



Original Article

Early period self-care ability and care requirements of schizophrenia patients after discharge

Sultan Taş, Kadriye Buldukoğlu

Department of Psychiatric Nursing, Akdeniz University Faculty of Nursing, Antalya, Turkey

Abstract

Objectives: This descriptive study was conducted to determine early-period self-care ability and care requirements of schizophrenia patients after discharge.

Methods: The study population comprised 31 schizophrenia patients who received inpatient treatment between April 2013 and April 2014 in Akdeniz University Hospital Psychiatry Clinic then discharged. Data collection took place during the first two weeks after their discharge using the Self-care Ability Scale and Care Requirements Determination Form.

Results: Self-care ability general point average of all individuals studied was 99.32 ± 21.86 ; that of individuals, who were single, did not have children, had a single child among those who had children, or had a family member with mental disease was significantly lower. Study patients had significant requirements in terms of self-concept, coping, need for knowledge, sleep, roles and relationships, treatment and care, safe environment, self-care and spiritual dimensions.

Conclusion: This study provided meaningful data on early-period self-care ability and care requirements of schizophrenia patients after discharge. Nurses working in the psychiatric clinic will benefit from these data when planning discharge.

Keywords: Discharge; schizophrenia; psychiatry nursing; requirements; self-care.

The length of hospital stays for persons with chronic mental illness has been shortened, leading to some undesirable situations for many patients, including maintenance of stubborn symptoms, recurrence of the disorder, and re-hospitalization.^[1,2] Repeated hospitalization among schizophrenic patients are the highest among those with chronic mental disorders.^[3] The most prominent symptom of repeatedly hospitalized schizophrenic patients is "being unable to meet basic needs".^[4] Schizophrenic patients practice fewer self-care and health-promoting activities than people with physical health problems.^[5,6] The discharge criteria for schizophrenic patients include the ability to engage in self-care, to maintain a safe environment, and to learn and apply ways to cope with stress.^[7] In the light of this information, the following question is very important: How much schizophrenia patients are capable to maintain their self-care after discharge? Psychiatric nurses should attempt to answer that question

as the major health professional among the mental health team.

Today's mental health understanding focuses on an individual's well-being to assist maintenance of a meaningful life. To provide effective transitional care after hospital discharge requires a deep understanding, based primarily on nursing theories and models as well as nursing ethical codes and global human rights.^[8] The author Orem states that all individuals have the potential ability and motivation necessary to provide care for themselves and dependents. When self-care is effectively performed, it helps to maintain structural integrity and human functioning, and it contributes to human development. Nursing care assumes the following roles to achieve this: guidance, physical and mental support, and providing an environment to support development and teaching.^[9] Patients' ability to perform activities of daily living independently is one of the

Address for correspondence: Dr. Sultan Taş, Akdeniz Üniversitesi Hemşirelik Fakültesi, Kampüs, Antalya, Turkey

Phone: +90 242 226 13 58 **E-mail:** sultantas9@gmail.com **ORCID:** 0000-0003-0726-938X

Submitted Date: December 28, 2016 **Accepted Date:** November 27, 2017 **Available Online Date:** January 19, 2018

©Copyright 2018 by Journal of Psychiatric Nursing - Available online at www.phdergi.org



care-provision standards of psychiatric nursing.^[7] Discharge planning of psychiatric nursing with the cooperation of the mental health team and its inclusion in post-discharge care will contribute to the integration and maintenance of care.^[10] The determination of self-care ability and care requirements of the patients in their early-discharge period aids healthcare professionals in developing an effective discharge plan and providing care in the social environment.

The databases of Turkish Medicine Index, Turkish Psychiatry Index, YOK thesis website, and Google Scholar were searched by the keyword of "self-care", and obtained results were examined. Studies conducted in Turkey related to individuals' self-care ability were mostly based on physical illness: only two studies evaluated the self-care abilities of mentally ill persons.^[5,11] Because person with mental disorders have difficulties defining their self-care requirements for themselves, their self-care levels should be improved by periodically organizing diagnostic and educational programs.^[11] The present descriptive study was conducted to determine the early-period self-care ability and care requirements of schizophrenia patients after discharge.

