
hayata nasıl bakıyor acaba	1
herşeye rağmen yaşam çabası var	1
ilgi	1
incitecek söz kullanmam	1
keşke yardım edebilsem	1
korumasız	1
ne kötüymüş	1
ne sorunu var?	1
paylaşmaya ihtiyaç duyan	1
sakin ol	1
sorunları olup yardıma ihtiyacı olan birisi	1
şefkat	1
tedavisi yok mu	1
umarım düzelir	1
üzücü	1
üzüldük	1
üzülürüm	1
vah vah yazık garibim	1
Total (n=50)	90

Table H9. List of all the words, terms and phrases that are included in the labels associated with normalization/denial category

Labels	n
mutlu	2
başarı	1
bilmiyorum	1
deli dolu	1
farkındalığı olan	1
genelde konuşmam	1
güçlü ol	1
hayat boş eğlen coş	1
hayata bakış açısı	1
hayatı güzel	1
hepimizde bir parça var	1
her şeyin bir çözümü vardır	1
herhangi bir kelime veya terim kullanmam normal biri gibi davranırım	1
herhangi farklı bir kelime/terim/deyiş kullanmazlar. normal insan için kullandıkları kelimeleri kullanırlar.	1
huzurlu	1
ismini kullanırım	1
kendine güven	1
kendini savunan	1
konuşmamayı terich ederim	1
ne ekersen onu biçersin	1
normal	1
normal kişi	1
o birey hakkında konuşurken ruhsal rahatsızlığına yönelik kelimeler kullanmam	1
o derim	1
olduğun gibi yaşa	1
onun gibi olmak istemem	1
onun yerinde olmama	1
özdeşleşmek	1
özünde iyi biri	1
pek fazla özel kelime kullanmam	1
sadece o kişi ile konuşurum	1
sana öyle geliyor	1
şirin	1
takmıyorum	1
tamam	1
uçurum kenarında bile olsan sırf hayata gıcıklık olsun diye gülümse dostum	1
umarım benim başıma gelmez	1
üstün IQ	1
yüzü gülüyor	1
Total (n=39)	40

Table H10. List of all the words, terms and phrases that are included in the derogatory labels category

Labels	n
deli	180
manyak	48
psikopat	39
kafayı yemiş	16
anormal/anormallik	15
agresif	10
normal değil/olmayan	8
çatlak	7
farklı	7
mal	7
garip	6
tuhaf	6
kafadan kontak	4
kıskanç	4
saldırgan	4
sıyırmış	4
uçuk	4
arıza/lı	3
değişik	3
kaçık	3
spastik	3
tehlikeli	3
46/46'lı	2
balatayı sıyırmış	2
beyni yanmış	2
çok kötü	2
delidir ne yapsa yeridir	2
fütursuz	2
gereksiz	2
gerizekalı	2
güçsüz	2
iki yüzlü	2
inatçı	2
kafadan sakat	2
kafası bozuk	2
kötü	2
mantıksız	2
psikolojik deli	2
salak	2
şuursuz	2
abuk subuk konuşma	1
acayip	1
acımasızca kişilere fiziksel zarar verebilen	1
agresif (aşırı)	1
agresif (çok)	1
akılsız	1
aklı başında olmayan	1
aklı gelip gidiyor	1
aklı gidik	1
aklından zoru var	1
aklını peynir ekmekle yemek	1
aklını yemiş	1
allah çene vermiş gerisini koyvermiş	1
allahı yerinde değil	1
aptal	1
asabi	1
asalak	1
azıcık noksan	1
baskın	1
bencil	1
bıkkınlık veren	1
biraz enteresan	1
birkaç tahtası eksik	1
bu ne perhiz bu ne lahana turşusu	1
buldumcuk	1
cinayet	1
çok fazla konuşuyor	1
çok garip ya	1
çok konuşur	1
deli deliyi görünce sopasını bırakırmış	1
deli deliyi görünce sopasını saklarmış diye düşünür yoldan çekilirim	1
deli deliyi görünce sopasını saklarmış. sakla ve yanaşma	1
delirmiş gibi davranıyor	1
deliye her gün bayram	1
düşüncesiz	1
eğitim düzeyi düşük	1
embesil	1
en yakın arkadaşım manik depresif ve kişilik bozukluğu tanısıyla Lape'de yatmıştı sürekli yalan söylüyordu ama aldırmıyordum dışlamamalı derken çok sağlam kazık yedim	1
enteresan	1
fazla haseti olan	1
gel-git akıllı	1
gıcık	1
haddini bil	1
hafif deli	1
hep aşırı	1
hepten sıyırdı	1
herşeyin aşırı	1
huzur bozucu	1
idiot	1
ilaç almazsa ne yapacağı belli olmaz	1
ilgi arsızı	1
insanı yoruyor	1
insanlardan nefret ediyorum	1
iradesiz	1
itici	1
iyice uçtu	1
kabul edilemez	1
kafa gitmiş	1
kafada bir şeyler eksik	1
kafadan çatlak	1
kafası yerinde değil	1
kafayı temizlemiş	1
karşındakini kesinlikle dinlemiyor	1
katil ruhlu	1
kayık	1
kendini topluma adapte	1

edemeyen bir insan	
kinci	1
kompleksli	1
menfaat	1
nefret ediyorum	1
negatif	1
ölçüsüz	1
psiko	1
psiko deli	1
psycho	1
rahatsız edici	1
rahatsızlık verici	1
raporlu	1
saçma sapan konuşan	1
saçmalıyor	1
samimiyetsiz	1
sapık	1
sevgisiz	1
sıra dışı	1
sinir	1
sinir bozucu	1
sorumsuz	1
sosyopat	1
şey biraz	1
şımarık	1
şizo	1
şu çok konuşan	1
tahtası eksik	1
terelelli	1
tırlatmış	1
topluma aykırı birey	1
uçmuş	1
üşütük	1
vahşi	1
yarım akıllı	1
yedisinde neyse yetmişinde o olur, değişmez	1
zaman paylaşılmayacak insanlar	1
zararlı	1
zayıf	1
zor biri	1
Total (n=145)	528

Table H11. Label responses for question A that are included in the medical labels category

