Original Article

Comparison of disability and social functionality levels and subjective recovery perceptions of the patients received and did not receive service from community mental health center*

 Selda Öztürk,[1] Nihan Altan Sarıkaya,[1] Sevcan Öz[2]

[1]Department of Mental Health and Psychiatric Nursing, Trakya University Faculty of Health Sciences, Edirne, Turkey
[2]Department of Mental Health and Psychiatric Nursing, Ege University Faculty of Nursing, İzmir, Turkey

Abstract

Objectives: This study was aimed to investigate the disability, social functioning and subjective recovery of patients who have been followed up and do not followed up in the Community Mental Health Center (CMHC).

Methods: This cross-sectional and descriptive research was conducted with patients who have been followed up in CMHC (n=19) and do not followed up in CMHC (n=19) in between dates of June-August 2018. Questionnaire form, Social Functioning Assessment Scale (SFAS) and Subjective Recovery Assessment Scale (SubRAS) were used for data collection. Data were analysed by the use of Independent-Samples t test, Chi-Square test and Spearman correlation Analysis.

Results: There was no statistical significance between the patients who followed up CMHC and do not followed up CMHC. It was determined that patients who followed up in CMHC had less disability, better functioning and subjective feeling of recovery. It was determined that as age of onset and income increased, the social functioning of the patients also increased (p=0.031, p=0.032, respectively). Significant negative correlation were found between SFAS and WHO-DAS-II (p=0.045) and positive correlation between SFAS and WHO-DAS-II total score (p=0.020). Significant negative correlations were found between WHO-DAS-II and SubRAS total score (p=0.002).

Conclusion: There was no significant difference between disability, social functioning and subjective feeling of recovery of patients who followed up in CMHC and do not followed up in CMHC.

Keywords: Community mental health center; mental illness; recovery; social functioning.

With community mental health services and protection coming to the fore across the world in the 1960s, it was aimed to be able to treat patients in the community. Hence, it was enabled that the patient was treated in his own environment thanks to the transition from the hospital-based model to the community-based service model.[1,2] The improvement of psychiatric treatment and rehabilitation services in our country, Turkey, was launched in the 1960s. By providing community mental health services through mental health dispensaries, which was established for this purpose, it was intended to reintegrate patients into society.[3,4] In line with the study of Turkey Mental Health Profile (1998) and the National Mental Health Policy recommendations published by the Republic of Turkey, Ministry of Health in 2006, the studies on community-based mental health care services were initiated in 2008. Based on the patient-centered approach, it has been planned to make the system widespread through community mental health centers (CMHC) to be opened.[2]

Severe mental illnesses are psychiatric conditions that progress with relapses and recovery and may lead to loss of functionality and disability in a significant number of patients. Reasons, such as frequent recurrences, delay in treatment, and inability to administer appropriate treatment, may increase

What is known on this subject?

• The disability, social functionality and subjective recovery perception levels of the patients who have received a regular health care service from the community mental health center are at a better level than the patients who have not received a regular health care service from the community mental health center.

What is the contribution of this paper?

• The findings reveal that there is no difference between the disability, social functionality, and subjective recovery levels of the patients who have received a regular service from the community mental health center and those who have not received regular service.

What is its contribution to the practice?

• The fact that there is a significant difference between the disability, social functionality and subjective recovery levels of patients who have received a regular service from community mental health centers and those who have not received suggest that the content of the provided services, the frequency of their implementation, and the factors that impact the quality of the services, such as the team, which provides the service should be reconsidered.

the severity of disability in the patient. Due to disability, the functionality of individuals decreases and they experience difficulties in fulfilling their expected academic, professional, and social roles.[5] Some studies in the literature suggest that in addition to medications, training, such as mental education, social skills training and parental education, can have a positive impact on recovery and enhancement in functionality. [6–8]

Recovery emerges as a crucial term, and in general, it can be defined as amelioration of symptoms or a decrease in their severity and enhancement of functionality level.[9,10] When the notion of recovery is examined more closely, it is noticed that it involves factors, such as the ability to benefit from social resources, establish satisfactory interpersonal relationships, take responsibility, acknowledging the disease, manage the disease, hope, and self-esteem.[11,12] Briefly, the ill person realizes the illness and continues the life by understanding it, that is, perceiving himself as healed.[13] It has been found in a study that at the end of the therapeutic intervention applied to patients, it was easier for patients to recover by realizing positive values regarding themselves.[14] In the study of Knutson and Newberry (2013)[15] on psychiatric patients, patients were provided with psycho-education with a recovery model to. The stages of psycho-education included developing interpersonal relationships, taking responsibility, symptom management, coping with problems, feeling safe and hope. Their findings showed that 37% of the patients rated the impact of psycho-education on recovery as very good, while 35% rated its impact as excellent.