Materials and Method

Research Sample

The research was conducted in Akdeniz University Hospital Psychiatry Clinic between April-2013 and April 2014. No sampling selection was performed in the research: 31 of 80 schizophrenia patients hospitalized within one year following the research permission and met research criteria were included. The inclusion criteria were: patients within the first two weeks after discharge, between 18 and 65 years old, knowing at least how to read and write, being resident in the Antalya Merkez district. The exclusion criteria were having mental deficiency, dementia, or a psychological disorder resulting from a general health condition, or having communication problems.

Data Collection

Research data were collected by the researcher through face-to-face home visits two weeks after discharge from the hospital. The first two weeks after discharge is defined as "early discharge",^[12] and the second week after discharge is the level of adaptation to the home environment.^[13] The researcher first interviewed patients 24 to 48 hours before discharge from the hospital, and determined thereby the date with the patients who volunteered for a meeting during the second week after discharge. Home visits were arranged by these pre-determined dates. Participants read and signed the informed consent forms at the beginning of each visit. Data collection was completed within 30 to 40 minutes.

Self-Care Ability Scale

This scale measures individuals' ability to carry out the activ-

ities required to sustain their health. The 43-item scale was originally developed by Kearney and Fleischer and titled The Exercise of Self-Care Agency Scale (ESCA). The validity and reliability of the scale was adapted by Nahcivan for Turkish adolescents and reduced to 35 items.^[14] The levels of self-care ability are defined as: 24–64, poor; 65–100, moderate; 101–112, good; and 113–140, very good.^[15] Cronbach's alpha value for the self-care ability scale was found 0.913 for this study, which indicated its reliability for this research.

Care Requirements Determination Form

This form was prepared by the researcher to determine care requirements of schizophrenic patients after discharge.^[16–18] The first section consists of 18 questions, including introductory patient information and disease characteristics. The second section consists of 37 open-ended questions to determine care requirements. Nine basic areas such that self-concept, coping, need for knowledge, sleep, roles and relationships, treatment and care, safe environment, self-care, and spiritual dimensions were determined to define requirements; these areas were assessed through sub-questions (Table 1).

Data Evaluation

In the data evaluation process, all the answers given to open-ended questions in the care requirements determination form were sequentially added to the form by computer. Individual statements were evaluated one-by-one; similar statements were combined and grouped based on the opinions of Three academic members from the Psychiatry Nursing, Public Health Nursing and the Faculty of Medicine Department. Percentages and frequencies drawn from this data were then calculated and assessed using SPSS 18. Numbers, percentages, arithmetic means, and standard deviation values were used to define the data. Cronbach alpha's value was used to determine the validity of the scale. The Kolmogorov–Smirnov test was applied to test normality of distribution of continuous variables, which were found to be normally distributed. The independent samples t-test was used to compare the means from two different groups of data, One-way variance analysis (ANOVA) was used to compare means of two or more samples, and Duncan's multiple-range test was used to establish significance between each group. Significance was established at the $p < 0.05$ level.

Ethical Dimension of the Study

A written permission on 07.08.2012 with the decision number B.30.2.AKD.20.05.05 was received from the Akdeniz University Research Ethics Committee for Non-Invasive Clinical Studies. Permission was received from Prof. Dr. Nursen Nahcivan to use the self-care ability scale. Research permission to conduct the study was received from Akdeniz University Hospital Psychiatry Clinic. All patients who met the research inclusion criteria were informed about the study, and their written informed

Table 1. Basic and sub-dimensions of care requirements

Self-Concept	Treatment and Care	Role and Relations
Defining self	Use of medication	The disease influence on family roles
Self-likes	Problems met while using the medication	The disease influence on husband-wife relationship
Self-dislikes	The way to solve these problems	The disease influence on the relationship with children
Desires to change	Non-medical treatments	The disease influence on relationship with relatives
	Family support for treatment	The disease influence on relationship with friends
	Support sources out of family	The disease influence on sex life
Coping	Self-care	Safe Environment
Coping methods	Practicing daily self-care	Feeling safe
The way of help required to manage	Problems met during the daily self-care	Practices to feel safe
People who assist to manage	The way to handle these problems	
Need for Knowledge	Sleep	Spirituality
Disease definition	Change in sleeping pattern	Health definition
Information regarding the disease	Reasons for this change	Significant people in the life
Information about the post-discharge period	The way to sleep regulation	Leisure time evaluation (Recreation)
People to be consulted to receive information		The disease's influence on spiritual beliefs
		The social view of the disease
		Future plans

consent was obtained after explaining that the research participation was voluntary.