Labels	n
hasta	34
rahatsız	20
paranoya/k	11
şizofren/i	8
depresyon	7
akıl hastası	6
depresif	4
psikolojik sorunları olan/var	4
ruh hastası	4
obsesif	3
panik	3
psikolojisi bozuk/bozulmuş	3
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	3
aklı yerinde değil/olmayan	2
borderline	2
danışan	2
engelli	2
nevrotik	2
obsesif kompulsif	2
özürlü	2
panik atak	2
patoloji/k	2
psikolojik deli	2
psikolojik rahatsız	2
sağlıksız	2
akıl sağlığı yerinde olmayan	1
akli dengesi yerinde olmayan	1
alkol	1
anksiyetesi olan	1
bağımlı	1
bipolar	1
davranış bozukluğu	1
doktor	1
halüsinasyon	1
hiperaktivite	1
ilaç	1
manik depresyon	1
melankolik	1
narsist	1
otistik	1
paranoid şizofren	1
psikoloji	1
psikolojik rahatsızlığı olan/bulunan/var	1
psikolojik vaka	1
rahatsızlığı var/olan	1
ruhsal bozukluğu olan hasta	1
ruhsal dengesi bozuk	1
ruhsal olarak sorunlu	1
ruhsal problemleri var	1
ruhsal sağlığı bozuk olan	1
sigara	1
sinir hastası	1
tedavisi var mıdır	1
zihinsel özürlü	1
Total (n=54)	159

Table H12. Label responses for question A that are included in the symptom related labels category

Labels	n
dengesiz/lik	29
mutsuz/luk	9
sıkıntılı	7
bunalım	4
karışık/karmaşık	4
sinirli	4
buhran/lı	3
çaresiz	3
değişken	3
içe/içine kapanık	3
umutsuz	3
düşünceli	2
gergin	2
kaygı/lı	2
tutarsız	2
uykusuzluk/uyuyamama	2
üzüntü/lü	2
yalnız/lık	2
acı	1
acı çeken	1
ağlama nöbeti	1
bunaldım	1
çevresinde mutlu olan insanları gördükçe dahada mutsuzluğa itiliyor	1
çıkmazda	1
çok yoğun strese maruz kalmış	1
dalgınlık	1
daraldım	1
derin	1
diken üstünde	1
dikkatli	1
durmak bilmeyen	1
duyarlı	1
duygusal	1
düşünmeden davranan	1
empati kurmaktan yoksun	1
endişeli	1
fevri hareketleri bulunan	1
gerçeğini kabul etmeme	1
gerçek dışında kendi ütopyalarında yaşamak	1
güvensizlik yaşayan	1
hareketlerini kontrol edemeyen	1
hareketli	1
hassas	1
huzursuz	1
hüzünlü	1
ilgisiz	1
intihar deneyimi yaşamış	1
istemsiz ağlamalar	1
kaotik	1
karamsar	1
kararsız	1
keder	1
kendiyle ilişkisi olmayan	1
kırılgan	1
kimi zaman çok sessiz kimi zaman çok neşeli	1
kollarına kesikler atan	1
konsantrasyon eksikliği	1
kontrolsüz	1
konuşma akışında bozukluk	1
kötümserlik	1
kuruntulu	1
kuşkucu	1
meczub	1
pasif	1
sıkıldım	1
sıkıntıları olan	1
sosyal ortamlardan kaçınan	1
şüpheci	1
takıntı	1
tedirgin	1
telaşlı	1
umursayamamak	1
unutkanlık	1
zayıf algı	1
zekayı tam kullanamayan	1
Total (n=75)	144

Tablo H13. Label responses for question A that are included in the labels related to personal/social problems category

Labels	n
sorunlu	20
problemli	5
aile	1
arkadaş	1
bazı sorunları var	1
çabalarının karşılığını alamamış	1
dağlanmış	1
güçlük	1
her şey kötü gidiyor	1
sorun	1
sorunları ile baş edememe ve derinleşememe hali	1
sorunlu aile düzeni	1
zorluk	1
Total (n=13)	36

Table H14. Label responses for question A that are included in the compassion/pity related labels category

Labels	n
yardıma ihtiyaç/muhtaç	8
Yazık	6
acıma/k	2
allah acil şifalar versin/şifa versin	2
Destek	2
geçmiş olsun	2
Sevgi	2
acaba neden kaynaklandı	1
acımasızca kişilere fiziksel zarar verebilen	1
allah düşmanına göstermesin	1
Bahtsız	1
gel!	1
Gülme	1
gülme komşuna gelir başına	1
korumasız	1
ne sorunu var?	1
Şefkat	1
umarım düzelir	1
Üzücü	1
Yardım	1
zavallı	1
Total (n=21)	40

Table H15. Label responses for question A that are included in the labels associated with normalization/denial category

Labels	n
Başarı	1
farkındalığı olan	1
hayat boş eğlen coş	1
her şeyin bir çözümü vardır	1
kendini savunan	1
Mutlu	1
ne ekersen onu biçersin	1
normal kişi	1
onun yerinde olmama	1
özdeşleşmek	1
uçurum kenarında bile olsan sırf hayata gıcıklık olsun diye gülümse dostum	1
umarım benim başıma gelmez	1
üstün IQ	1
Total (n=13)	13

Table H16. Label responses for question A that are included in the derogatory labels category