Severe mental illnesses, such as schizophrenia, schizoaffective disorder and bipolar disorder, may lead to insufficiency in many aspects of life, such as self-care, interpersonal relationships, work-life and daily life skills, as well as decreased social and cognitive functions.[12,16] Through psychosocial support and skills training, which is provided in community mental health centers, the functionality level of patients with severe mental illness is enhanced and it is aimed to reintegrate patients as independent individuals in society.[8,17]

As a problem with social, economic, legal, and medical dimensions, severe mental illnesses affect patients and society in various ways[18] Disability and loss of functionality lead to social and economic losses in individuals. As a result, individuals experience difficulties since they cannot fulfill the roles expected of them in society.[19] This outcome might have a negative impact on the treatment compliance and recovery processes of individuals. During the patient's treatment compliance and psychiatric rehabilitation period, psychiatric nurses provide training programs in the use of drugs, give education and enhance social functionality. Frequent hospitalizations of the patients can be prevented, and their social functionality could be enhanced through the training programs that are implemented by the psychiatric nurse and the CMHC team.[20] Hence, the present study aims to examine the disability and social functionality levels and subjective recovery perceptions of patients who have been provided with service by community mental health centers and have not been provided. In this research, answers for the following questions were sought:

1. Is there a difference between disability, social functionality levels, and subjective recovery perceptions of patients who receive and do not receive service from community mental health centers?

2. Is there a correlation between disability, social functionality levels, and subjective perception of recovery, and individual characteristics of patients who received service from community mental health centers and have not received it?

Materials and Method

Study Population and Sample

The data of this comparative and correlational study were collected from patients who were registered in a Community Mental Health Center between June 2018 and August 2018. According to the weekly program of the center, social skills training and patient psycho-education are provided once a week under the supervision of a nurse or psychologist. Individual counseling services are provided by nurses, psychologists, and social workers. In the center, artistic activities, such as painting and occupational therapy, music therapy, drama are carried out with a qualified instructor who was assigned by the public education center every day, and activities, such as movie screening, cooking, doing sport, computer courses, and exam preparation courses are carried out.

The population of this study consisted of 672 patients with severe mental illness who were registered in CMHC. The sample group consisted of 38 patients, 19 of whom participated in rehabilitation programs regularly (at least one day a week) for the last year and 19 who did not participate in rehabilitation programs at all. The inclusion criteria were determined as having a severe mental illness (having a diagnosis of schizophrenia, bipolar disorder, schizoaffective disorder, and atypical psychosis), having insight, not having language problems at a level that hinders speech and understanding, and volunteering to participate in this study. Written informed consent was obtained from patients who agreed to participate in this study. Patients not

receiving services from CMHC were determined using a simple random sampling table from the patient list. New patients were selected from the list using the sampling table, in substitution for the patients who did not agree to participate in this study. Patients who did not receive regular service from CMHC were the patients who were followed up in the psychiatry outpatient clinic of the state hospital to which CMHC was affiliated. The characteristics of the patients who received and did not receive services from CMHC were similar concerning age, sex, marital status, educational status, employment status, diagnosis of disease, and the number of hospitalizations (p>0.05).

Data Collection Tools

The data were collected using the Information Form prepared by the researchers, the Disability Assessment Schedule (WHO-DAS-II), the Social Functioning Assessment Scale (SFAS), and the Subjective Recovery Assessment Scale (SubRAS).

Demographic Information Form: In line with the literature review[4,6–11,16] conducted by the researchers, it consisted of 13 queries, including seven questions about the sociodemographic characteristics (age, income per capita, gender, marital status, educational status, employment status, cohabitation) of the patients who volunteered to participate in this study and six queries about the characteristics of the disease history (disease diagnosis, age of onset, the number of hospitalizations, mental illness in the family, physical violence behavior, suicide attempt).