Results

Characteristics of Individuals

The research sample included 31 schizophrenia patients with a mean age of 35.58 ± 11.57 years. The largest group of individuals were in the 25 to 34 age group; most were female and single. The number of individuals who had a profession was low. Disease characteristics indicated that the mean age of the disorder outset was 23.81 ± 8.38 years (Table 2).

Self-Care Abilities of Individuals

The self-care ability general point average of all individuals in the study was 99.32 ± 21.86 ; participants received 46 at minimum and 136 at maximum (scores range from 0–140). The self-care ability point average of individuals who were single, did not have children, possessed a single child among the ones who had children, or had a member of family with mental disease was significantly lower. Self-care ability mean was significantly lower for single individuals than for married and divorced individuals, individuals who had no child than for those who had children, and those with one child than individuals with at least two children ($p < 0.05$) (Table 2).

The mean self-care ability value was based on disease characteristics, and was that was significantly lower for the individuals who had a mentally disordered family member than for those without ($p < 0.05$). No significant difference was found in terms of the variables age, gender, education, profession, employment status, diagnosis period, having any other chronic

diseases, the number of hospitalization, and currently used medications ($p > 0.05$) (Table 2).

Care Requirements After Discharge

Findings obtained from the open-ended questionnaire form that was designed to determine the requirements given as percentages (Table 3a-c). In addition, direct quotations of the participants were used to strengthen the expression.

Self-Concept

The term self-concept is a general term that refers to how a person thinks about, evaluates or perceives themselves, and what they seek to change. The study participants defined themselves by their spiritual, social, communicative, mental, and physical characteristics, in that order. Their favorite dimension was mental characteristics, followed by their spiritual characteristics. They disliked their personal characteristics most, at a ratio of 44.8%. In addition, "communication skills" and "obsessive thoughts" were among the self-concept dimensions that they disliked. Most study participants had at least one dimension that they wanted to change for themselves, for instance "to have an active social life, promote health, and have a good profession" (Table 3a).

Coping

The coping dimension was used to find how people manage their problems, who supports them to manage their stress and how those persons help. We determined that 74.2% of the individuals pursued functional approaches such as "thinking, talking, receiving help), whereas 32.3% followed non-func-

Table 2. Distribution of self-care ability scores of individual socio-economic and disease characteristics