Labels	n
46/46'lı	1
abuk subuk konuşma	1
aciz	2
agresif	8
agresif (aşırı)	1
aklı başında olmayan	1
aklından zoru var	1
aklını peynir ekmekle yemek	1
allah çene vermiş gerisini koyvermiş	1
allahı yerinde değil	1
anormal/anormallik	7
arıza/lı	2
baskın	1
bıkkınlık veren	1
bu ne perhiz bu ne lahana turşusu	1
buldumcuk	1
çatlak	2
değişik	1
deli	34
deli deliyi görünce sopasını bırakırmış	1
deli deliyi görünce sopasını saklarmış diye düşünür yoldan çekilirim	1
delidir ne yapsa yeridir	2
deliye her gün bayram	1
düşüncesiz	1
en yakın arkadaşım manik depresif ve kişilik bozukluğu tanısıyla Lape'de yatmıştı sürekli yalan söylüyordu ama aldırmıyordum dışlamamalı derken çok sağlam kazık yedim	1
farklı	5
fütursuz	1
garip	3
haddini bil	1
herşeyin aşırı	1
iki yüzlü	1
ilaç almazsa ne yapacağı belli olmaz	1
ilgi arsızı	1
inatçı	1
insanlardan nefret ediyorum	1
itici	1
kaçık	1
kafadan çatlak	1
kafayı yemiş	5
karşındakini kesinlikle dinlemiyor	1
katil ruhlu	1
kıskanç	1
kinci	1
kompleksli	1
kötü	1
mal	2
mantıksız	2
manyak	9
nefret ediyorum	1
negatif	1
normal değil	1
psikopat	13
rahatsız edici	1
raporlu	1
saçma sapan konuşan	1
saldırgan	4
samimiyetsiz	1
sapık	1
sıra dışı	1
sorumsuz	1
sosyopat	1
spastik	1
tehlikeli	2
tuhaf	1
uçuk	2
üşütük	1
zaman paylaşılmayacak insanlar	1
zararlı	1
Total (n=68)	157

Table H17. Label responses for question B that are included in the medical labels category

Labels	n
hasta	42
rahatsız	35
ruh hastası	7
depresif	6
psikolojik sorunları olan/var	5
akıl hastası	4
ruhsal rahatsızlığı olan birey/kişi/şahıs	4
paranoya/k	3
psikolojisi bozuk/bozulmuş	3
depresyon	2
panik atak	2
psikolojik rahatsızlığı olan/bulunan/var	2
rahatsızlığı var/olan	2
sinir hastası	2
zihinsel özürlü	2
akıl sağlığı yerinde değil	1
akıldan rahatsız	1
aklı salim değil	1
akli dengesi yerinde olmayan	1
alkolik	1
anksiyöz	1
biraz rahatsız	1
biri var ya hani ruhsal bozukluğu olan	1
bu çocuk şizofren	1
düzenli ilaç ve terapi	1
engelli	1
extacy	1
genellikle engelli diye hitap ederim	1
hasta olduğu konusunda	1
hastalığı ne ise ismini söylerim şizofreni gibi	1
hastalık hastası	1
hastalıklı	1
kişilik bozukluğu var	1
mental bozukluğu var	1
mental hasta	1
nevroz	1
özürlü	1
psikolojik açıdan sorunlu	1
psikolojik hasta	1
psikolojik hastalığı var	1
psikolojik rahatsız	1
psikolojik rahatsızlıkları var	1
ruh sağlığı bozuk	1
ruh sağlığı iyi değil	1
ruhsal açıdan sorunları olan	1
ruhsal bozukluk	1
ruhsal hasta	1
ruhsal sağlığı bozuk	1
ruhsal sorunlu	1
sakat	1
Total (n=50)	156

Table H18. Label responses for question B that are included in the symptom related labels category

Labels	n
dengesiz/lik	17
sinirli	6
mutsuz	4
sıkıntılı	4
asosyal	3
bunalım	3
endişeli	2
gergin	2
kararsız	2
ağlamak	1
bıkkın	1
boş bakıyor	1
çatışmalı	1
dini takıntıları var	1
donuk	1
farkında olmadan böyle davranıyor	1
hayata küsmüş	1
herşeyi kafaya takan	1
huylu	1
huzursuz	1
kafasında çok şey var	1
kaygılı	1
Kendi halinde	1
kendinden memnun değil	1
keyifsiz	1
kızgın	1
kontrolsüz	1
korkuları var	1
meczub	1
neşesiz	1
öfkeli	1
sahip olduklarının farkında değil	1
sakin	1
saplantılı	1
sessiz	1
sıkıntılı bir dönemde	1
sinir krizleri geçiren	1
sinirlerine çoğunlukla hakim olamayan	1
stresli	1
suskun	1
şüpheyle bakma	1
tahmin edilemeyen	1
takıntılı	1
titiz	1
üzgün	1
üzüntülü	1
yalnız	1
yorgun	1
zeka	1
Total (n=48)	80

Table H19. Label responses for question B that are included in the labels related to personal/social problems category

Labels	n
sorunlu	26
problemli	11
sorunları olan/var	2
başa çıkamama	1
bazı problemler yaşıyor	1
bir problemi var	1
birçok zorlukla karşılaşmak	1
bulunduğu durumdan rahatsız	1
çözümsüzlükler	1
gerçekten durumu çok zor	1
gerçekten sorunları var	1
o iyi değil	1
önemsiz konuların probleme dönüşmesi	1
zor	1
zor yaşam	1
zorlanmak	1
Total (n=16)	54

Table H20. Label responses for question B that are included in the compassion/pity related labels category

Labels	n
yardıma ihtiyaç/muhtaç	5
yazık	5
anlamak/anlayış	2
yardım	2
allah başa vermesin	1
allah korusun ama	1
ben elimden geleni yaptım	1
bir sakin ol	1
çaba harcıyor	1
çocuk	1
çok acıyorum ona	1
gariban	1
hayata nasıl bakıyor acaba	1
herşeye rağmen yaşam çabası var	1
incitecek söz kullanmam	1
keşke yardım edebilsem	1
paylaşmaya ihtiyaç duyan	1
sakin ol	1
sorunları olup yardıma ihtiyacı olan birisi	1
üzülürüm	1
zavallı	1
Total (n=21)	31

Table H21. Label responses for question B that are included in the labels associated with normalization/denial category

Labels	n
genelde konuşmam	1
güçlü ol	1
hayata bakış açısı	1
hayatı güzel	1
hepimizde bir parça var	1
herhangi bir kelime veya terim kullanmam normal biri gibi davranırım	1
huzurlu	1
ismini kullanırım	1
kendine güven	1
konuşmamayı terich ederim	1
mutlu	1
normal	1
o birey hakkında konuşurken ruhsal rahatsızlığına yönelik kelimeler kullanmam	1
o derim	1
olduğun gibi yaşa	1
onun gibi olmak istemem	1
özünde iyi biri	1
pek fazla özel kelime kullanmam	1
sana öyle geliyor	1
şirin	1
takmıyorum	1
tamam	1
yüzü gülüyor	1
Total (n=23)	23