World Health Organization-Disability Assessment Schedule-II; WHO-DAS-II: It was developed by the World Health Organization in 1999 to investigate the limitations of the individual's level of efficiency and participation in society, independent of medical diagnosis.[21] It uses the "International Classification of Impairments, Disabilities and Handicaps-ICIDH-II" classification system. There were forms containing 36 or 12 items administered by the patient, interviewer, or patient relative. Its Turkish validity and reliability study was performed by Ulug and Ertugrul[22] (2001). In this study, a 12-item screening form was used. The increase in the score, which is obtained from the scale, indicates that the individual's disability increases. The Cronbach's Alpha reliability coefficient of the scale in the present study was determined to be 0.920,[21] and test reliability for this study was assessed using Cronbach's Alpha, and its alpha coefficient was 0.868.

Social Functioning Assessment Scale (SFAS): It is a 19-item Likert-type scale, specific to Turkish culture, and the scale has been developed by Yildiz et al.[23] in 2018 for patients with schizophrenia. Each item is scored from 1 to 3. Higher scores obtained from the scale suggest that the individual's social functionality is better. The Cronbach's Alpha coefficient of the scale in the present study was 0.842,[22] the test reliability for this study was assessed using Cronbach's Alpha, and the alpha value was 0.780.

Subjective Recovery Assessment Scale (SubRAS): It is a 17-item Likert-type self-administered scale, which has been developed by Yildiz et al.[24] in 2016. Each item is scored from 1 to 5. Higher scores obtained from the scale indicate that the individual perceives himself as recovered better. The Cronbach's Alpha coefficient of the scale in the present study was determined to be 0.987[23] and the test reliability for this study was assessed using Cronbach's Alpha, and the alpha value was 0.908.

Process

Before starting the data collection, the participants were informed about the objective of this study, and the verbal and written consent of the participants was obtained. The questionnaire forms used in this study were filled in by the researcher using the face-to-face interview in an average of 10 to 15 minutes in the interview room at the CMHC. The forms for the patients who did not receive services from the CMHC were also filled in the interview room by the researcher using the face-to-face interview in an average of 10 to 15 minutes. Participants were informed about the number of queries and their contents before answering their queries, and the fact that it was avoided to include open-ended questions in the questionnaire, and the expressions were explained with simple sentences made it easier to answer the queries.

Data Analysis

The data obtained in this study were analyzed using the software of SPSS (Statistical Package for Social Sciences) for Windows 20.0. Cronbach-alpha coefficients for the scales were calculated. Since the number of people included in each sample group was less than 30, the non-parametric statistics Mann-Whitney U and Chi-Square tests were used.[25] To examine the correlation between the continuous variables of the study (n=38), the conformity of the variables to the normal distribution was examined using visual (histogram and probability graphs) and analytical methods (Skewness and Kurtosis values).[26] Pearson Correlation analysis was used as the distribution of the data was normally distributed. Number, percentage, mean and standard deviation were used as descriptive statistical methods. The results were considered statistically significant at p<0.05.[27]

Ethical Aspect of the Research

The ethical approval was obtained from the scientific research ethics committee of a university's medical faculty (TÜTF-BAEK 2018/197), and the written permission was obtained from the institution where this study was conducted for the ethical compliance of the study. This study adhered to the ethical principles of the Declaration of Helsinki. Moreover, written consent was obtained from the patients who participated in this study.

Limitations of the Study

The limitations of this study included that this study was performed on only patients who had received service from one CMHC, and the sample size was small.

Table 1. Comparison of characteristics of the patients received and did not receive service from community mental health center