Table H22. Label responses for question B that are included in the derogatory labels category

Labels	n
deli	27
manyak	10
psikopat	8
kafayı yemiş	6
normal değil/olmayan	5
anormal	3
agresif	2
kıskanç	2
mal	2
sıyırmış	2
tuhaf	2
asabi	1
asalak	1
balatayı sıyırmış	1
bencil	1
beyni yanmış	1
biraz enteresan	1
cinayet	1
çatlak	1
çok garip ya	1
çok konuşur	1
değişik	1
eğitim düzeyi düşük	1
enteresan	1
farklı	1
fazla haseti olan	1
fütursuz	1
garip	1
güçsüz	1
hafif deli	1
hep aşırı	1
inatçı	1
iyice uçtu	1
kaçık	1
kafada bir şeyler eksik	1
kafadan kontak	1
kayık	1
kendini topluma adapte edemeyen bir insan	1
kötü	1
menfaat	1
ölçüsüz	1
psiko	1
rahatsızlık verici	1
saçmalıyor	1
salak	1
sinir	1
sinir bozucu	1
sipastik	1
şu çok konuşan	1
şuursuz	1
tehlikeli	1
vahşi	1
yarım akıllı	1
zayıf	1
zor biri	1
Total (n=55)	115

Table H23. Label responses of question C that are included in the medical labels category

Labels	n
hasta	61
rahatsız	41
ruh hastası	12
depresyon	9
özürlü	4
paranoya/k	4
akıl hastası	3
akli dengesi yerinde değil/olmayan	3
depresif	3
psikolojik rahatsız	3
psikolojisi bozuk/bozulmuş	3
hastalıklı	2
ruhsal rahatsızlığı olan birey/kişi/şahıs	2
ruhsal sağlığı bozuk	2
sinir hastası	2
akıl sağlığı bozuk	1
aklı salim düşünemiyor	1
aklı yerinde olmayan	1
akli dengesi bozuk	1
davranış bozukluğu	1
doktorluk	1
engelli	1
hastanelik	1
ilaç kullanıyormuş	1
nevrotik	1
panik atak	1
psikolojik durumu iyi değil	1
psikolojik rahatsızlığı olan/bulunan/var	1
psikolojik sorunlu	1
rahatsızlığı var/olan	1
rahatsızlığı yüzünden	1
ruhsal sorunlu	1
sakat	1
şizofren	1
tedavi olması gerek	1
tedaviye muhtaç/tedavi edilmeye ihtiyaç duyan	1
terapiye gitmeli	1
zihinsel engelli	1
zihinsel özürlü	1
Total (n=39)	178

Table H24. Label responses of question C that are included in the symptom related labels category

Labels	n
dengesiz/lik	15
sıkıntılı	4
sinirli	3
takıntılı	2
asosyal	1
aşırı derecede kararsız	1
bunalım	1
canı sıkkın	1
dengesiz hareketleri var	1
dertli	1
dışarı çıkmak istemiyor	1
esirekli	1
fazla hassas	1
fazla kırılgan	1
karmaşık yapısı var	1
keyifsiz	1
mükemmeliyetçi	1
sinirleri bozulmuş	1
sinirli (aşırı)	1
stresli	1
tutarsız	1
üzgün	1
yalnız/lık	1
yardıma ihtiyaç/muhtaç	1
Total (n=24)	44

Table H25. Label responses for question C that are included in the labels related to personal/social problems category

Labels	n
sorunlu	35
problemli	11
bir sorunu var herhalde yazık	1
çok kötü durumda	1
çok zor bir şey	1
durumu çok kötü	1
onun problemleri var	1
sorunları var herhalde	1
yaşadıkları kolay değil	1
zor	1
Total (n=10)	54

Table H26. Label responses for question C that are included in the compassion/pity related labels category

Labels	n
yazık	4
zavallı	2
akıl fikir versin	1
allah akıl fikir versin	1
allah akıl versin	1
allah kurtarsın	1
allahın garibi	1
bizim de başımıza gelebilirdi	1
gariban	1
ilgi	1
ne kötüymüş	1
tedavisi yok mu	1
üzüldük	1
vah vah yazık garibim	1
Total (n=14)	18

Table H27. Label responses for question C that are included in the labels associated with normalization/denial category

Labels	n
Bilmiyorum	1
deli dolu	1
herhangi farklı bir kelime/terim/deyiş kullanmazlar. normal insan için kullandıkları kelimeleri kullanırlar.	1
kendi halinde	1
sadece o kişi ile konuşurum	1
Total (n=5)	5

Table H28. Label responses for question C that are included in the derogatory labels category

Labels	n
deli	119
manyak	29
psikopat	18
anormal	5
kafayı yemiş	5
çatlak	4
kafadan kontak	3
mal	3
tuhaf	3
çok kötü	2
garip	2
gereksiz	2
gerizekalı	2
kafadan sakat	2
kafası bozuk	2
normal değil/olmayan	2
sıyırmış	2
uçuk	2
46/46'lı	1
acayip	1
agresif (çok)	1
akılsız	1
aklı gelip gidiyor	1
aklı gidik	1
aklını yemiş	1
aptal	1
arıza	1
azıcık noksan	1
balatayı sıyırmış	1
beyni yanmış	1
birkaç tahtası eksik	1
çok fazla konuşuyor	1
değişik	1
deli deliyi görünce sopasını saklarmış. sakla ve yanaşma	1
delirmiş gibi davranıyor	1
embesil	1
farklı	1
gel-git akıllı	1
gıcık	1
güçsüz	1
hepten sıyırdı	1
huzur bozucu	1
idiot	1
iki yüzlü	1
insanı yoruyor	1
iradesiz	1
kabul edilemez	1
kaçık	1
kafa gitmiş	1
kafası yerinde değil	1
kafayı temizlemiş	1
psiko deli	1
psycho	1
salak	1
sevgisiz	1
spastik	1
şey biraz	1
şımarık	1
şizo	1
şuursuz	1
tahtası eksik	1
terelelli	1
tırlatmış	1
topluma aykırı birey	1
uçmuş	1
yedisinde neyse yetmişinde o olur, değişmez	1
Total (n=66)	255

Appendix I: Results of Analyses Among Label Themes

Table I1. Results of chi-square comparisons between question responses that belong to a label theme

Labels	χ^2	p	n
Medical			
A X B	40.931	0.000	298
B X C	12.378	0.000	297
A X C	8.064	0.005	295
Symptom related			
A X B	27.205	0.000	298
B X C	18.403	0.000	297
A X C	22.093	0.000	295
Personal/social related			
A X B	11.802	0.002 [a]	298
B X C	17.197	0.000	297
A X C	7.55	0.014 [a]	295
Compassion/pity related			
A X B	28.219	0.000 [a]	298
B X C	41.343	0.000 [a]	297
A X C	3.778	0.074 [a]	295
Normalization/denial related			
A X B	18.505	0.002 [a]	298
B X C	17.083	0.014 [a]	297
A X C	0.106	1.000 [a]	295
Derogatory			
A X B	22.965	0.000	298
B X C	1.7	0.192	297
A X C	10.595	0.001	295

Note. $Df = 1$
[a] Fisher's Exact Test

Appendix J: Results for Attitudes Toward Depression Questionnaire

Table J1. Responses about recognition of depressive symptoms

Question about the case vignette	n	% (N=320)	% (n=312)
Which of the following do you think describes Ms Fatma's situation?			
Mrs Fatma has a somatic disease	2	0.6	0.6
Mrs Fatma has a mental disease ("ruhsal hastalık")	262	81.9	84.0
Mrs Fatma has a mental illness ("akıl hastalığı")	1	0.3	0.3
Mrs Fatma has a neurological disease	20	6.3	6.4
Mrs Fatma does not have a disease	12	3.8	3.8
Other	15	4.7	4.8
missing	2	0.6	
DISCARDED[a]	6	1.9	
	320	100.0	

[a]Discarded due to double answers

Table J2. Responses on items about perception and causal attributions of depressive symptoms

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ms Fatma's condition is due her social problems – ex:unemployment. poverty. family problems. etc (*n* = 318)	125	39.1	138	43.1	263	82.2	18	5.6	16	5.0	34	10.6	21	6.6	2	0.6
Ms Fatma's condition is due to the weakness of her personality (*n* = 316)	31	9.7	76	23.8	107	33.4	92	28.8	92	28.8	184	57.5	25	7.8	4	1.3
Ms Fatma's condition is a state of extreme sadness. (*n* = 318)	74	23.1	136	42.5	210	65.6	56	17.5	39	12.2	95	29.7	13	4.1	2	0.6
Ms Fatma's condition is a condition that everyone may experience from time to time (*n* = 317)	157	49.1	121	37.8	278	86.9	29	9.1	5	1.6	34	10.6	5	1.6	3	0.9
Ms Fatma's condition depends on genetic factors (*n* = 318)	8	2.5	50	15.6	58	18.1	75	23.4	134	41.9	209	65.3	51	15.9	2	0.6
Ms Fatma's condition has a biological basis. and is due to the fluctuations in the biochemistry of her brain (*n* = 319)	16	5.0	77	24.1	93	29.1	73	22.8	80	25.0	153	47.8	73	22.8	1	0.3
Ms Fatma's condition is due to her infantile/early childhood problems (*n* = 319)	18	5.6	118	36.9	136	42.5	75	23.4	50	15.6	125	39.1	58	18.1	1	0.3

[a] Discarded due to double responses

Table J3. Responses on items about attitudes and social distance regarding people with depression

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
People with similar complaints as Ms Fatma. shouldn't be free in the community	9	2.8	9	2.8	18	5.6	26	8.1	258	80.6	284	88.8	16	5.0	2	0.6
I could work with a person with similar complaints as Ms Fatma	84	26.3	97	30.3	181	56.6	70	21.9	40	12.5	110	34.4	28	8.8	1	0.3
I could marry a person with similar complaints as Ms Fatma	25	7.8	49	15.3	74	23.1	81	25.3	136	42.5	217	67.8	26	8.1	3	0.9
Having a neighbour with similar complaints as Ms Fatma does not make me uneasy	130	40.6	96	30.0	226	70.6	47	14.7	30	9.4	77	24.1	16	5.0	1	0.3
I would not rent my house to a person with similar complaints as Ms Fatma	16	5.0	32	10.0	48	15.0	76	23.8	183	57.2	259	80.9	11	3.4	2	0.6
Persons with similar complaints as Ms Fatma are aggressive	5	1.6	37	11.6	42	13.1	95	29.7	162	50.6	257	80.3	18	5.6	3	0.9
People with similar complaints as Ms Fatma cannot make correct decisions about their own lives	40	12.5	143	44.7	183	57.2	78	24.4	47	14.7	125	39.1	6	1.9	6	1.9

[a] Discarded due to double responses

Table J4. Responses on items about the treatment of depression

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Ms Fatma's condition cannot be treated without solving her social problems – ex: unemployment. poverty. family problems. etc.	76	23.8	136	42.5	212	66.3	63	19.7	27	8.4	90	28.1	16	5.0	2	0.6
Ms Fatma's condition will never improve completely	10	3.1	28	8.8	38	11.9	94	29.4	164	51.3	258	80.6	22	6.9	2	0.6
Ms Fatma's condition is treatable condition	226	70.6	61	19.1	287	89.7	9	2.8	5	1.6	14	4.4	16	5.0	3	0.9
Ms Fatma's condition can be treated by drugs	51	15.9	110	34.4	161	50.3	73	22.8	27	8.4	100	31.3	55	17.2	4	1.3
Ms Fatma's condition can be treated by psychotherapy	147	45.9	102	31.9	249	77.8	19	5.9	7	2.2	26	8.1	41	12.8	4	1.3
People with similar complaints as Ms Fatma should be hospitalized	9	2.8	27	8.4	36	11.3	85	26.6	164	51.3	249	77.8	34	10.6	1	0.3

[a] Discarded due to double responses

Table J5. Responses on items about help seeking options for people with depression