Characteristics of patients	Receive services from CMHC (n=19)	Did not receive services from CMHC (n=19)	Statistical analysis
Age (mean±SD)	42.05±11.01	42.08±11.92	Z=-0.175 p=0.868
Income per capita (mean±SD)	689.47±423.47	1123.68±816.38	Z=-2.491 p=0.012
Gender, n (%)			
Female	10 (52.6)	10 (52.6)	χ^2: 1.000
Male	9 (47.4)	9 (47.4)	p>0,05[a]
Marital status, n (%)			
Single	12 (63.2)	11 (57.9)	χ^2: 2.243
Married	1 (5.3)	4 (21.1)	p=0.326[a]
Divorced/widowed	6 (31.6)	4 (21.1)	
Educational status, n (%)			
Primary school	7 (36.8)	5 (26.3)	χ^2: 4.833
Secondary school	3 (15.8)	5 (26.3)	p=0.184[a]
High school and equivalent	8 (42.1)	4 (21.1)	
College	1 (5.3)	5 (26.3)	
Employment status, n (%)			
Unemployed	17 (89.5)	15 (78.9)	χ^2: 2.125
Retire on disability	1 (5.3)	1 (5.3)	p=0.547[a]
Employed	0	2 (10.5)	
Student	1 (5.3)	1 (5.3)	
Cohabitation, n (%)			
Wit family-mother/father	15 (78.9)	14 (73.7)	χ^2: 0.234
Spouse/	2 (10.5)	3 (15.8)	p=0.889[a]
Alone	2 (10.5)	2 (10.5)	
Disease diagnosis, n (%)			
Schizophrenia	6 (31.6)	7 (36.8)	χ^2: 5.327
Schizoaffective disorder	3 (15.8)	8 (42.1)	p=0.149[a]
Atypical psychosis	7 (36.8)	2 (10.5)	
Bipolar disorder	3 (15.8)	2 (10.5)	
Age of onset (mean±SD)	21.4±6.3	24.5±6.8	t: 1.434*
The number of hospitalizations, n (%)			
1	8 (42.1)	5 (26.3)	χ^2: 1.950
2–5	6 (31.6)	5 (26.3)	p=0.583[a]
6–10	3 (15.8)	5 (26.3)	
Over 10	2 (10.5)	4 (21.1)	
Mental illness in the family, n (%)			
1. degree relatives	3 (15.8)	7 (36.8)	χ^2: 3.643
2. degree relatives	3 (15.8)	1 (5.3)	p=0.303[a]
1. ve 2. degree relatives	1 (5.3)	–	
None	12 (63.2)	11 (57.9)	
Physical violence behavior, n (%)			
No	16 (84.2)	14 (73.7)	p=0.693[b]
Yes	3 (15.8)	5 (26.3)	
Suicide attempt, n (%)			
No	14 (73.7)	11 (57.9)	χ^2: 1.052
Yes	5 (26.3)	8 (42.1)	p=0.305[a]

χ^2= Chi-Square Statistic (a: Pearson Chi-Square; b:Fisher Exact Test) Z=Mann-Whitney U Test. SD: Standard deviation.

Table 2. Comparison of the mean scores of WHO-DAS II, SFAS and SubRAS of the patients who received and did not receive service from CMHC

	Receive services from CMHC (Mean±SD)	Did not receive services from CMHC (Mean±SD)	Statistical analysis
WHO-DAS II	25.63±7.82	27.89±10.39	Z=-0.453 p=0.659
SFAS	42.11±4.69	41.79±8.07	Z=-0.132 p=0.902
SubRAS	62.26±15.52	61.42±15.39	Z=-0.146 p=0.891

Z=Mann-Whitney U Test; WHO-DAS II: Disability Assessment Schedule; SFAS: Social Functioning Assessment Scale; SubRAS: Subjective Recovery Assessment Scale; SD: Standard deviation.

Table 3. Relationship between the mean scores of WHO-DAS II, SFAS and SubRAS and some characteristics of the patients

		WHO-DAS II	SFAS	SubRAS
Age of onset	r_p	-0.261	0.351	0.222
	p	0.114	0.031*	0.180
Income per capita	r_p	-0.085	0.349	0.060
	p	0.613	0.032*	0.718
WHO-DAS II	r_p	–	-0.327*	-0.482**
	p	–	0.045	0.002
SFAS	r_p	-0.327*	–	0.377*
	p	0.045	–	0.020

rp: Pearson Correlation Analysis; *p<0.05; ** p<0.005; WHO-DAS II: Disability Assessment Schedule; SFAS: Social Functioning Assessment Scale; SubRAS: Subjective Recovery Assessment Scale.

Results

When the introductory characteristics of the patients were examined, the mean age of the patients attending CMHC was 42.05±11.01, the mean income per capita was 689.47±423.47, 52.6% were female, 63.2% were single, 42.1% had an educational status of high school and equivalent, 89.5% were unemployed, 78.9% lived with their families, 31.6% had a diagnosis of atypical psychosis, the mean age of onset was 21.4±6.3, 42.1% had one hospitalization, 63.2% of the patients had a mental illness in their first and second-degree relatives, 15.8% were exposed to physical violence, and 26.3% had suicide attempts. When the introductory characteristics of the patients who did not receive services from CMHC were examined, the mean age was 41.08±11.92, the mean amount of income per capita was 1123.68±816.38, 52.6% were female, 57.9% were single, 21.1% were high school graduates, 78.9% of the patients were unemployed, 73.7% lived with their families, 42.1% had a diagnosis of schizoaffective disorder, the mean age of the patients' disease onset was 24.5±6.8, 21.1% had more than 10 hospitalizations, 57.9% of the patients had a mental illness in their first and second-degree relatives, 26.3% of them were subjected to physical violence, and 42.1% had suicide attempts (Table 1). While the mean score of WHO-DAS-II of patients receiving ser-