Question about the case vignette	n	% (N=320)	% (n=306)
What should people with similar complaints as Ms Fatma do to recover from this condition?			
They should give precedence to a physician	14	4.4	4.6
They should give precedence to a mental health specialist – psychiatrist. psychologist. psychotherapist	196	61.3	64.1
They should give precedence to being strong. if they want they can cope with this condition.	38	11.9	12.4
They should give precedence to leaving from their stressful environment – taking a vacation etc	28	8.8	9.2
The conditions of their life should be corrected in the first instance	25	7.8	8.2
They should give precedence to seeking help from traditional methods – ex: religion. hodjas. etc	2	0.6	0.7
Other	3	0.9	1.0
Missing	3	0.9	
Discarded[a]	11	3.4	
	320	100.0	

[a]Discarded due to double answers

Appendix K: Results for Attitudes Toward Schizophrenia Questionnaire

Table K**1**. Responses about recognition of schizophrenia

Question about the case vignette	n	% (N=320)	% (n=304)
Which of the following do you think describes Mr Ahmet's situation?			
Mr Ahmet has a somatic disease	1	0.3	0.3
Mr Ahmet has a mental disease	85	26.6	28.0
Mr Ahmet has a mental illness	190	59.4	62.5
Mr Ahmet has a neurological disease	21	6.6	6.9
Mr Ahmet does not have a disease	4	1.3	1.3
Other	3	0.9	1.0
missing	7	2.2	
DISCARDED[a]	9	2.8	
	320	100.0	

[a]Discarded due to double answers

Table K2. Responses on items about perception and causal attributions of schizophrenia

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mr Ahmet's condition is due to social problems – ex:unemployment. poverty. family problems. etc	18	5.6	87	27.2	105	32.8	77	24.1	109	34.1	186	58.1	27	8.4	2	0.6
Mr Ahmet's condition is due to the weakness of his personality	34	10.6	89	27.8	123	38.4	63	19.7	104	32.5	167	52.2	27	8.4	3	0.9
Mr Ahmet's condition is a state of extreme sadness.	8	2.5	31	9.7	39	12.2	82	25.6	175	54.7	257	80.3	22	6.9	2	0.6
Mr Ahmet's condition is a condition that everyone may experience from time to time	6	1.9	37	11.6	43	13.4	87	27.2	176	55.0	263	82.2	10	3.1	4	1.3
Mr Ahmet's condition depends on genetic factors	58	18.1	131	40.9	189	59.1	46	14.4	43	13.4	89	27.8	37	11.6	5	1.6
Mr Ahmet's condition has a biological basis. and is due to the fluctuations in the biochemistry of his brain	108	33.8	108	33.8	216	67.5	26	8.1	28	8.8	54	16.9	47	14.7	3	0.9
Mr Ahmet's condition is due to his infantile/early childhood problems	34	10.6	128	40.0	162	50.6	50	15.6	43	13.4	93	29.1	63	19.7	2	0.6

[a] Discarded due to double responses

Table K**3**. Responses on items about attitudes and social distance regarding people with schizophrenia

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
People with similar complaints as Mr Ahmet. shouldn't be free in the community	64	20.0	120	37.5	184	57.5	75	23.4	50	15.6	125	39.1	8	2.5	3	0.9
I could work with a person with similar complaints as Mr Ahmet	17	5.3	33	10.3	50	15.6	97	30.3	152	47.5	249	77.8	15	4.7	6	1.9
I could marry a person with similar complaints as Mr Ahmet	4	1.3	7	2.2	11	3.4	40	12.5	253	79.1	293	91.6	13	4.1	3	0.9
Having a neighbour with similar complaints as Mr Ahmet does not make me uneasy	26	8.1	40	12.5	66	20.6	90	28.1	144	45.0	234	73.1	18	5.6	2	0.6
I would not rent my house to a person with similar complaints as Mr Ahmet	87	27.2	91	28.4	178	55.6	63	19.7	58	18.1	121	37.8	19	5.9	2	0.6
Persons with similar complaints as Mr Ahmet are aggressive	64	20.0	140	43.8	204	63.8	58	18.1	24	7.5	82	25.6	30	9.4	4	1.3
People with similar complaints as Mr Ahmet cannot make correct decisions about their own lives	186	58.1	90	28.1	276	86.3	21	6.6	8	2.5	29	9.1	12	3.8	3	0.9

[a] Discarded due to double responses

Table K4. Responses on items about the treatment of schizophrenia

	I agree		I slightly agree		Total agree		I slightly disagree		I disagree		Total disagree		I have no idea		Missing or Discarded[a]	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mr Ahmet's condition cannot be treated without solving his social problems – ex: unemployment. poverty. family problems. etc.	37	11.6	49	15.3	86	26.9	81	25.3	118	36.9	199	62.2	29	9.1	6	1.9
Mr Ahmet's condition will never improve completely	47	14.7	116	36.3	163	50.9	66	20.6	48	15.0	114	35.6	41	12.8	2	0.6
Mr Ahmet's condition is treatable condition	90	28.1	126	39.4	216	67.5	42	13.1	19	5.9	61	19.1	37	11.6	6	1.9
Mr Ahmet's condition can be treated by drugs	117	36.6	111	34.7	228	71.3	26	8.1	21	6.6	47	14.7	43	13.4	2	0.6
Mr Ahmet's condition can be treated by psychotherapy	76	23.8	118	36.9	194	60.6	55	17.2	28	8.8	83	25.9	41	12.8	2	0.6
People with similar complaints as Mr Ahmet should be hospitalized	136	42.5	91	28.4	227	70.9	40	12.5	19	5.9	59	18.4	32	10.0	2	0.6

[a] Discarded due to double responses

Table K5. Responses on items about help seeking options for people with schizophrenia

Question about the case vignette	n	% (N=320)	% (n=300)
What should people with similar complaints as Mr Ahmet do to recover from this condition?			
They should give precedence to a physician	40	12.5	13.3
They should give precedence to a mental health specialist – psychiatrist. psychologist. psychotherapist	246	76.9	82.0
They should give precedence to being strong. if they want they can cope with this condition.	5	1.6	1.7
They should give precedence to leaving from their stressful environment – taking a vacation etc	4	1.3	1.3
The conditions of their life should be corrected in the first instance	3	0.9	1.0
They should give precedence to seeking help from traditional methods – ex: religion. hodjas. etc	0	0.0	0.0
Other	2	0.6	0.7
Missing	13	4.1	
Discarded[a]	7	2.2	
	320	100.0	