vices from CMHC was 25.63±7.82, the mean score of SFAS was 42.11±4.69, and the mean score of SubRAS was 62.26±15.52, the mean score of WHO-DAS-II of patients not receiving services from CMHC was 27.89±10.39, the mean SFAS score was 41.79±8.07, and the mean score of SubRAS was 61.42±15.39. There was no significant difference between the mean scale scores of the patients who received CMHC service and those who did not receive it, whereas the patients who received CMHC service had a lesser disability, their functionality and subjective perception of recovery were better (Table 2).

When the correlation between the mean scores of WHO-DAS II, SFAS and SubRAS was examined, a statistically significant positive correlation was found between SFAS and SubRAS (r=0.377; p=0.020), whereas there was a significant negative correlation between the mean scores of WHO-DAS II and SubRAS (r=-0.482; p=0.002) and there was a statistically significant negative correlation (r=-0.327; p=0.045) between the WHO-DAS II and the mean score of the SFAS. Accordingly, as the subjective perception of recovery increased, social functionality increased, and as disability increased, their subjective perception of recovery and social functionality decreased. When the correlation between the mean scores of WHO-DAS II, SFAS, and SubRAS and some individual characteristics were examined, a statistically significant positive correlation was

determined between the onset age of the disease and the mean score of SFAS (r=0.351; p=0.031). Based on this finding, as the onset age of the disease increased, its social functionality also increased. A statistically significant positive correlation was found between the patients' income amount and the mean SFAS score (r=0.349; p=0.032). Accordingly, the findings showed that as the income amount of the patients increased, their social functionality also increased (Table 3).

Discussion

Based on the results of this study, which examined the disability, social functionality levels, and subjective recovery perceptions of the patients who received and did not receive service from the community mental health center, the findings showed that there was no significant difference between the levels of disability, and social functionality and subjective recovery perceptions of the patients who received and did not receive service from the community mental health center. This finding suggests that both patients cannot have the same characteristics concerning their individual characteristics and that the services provided by CMHCs cannot have the same content and quality in every center. The primary goal of the services provided to patients in CMHCs is to improve the cognitive, social, and physical skills of patients to increase their functionality, to continue their lives independently in society, and to ensure recovery. When previous studies on this subject were examined, the findings suggested that the rehabilitation training had a positive impact on patients.[6,8,28] It should be noted that in this study, the social functionality, subjective perception of recovery, and disability levels of patients who have received regular services from CMHC are higher than those who did not receive regular services from CMHC, although the difference is insignificant. It should be noted that patients who did not receive regular services from CMHC were frequently followed up by the same physician by the psychiatry outpatient clinic of the state hospital to which CMHC is affiliated. Having a regular follow-up in outpatient clinics increases the compliance of the patients to the treatment and concordantly and the social functionality.[29]

Social functionality also increases with individuals' rebuilding their lives, re-finding their self and being hopeful for the future, that is, perceiving themselves as cognitively, emotionally, socially, physically, and mentally recovered.[30] In parallel with this situation, in this study, the findings showed that the social functionality of the participants increased as their subjective perception of recovery increased. Oorschot et al.[31] (2012) determined in their study on schizophrenia patients that functionality increased as the subjective perception of recovery increased. The results of this study are consistent with the results of similar studies in the literature.[32–34]

As the disability of the individuals participating in this study decreased, their subjective perception of recovery became higher. Similarly, Temesgen et al.[35] (2019) found that as the subjective perception of recovery of individuals with severe mental illness increased, their disability level decreased. Likewise, Candan[36] (2019) revealed that as the disability of individuals with severe mental illness decreased, their subjective recovery increased. The higher subjective recovery perception of the individual with mental illness allows the individual to realize his/her illness and perform activities, which enable the individual to continue his life independently, and at the same time, a decrease in the disability level of the individual.