[a]Discarded due to double answers

Appendix L: Results of Analyses for Comparisons Between Attitudes Toward Depression and Schizophrenia

Table L1. Paired sample t-test results of item comparisons between Attitudes Toward Depression and Schizophrenia Questionnaires

Item Number	Depression		Schizophrenia				
	M	*SD*	*M*	*SD*	*df*	*t*	*p*
2	3,03	1,12	1,87	1,07	315	15,67	0,00
3	1,98	1,12	2,01	1,17	312	-.34	0,74
4	2,69	1,09	1,46	0,86	315	16.65	0,00
5	3,33	0,83	1,53	0,81	312	30.47	0,00
6	1,46	1,02	2,41	1,27	312	-12.86	0,00
7	1,62	1,22	2,65	1,40	315	-11.83	0,00
8	1,96	1,22	2,09	1,32	316	-1.72	0,09
9	1,17	0,69	2,58	1,06	314	-20.72	0,00
10	2,53	1,25	1,63	0,93	312	13.01	0,00
11	1,71	1,07	1,17	0,59	314	9.45	0,00
12	2,92	1,18	1,72	1,03	317	17.04	0,00
13	1,56	0,91	2,54	1,23	316	-13.46	0,00
14	1,52	0,84	2,59	1,18	313	-14.70	0,00
15	2,52	0,96	3,35	0,99	311	-14.42	0,00
16	2,70	1,07	1,82	1,16	312	11.10	0,00
17	1,50	0,87	2,26	1,25	316	-10.03	0,00
18	3,50	1,01	2,68	1,28	312	10.26	0,00
19	2,24	1,32	2,75	1,37	314	-6.06	0,00
20	2,97	1,34	2,51	1,30	314	5.48	0,00
21	1,42	0,89	2,88	1,30	317	-18.21	0,00

Appendix M: Results of Chi-square Analyses for Demographic Variables and Label Themes

Table M1. Results of chi-square analyses of label themes for question A and demographic variables (*continued on next page)*

	Labels											
Variables	**Medical**		**Symptom**		**Personal/Social**		**Compassion/Pity**		**Normalization/Denial**		**Derogatory**	
Gender n=306												
Female	44.9	0.200	30.8	0.154	11.2	0.509	7.9	0.007**	4.7	0.183[a]	37.4	0.518
Male	37.0		22.8		8.7		18.5		1.1		41.3	
Major n=303												
Psychology	46.4	0.172	30.7	0.339	12.9	0.228	6.4	0,014*	4.3	0.572	32.9	0.044*
Non-psychology	38.7		25.8		8.6		15.3		3.1		44.2	
Year of study n=295												
1	16.7	0.001**	29.2	0.911	6.2	0.754	18.8	0.163	4.2	0.597	45.8	0.188
2	43.6		29.7		11.9		11.9		5.0		37.6	
3	53.2		25.3		11.4		6.3		1.3		45.6	
4 and more	47.8		29.9		10.4		9.0		4.5		29.9	
Psychology year of study n=139												
2	43.6	0.588	32.7	0.885	16.4	0.520	7.3	0.288	5.5	0.180	29.1	0.007**
3	52.2		28.3		8.7		2.2		0.0		50.0	
4 and 4<	42.1		31.6		13.2		10.5		7.9		18.4	
Birth place n=306												
Non-big city	37.7		28.3		6.6	0.109	11.3	0.932	6.6	0,053[a]	42.5	0.309
Big city	45.0	0.221	28.5	0.971	12.5		11.0		2.0		36.5	
Place of residence n=306												
Non-big city	45.0		27.5		10.0	0.876	16.2	0.089	3.8	0.931[a]	31.2	0.118
Big city	41.6	0.596	28.8	0.830	10.6		9.3		3.5		41.2	
Socioeconomic Status n=305												
Low—middle	38.6	0.259	27.3	0.672	12.9	0.235	11.4	0.917	5.3	0.218[a]	39.4	0.825
High-middle—high	45.1		29.5		8.7		11.0		2.3		38.2	

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category
[a] p value for Fisher's Exact Test

* $p<.05$. **$p<.01$

Table M1(continued) . Results of chi-square analyses of label themes for question A and demographic variables

	Labels											
Variables	**Medical**		**Symptom**		**Personal/Social**		**Compassion/Pity**		**Normalization/Denial**		**Derogatory**	
Work Study/paid job n=306												
No	41.1	0.214	29.3	0.417	8.7	0.027*[a]	10.6	0.599[a]	3.0	0.190[a]	38.0	0.632
Yes	51.2		23.3		20.9		14.0		7.0		41.9	
Mother's education n=306												
No education-High school	38.5	0.059	29.7	0.500	9.7	0.589	12.8	0.207	3.1	0.536[a]	40.5	0.353
University and above	49.5		26.1		11.7		8.1		4.5		35.1	
Father's Education n=306												
No education-High school	42.7	0.944	29.9	0.651	12.0	0.498	12.0	0.708	2.6	0.541[a]	37.6	0.787
University and above	42.3		27.5		9.5		10.6		4.2		39.2	
History of MI n=306												
No	42.3	0.911	25.6	0.051*	9.4	0.277.	12.0	0.391	3.8	1.000[a]	42.3	0.015*
Yes	43.1		37.5		13.9		8.3		2.8		26.4	
History of MI treatment n=305												
No	41.1	0.390	27.4	0.373	9.7	0.333	12.1	0.134	4.0	0.696[a]	39.5	0.387
Yes	47.4		33.3		14.0		5.3		1.8		33.3	
Contact with MI n=305												
No	38.9	0.170	39.5	0.009**	7.0	0.041*	10.8	0.855	3.8	0.836	40.8	0.374
Yes	46.6		60.5		14.2		11.5		3.4		35.8	

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category

[a] p value for Fisher's Exact Test

* $p<.05$. ** $p<.01$

Table M2 Results of chi-square analyses of label themes for question B and demographic variables(*continued on next page)*

	Labels									
Variables	**Medical**		**Symptom**		**Personal/Social**	**Compassion/Pity**		**Normalization/Denial**		**Derogatory**
Gender (n=304)										
Female	44,4	0.993	22,4	0,011*	17,3	9,3		5,1		27,1
Male	44,4		10.0		8,9	7,8		7,8		36,7
Major (n=301)										
Psychology	45,7		23,9	0,029*	17,4	10,1		4,3		27,5
Non-psychology	44.2		14,1		12,3	8.0		6,7		32.5
Year of study (n=292)										
1	31.2		22,9		10,4	8,2		12,5	0,021*[a]	25.0
2	41,4		23,2		16,2	13,1		7,1		28,3
3	50,0		14,1		23,1	5,1		0,0		37,2
4 and more	52,2		16,4		9,0	9,0		4,5		26,9
Psychology year of study (n=136)										
2	41,5		32,1		15,1	18,9	0,031*[a]	5,7		22,6
3	44,4		17,8		24,4	4,4		0,0		33,3
4 and 4<	50,0		21,1		13,2	5,3		7,9		28,9
Birth Place (n=304)										
Non-big city	43.0		14.0		13,1	7,5		10,3	0,018*	28.0
Big city	45,2		21,3		15,7	9,6		3,6		31,0
Place of residence (n=304)										
Non-big city	46,6		13,6		18,5	8,6		4,5		24,7
Big city	43.3		20,6		13,5	9,0		9,9		31,8
Socioeconomic Status (n=302)										
Low—Middle	46,2		13.0	0,029*	16.0	6,9		5,3		32,8
High-Middle—High	43,3		22,8		13,5	10,5		6,4		28,1

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category
[a] p value for Fisher's Exact Test * p<.05. **p<.01

Table M2(continued). Results of chi-square analyses of label themes for question B and demographic variables

			Labels			
Variables	**Medical**	**Symptom**	**Personal/Social**	**Compassion/Pity**	**Normalization/Denial**	**Derogatory**
Work Study/paid job (n=304)						
No	43,9	19,1	14,1	8,4	5,7	29,8
Yes	47.6	16,7	19.0	11,9	7,1	31.0
Mother's education (n=303)						
No education-High school	45.1	19,2	11,9	9,8	4,7	28,5
University and above	43,6	18,2	19,1	7,3	8,2	32,7
Father's Education (n=303)						
No education-High school	45.2	16,5	12,2	11,3	4,3	29,6
University and above	44,1	20,2	16,0	7,4	6,9	30,3
History of MI (n=304)						
No	44,2	16,9	14,3	7,4	6,9	31,2
Yes	45.2	24,7	16,4	13,7	2,7	26.0
History of MI treatment (n=303)						
No	43,7	18.0	14,7	8,2	6,9	30.2
Yes	46,6	22,4	15,5	12,1	1,7	27,6
Contact with MI (n=303)						
No	44,2	16,2	13,6	9,7	5,8	29,2
Yes	45.0	21,5	16,1	8,1	5,4	30.9

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category
[a] p value for Fisher's Exact Test * $p<.05$. ** $p<.01$

Table M3. Results of chi-square analyses of label themes for question C and demographic variables (*continued on next page*)

					Labels				
Variables	**Medical**	**Symptom**	**Personal/Social**		**Compassion/Pity**		**Normalization/Denial**		**Derogatory**
Gender (n=303)									
Female	52,3	12,1	17,7		7,0	0,046*[a]	0,5	0,075[a]	59,5
Male	47,9	9,1	10,2		1,1		3,4		59,1
Major (n=300)									
Psychology	49,6	12,8	19,9	0,041*	5,7		0,7		63,1
Non-psychology	49,1	10,1	11,3		5,0		1,9		56,6
Year of study (n=291)									
1	43,2	9,1	6,8		0,0	0,022*[a]	2,3		59,1
2	49,0	16,0	21,0		10,0		1,0		56,0
3	52,6	11,5	15,4		1,3		0,0		62,8
4 and more	52,2	5,8	15,9		5,8		0,0		62,3
Psychology year of study (n=139)									
2	56,4	18,2	23,6		10,9		0		54,5
3	47,8	13,0	15,2		2,2		0		67,4
4 and 4<	44,7	5,3	21,1		2,6		0		68,4
Birth Place (n=303)									
Non-big city	47,1	11,8	9,8		2,0		1,0		55,9
Big city	50,2	10,9	18,4		7,0		1,5		61,2
Place of residence (n=303)									
Non-big city	56,4	9,0	12,8		3,8		1,3		56,4
Big city	46,7	12,0	16,4		5,8		1,3		60,4

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category

[a] p value for Fisher's Exact Test

* $p<.05$. ** $p<.01$

Table M3(*continued*). Results of chi-square analyses of label themes for question C and demographic variables

	Labels							
Variables	**Medical**		**Symptom**		**Personal/Social**	**Compassion/Pity**	**Normalization/Denial**	**Derogatory**
Socioeconomic Status (n=301)								
Low—Middle	49,6		7,6		13,0	4,6	0,0	61,1
High-Middle—High	49,4		14,1		17,6	5,9	2,4	57,6
Work Study/paid job (n=303)								
No	47,7		11,2		15,5	4,7	1,6	59,7
Yes	57,8		11,1		15,6	8,9	0,0	57,8
Mother's education (n=302)								
No education-high school	46,4		12,0		14,6	3,6	1,6	57,8
University and above	54,5		10,0		17,3	8,2	0,9	61,8
Father's Education (n=302)								
No education-High school	44,8		11,2		15,5	6,0	0,0	59,5
University and above	52,2		11,3		15,6	4,8	2,2	59,1
History of MI (n=303)								
No	47,4		10,5		15,4	6,1	1,3	61,0
Yes	54,7		13,3		16,0	2,7	1,3	54,7
History of MI treatment (n=302)								
No	48,3		11,6		14,5	5,4	1,2	60,7
Yes	51,7		10,0		20,0	5,0	1,7	53,3
Contact with MI (n=303)								
No	41,8	0,010*	6,5	0,009**	13,7	4,6	1,3	62,7
Yes	56,7		16,0		17,3	6,0	1,3	56,0

Note. "Mental illness" is abbreviated as MI. Different chi-square analyses have been conducted for each variable and label category
[a] p value for Fisher's Exact Test

* $p<.05$. ** $p<.01$