When the correlation between the social functionality of the participants and their disability was examined, their disability decreased as their social functionality increased. It was found in the study of Ensari et al.[6] (2013), which assessed the functionality and disability levels of patients who regularly attended CMHC, that disability scale scores decreased and functionality scale scores increased. The primary goal of the training, which is organized at CMHC, is to increase the functionality level of the patients and to reduce their disability. It is aimed to regain or prevent the deterioration of the skills necessary for the patients to carry out their daily life activities independently, self-care, interpersonal relationships, and job success.

As the onset age of the disease and the income amount of the participants increased, the level of social functionality also increased. When we examined the previous studies in the literature, in a study performed on patients with a diagnosis of bipolar disorder, the findings showed that those with a later age of onset had better functionality.[37] When we examined other similar studies, as the onset age of the disease increased, the functionality level of the patients increased.[38–40] The prognosis and functionality level of the disease was better in patients with late-onset of severe mental illness.[41] It was found that as the income amount of the participants increased, their social functionality level also increased. Sirin[42] (2008) found in her study that the functionality level of those with lower income levels was lower. The higher level of income suggests that it is easier to access services related to the rehabilitation of psychiatric diseases. The prevalence of psychiatric disorders is higher among people with lower income levels, and it is a perpetual cause concerning the continuity of the disease.[43]

Conclusion

When the results of the study are considered in general, it is noticed that subjective recovery, disability, and functionality are interrelated for those with severe mental illness. There was no difference between the patients who received regular service from CMHC and those who did not, concerning levels of disability and social functionality as well as subjective perceptions of recovery. However, the subjective recovery, disability, and functionality levels of patients who received regular services from CMHC were higher than patients who did not receive regular services from CMHC. It is crucial to perform long-term follow-up studies to assess the impact of these results on the course of the disease. When we consider all patients, it is clearly seen that disability decreases as the subjective improvement and functionality of the patients increase. This

situation shows the positive effects of improvement studies, which increase the subjective perception and functionality of the patients in the psychiatric rehabilitation process, and suggests that improvement efforts should be prioritized. It is suggested that more comprehensive studies should be performed to assess the effectiveness and content of the training, which are provided to patients by psychiatric nurses in community mental health centers, and the factors impacting the quality of the provided services should be reviewed.

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

Peer-review: Externally peer-reviewed.

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

References

1. Çiçekoğlu P, Duran S. Dünyada ve Türkiye'de toplum temelli koruyucu ruh sağlığı hizmetleri. Ünsal Barlas G, editor. Toplum Ruh Sağlığı Hemşireliği. 1st ed. Ankara: Türkiye Klinikleri; 2018. p. 8–14.

2. Erkoç Y, Çom S, Torunoğlu MA, Alataş G, Kahiloğulları AK. T.C. Sağlık Bakanlığı Ulusal Ruh Sağlığı Eylem Planı (2011-2023). Ankara, T.C. Sağlık Bakanlığı Yayınları. Yayın No: 847:33–4. Available at: https://dosyamerkez.saglik.gov.tr/Eklenti/30333,ulusal-ruh-sagligi-eylem-planipdf.pdf?0. Retrieved May, 2019.

3. Eren HK. Ruh Sağlığına Yönelik Dünya'daki ve Türkiye'deki Mevcut Uygulamalar. Gürhan N, editör. Ruh sağlığı ve psikiyatri hemşireliği. Ankara: Nobel Tıp Kitabevleri; 2016. p. 844–70.

4. Üstün G, Küçük L, Buzlu S. Bir Toplum Ruh Sağlığı Merkezi'nde uygulanan rehabilitasyon programlarına katılan ve katılmayan şizofreni hastalarının bazı sosyodemografik ve hastalıkla ilişkili özellikleri ile tedaviye uyumları ve öz-yeterlilikleri açısından tanımlanması. J Psychiatric Nurs 2018;9:69–79,

5. Yıldız M. Ciddi ruhsal hastalıklarda ruhsal toplumsal tedaviler. Türkiye Klinikleri Journal of Psychiatry-Special Topics 2009;2:52–6.

6. Ensari H, Gültekin BK, Karaman D, Koç A, Beşkardeş AF.. Bolu Toplum Ruh Sağlığı Merkezi hizmetlerinin şizofreni hastalarındaki yaşam kalitesi, yeti yitimi, genel ve sosyal işlevsellik üzerine etkisi: Bir yıllık izleme sonuçları. Anadolu Psikiyatri Derg 2013;14:108–14.

7. Söğütlü L, Özen Ş, Varlık C, Güler A. Toplum ruh sağlığı merkezinde şizofreni hastalarına ruhsal toplumsal beceri eğitimi uygulanması ve sonuçları. Anadolu Psikiyatri Derg 2017;18:121–8.

8. Şahin Ş, Elboğa G. Toplum ruh sağlığı merkezinden yararlanan hastaların yaşam kalitesi, tıbbi tedavi uyumu, içgörü ve işlevsellikleri. Cukurova Medical Journal 2019;44:431–8.

9. Rossi A, Amore M, Galderisi S, Rocca P, Bertolino A, Aguglia E, et al; Italian Network for Research on Psychoses. The complex relationship between self-reported 'personal recovery' and clinical recovery in schizophrenia. Schizophr Res 2018;192:108–12.

10. Çam O, Yalçıner N. Ruhsal Hastalık ve İyileşme. J Psychiatric Nurs 2018;9:55–60.

11. İpçi K, İncedere A, Kiras F, Yıldız M. Şizofreni hastalarında öznel iyileşme ile bilişsel içgörü arasındaki ilişkinin araştırılması. Kocaeli Üniversitesi Sağlık Bilimleri Dergisi 2018;4:1–4.

12. Drake RE, Whitley R. Recovery and severe mental illness: description and analysis. Can J Psychiatry 2014;59:236-42.

13. Eneman M, Vanhee L, Liessens D, Luyten P, Sabbe B, Corveleyn J. Humanistic psychiatry and psychotherapy: listening to patients as persons in search of meaning. the case of schizophrenia. Journal of Humanistic Psychology 2019;59:148–69.

14. Chiba R, Miyamoto Y, Kawakami N, Harada N. Effectiveness of a program to facilitate recovery for people with long-term mental illness in Japan. Nurs Health Sci 2014;16:277–83.

15. Knutson MB, Newberry S, Schaper A. Recovery education: a tool for psychiatric nurses. J Psychiatr Ment Health Nurs 2013;20:874–81.

16. Delice MA, Akgül SM, Yıldız M. Toplum Ruh Sağlığı Merkezi'nden hizmet alan bir Şizofrenili olguda bütüncül yaklaşımın hastalığın gidişine etkisi. Marmara Üniversitesi Sağlık Bilimleri Enstitüsü Dergisi 2014;4:122–5.

17. İçel S, Özkan B, Aydoğan A. Toplum ruh sağlığı merkezlerinde hemşirenin rolü. Ankara Medical Journal 2016;16:208–14.

18. Saruç S, Kılıç AK. Toplum ruh sağlığı merkezinden hizmet alan hastaların sosyal profili ve merkezde verilen hizmetler. Toplum ve Sosyal Hizmet 2015;26:53–71.

19. Duman ZÇ, Bademli K. Kronik psikiyatri hastalarının aileleri: sistematik bir inceleme. Psikiyatride Güncel Yaklaşımlar 2013;5:78–94.

20. Dikeç G, Kutlu Y. Ruhsal bozukluklarda tedavi uyumunu artırmak için bir yöntem: tedaviye uyum programı. J Psychiatric Nurs 2015;6:40–6.

21. WHO. WHO Disability Assessment Schedule-II (WHO-DAS-II). Available at: https://www.who.int/classifications/icf/whodasii/en/.

22. Uluğ B, Ertuğrul A, Göğüş A, Kabakçı, E. Yetiyitimi Değerlendirme Çizelgesinin (WHO-DAS-II) şizofreni hastalarında geçerlilik ve güvenilirliği. Turk Psikiyatr Derg 2001;12:121–30.

23. Yıldız M, Kiras F, İncedere A, Esen D, Gürcan MB, Abut B, et al. Şizofreni hastaları için toplumsal işlevselliği değerlendirme ölçeğinin geliştirilmesi: geçerlilik ve güvenirlik çalışması. Anadolu Psikiyatri Dergisi 2019;20:29–38.

24. Yıldız M, Erim R, Soygür H, Tural U, Kiras F, Gules E. Development of the subjective recovery scale for the patients with schizophrenia. Psychiatry and Clinical Psychopharmacology 2018;28:163–9.

25. Özdamar K. SPSS ile Biyoistatistik. 9th ed. Nisan Kitabevi: Ankara; 2013.

26. Tabachnick BG, Fidell LS. Using multivariate statistics. 6th ed. Boston: Pearson; 2013.

27. Kayri M. Araştırmalarda gruplar arası farkın belirlenmesine yönelik çoklu karşılaştırma (post-hoc) teknikler. Fırat Üniversi-

tesi Sosyal Bilimler Dergisi 2009;19:51–64.

28. Özdemir İ, Şafak Y, Örsel S, Karaoğlan Kahiloğulları A, Karadağ H. Bir toplum ruh sağlığı merkezinde şizofreni hastalarına uygulanan ruhsal-toplumsal uyumlandırma etkinliğinin araştırılması: kontrollü çalışma. Anadolu Psikiyatri Derg 2017;18:419–27.

29. Demirkol ME, Tamam L, Evlice YE, Karaytuğ MO. Psikiyatri hastalarının tedaviye uyumu. Cukurova Medical Journal 2015;40:555–68.

30. Morrison AP, Shryane N, Beck R, Heffernan S, Law H, McCusker M, et al. Psychosocial and neuropsychiatric predictors of subjective recovery from psychosis. Psychiatry Res 2013;208:203–9.

31. Oorschot M, Lataster T, Thewissen V, Lardinois M, van Os J, Delespaul PA, et al. Symptomatic remission in psychosis and real-life functioning. Br J Psychiatry 2012;201:215–20.

32. Jaracz K, Górna K, Kiejda J, Grabowska-Fudala B, Jaracz J, Suwalska A, et al. Psychosocial functioning in relation to symptomatic remission: A longitudinal study of first episode schizophrenia. Eur Psychiatry 2015;30:907–13.

33. Wright A, Fowler D, Greenwood K. Influences on functional outcome and subjective recovery in individuals with and without First Episode Psychosis: A metacognitive model. Psychiatry Res 2020;284:112643.

34. İpçi K, Yildiz M, İncedere A, Kiras F, Esen D, Gürcan MB. Subjective Recovery in Patients with Schizophrenia and Related Factors. Community Ment Health J 2020;56:1180–7.

35. Temesgen WA, Chien WT, Bressington D. Factors influencing subjective recovery of people with recent-onset psychosis: A cross-sectional study in a low-income Sub-Saharan country. Psychiatry Res 2019;274:421–9.

36. Candan İE. Kronik şizofreni hastalarında bilişsel içgörü, yeti yitimi ve öznel iyileşmenin değerlendirilmesi. [Yayınlanmamış Yüksek Lisans Tezi] İstanbul: Marmara Üniversitesi Sağlık Bilimleri Enstitüsü; 2019.

37. Tütüncü R, Örsel S, Özbay MH. Bipolar bozukluk başlangıç yaşının klinik ve gidiş özellikleriyle ilişkisi. Klinik Psikiyatri Dergisi 2007;10:63–8.

38. van Liempt S, Dols A, Schouws S, Stek ML, Meesters PD. Comparison of social functioning in community-living older individuals with schizophrenia and bipolar disorder: a catchment area-based study. Int J Geriatr Psychiatry 2017;32:532–8.

39. Rosa AR, Reinares M, Franco C, Comes M, Torrent C, Sánchez-Moreno J, et al. Clinical predictors of functional outcome of bipolar patients in remission. Bipolar Disord 2009;11:401–9.

40. Wingo AP, Baldessarini RJ, Compton MT, Harvey PD. Correlates of recovery of social functioning in types I and II bipolar disorder patients. Psychiatry Res 2010;177:131–4.

41. Turan N. Şizofreni ve diğer psikotik bozukluklar. In: Gürhan N, editor. Ruh sağlığı ve psikiyatri hemşireliği. Ankara: Nobel Tıp Kitabevleri; 2016. p. 540–60.

42. Şirin B. Bir sağlık ocağına başvuran ruh sağlığı bozulmuş hastaların yaşam kalitesi ve sosyal işlevsellik durumunun değerlendirilmesi. [Yayınlanmamış Yüksek Lisans Tezi] İstanbul: Haliç Üniversitesi Sağlık Bilimleri Enstitüsü; 2008.

43. Kaya B. Depresyon: Sosyo-ekonomik ve kültürel pencereden bakış. Klinik Psikiyatri 2007;10(Suppl 6):11–20.