	n	%	Self-care ability (Mean±SD)	Assessment
Descriptive characteristics				
Age (years)				
Younger than 25	7	22.6	81.71±24.17	
25-34	10	32.3	99.80±14.28	F=2.824
35-44	7	22.6	112.00±16.31	p=0.058
45 and older	7	22.6	103.57±25.74	
Gender				
Female	18	58.1	101.05±24.38	t=0.513
Male	13	41.9	96.92±18.48	p=0.612
Educational status				
Primary/secondary school	13	41.9	97.07±22.10	F=0.855
High school	13	41.9	104.84±21.78	p=0.436
University and above	5	16.1	90.80±22.09	
Marital status				
Married	8	25.8	111.87±14.58	F=4.499
Single	16	51.6	89.12±23.93	p=0.020
Divorced	7	22.6	108.28 ±11.33	
Professional status				
Housewife	9	29.0	103.00±15.40	
Retired	4	12.9	112.50±12.81	F=1.349
Unemployed	12	38.7	89.08±27.84	p=0.279
Self-employment	3	9.7	100.33±18.55	
Civil servant	3	9.7	110.66±11.50	
Employment status				
Employed	5	16.1	110.40±9.91	t=1.249
Unemployed	26	83.9	97.19±22.98	p=0.222
Have any children?				
Yes	12	38.7	109.41±13.68	t=-2.165
No	19	61.3	92.94±23.89	p=0.039
Number of children				
1	7	58.3	102.43±8.69	t=-2.572
2 children and more	5	41.6	119.20±14.02	p=0.028
Disease characteristics				
Diagnosis time				
Up to 5 years	9	29.0	98.77±25.73	F=0.234
6-14 years	12	38.7	96.58±18.42	p=0.793
>15 years	10	32.3	103.10±23.72	
Have any other disease				
No	22	71.0	95.05±22.76	t=-1.762
Yes	9	29.0	109.78±16.11	p=0.089
Number of hospitalization				
One	8	25.8	97.25±26.54	t= -0.307
Two or more	23	74.2	100.04±20.63	p=0.761
Any mental disease in the family				
No	19	61.3	105.84±15.81	t=2.222
Yes	12	38.7	89.00±26.54	p=0.034
Currently used medication				
Antipsychotic monotherapy	14	45.2	101.85±26.15	F=2.699
Antipsychotic polypharmacy	12	38.7	104.50±12.13	p=0.085
I can't say the medication	5	16.1	79.80±19.43	
Total	31	100	99.32±21.86	

SD: Standard deviation; t: t-test; F: One-way Anova.

Table 3a. Care requirements of the participants after discharge

	n	%		n	%
Self concept			The way of help required to manage (n=31)		
Self-definition* (n=31)			Emotional support	14	45.2
Based on spiritual features	13	41.9	Instrumental support	9	29.0
Based on social role and features	11	35.5	Undefined help	8	25.8
Based on communication features	9	29.0	People who assist managing* (n=29)		
Based on mental features	4	12.9	Spouse and family	21	72.4
Based on physical features	3	9.7	Relatives and friends	6	20.7
Self-likes* (n=30)			Healthcare professionals	5	17.2
Mental features	10	33.3	Other	4	13.8
Spiritual features	9	30.0	Need for knowledge		
Personal features	5	16.7	Disease definition* (n=31)		
Other	4	13.3	As a bad luck, desperateness	18	58.1
Physical features	3	10.0	Associated with psychotic symptoms	14	45.2
Self-dislikes* (n=29)			As a temporary disease	4	12.9
Personal features	13	44.8	Information regarding the disease* (n=31)		
Nothing	7	24.1	Its treatment and how to cope with it	14	45.2
Communication features	4	13.8	Characteristics of the disease	12	38.7
Obsessive thoughts	4	13.8	There is nothing to learn	9	29.0
Physical features	2	6.9	Information about the post-discharge period* (n=31)		
Desires to change* (n=31)			There is nothing to learn	15	48.4
There is nothing to change	10	32.3	Cope with the disease and its symptoms	10	32.3
Have an active social life	8	25.8	Use of medication	10	32.3
Promote health	8	25.8	People to be consulted to receive information* (n=18)		
Have a good profession	6	19.4	Healthcare professionals	14	77.8
Coping			Family members	3	16.7
Coping method* (n=31)			Other	2	11.1
Functional approach	23	74.2			
Non-functional approach	10	32.3			

*Individuals' answers could be more than one. Therefore, the percentages were calculated over the number of respondents.

tional approaches such as "telling lies, consuming alcohol, leaving things to time". We found that 45.2% of the individuals required emotional support to manage their problems, that 72.4% of them received help from their spouses and families, whereas 17.2% received help from healthcare professionals (Table 3a).

Need for Knowledge

This dimension is intended to determine how the study participants defined their disease, what they wanted to learn about it, what they needed to know after discharge from hospital, and from whom they preferred to receive this information. Among the study participants, 58.1% defined the disease as "bad luck, helplessness", 45.2% associated the disease with psychotic symptoms, and 12.9% defined it as a "temporary illness". 45.2% of the participants stated that they wanted to know about treatment and how to manage the disease, and 38.7% of them asked to learn the characteristics of the disease. They also stated that they needed some information for the

post-discharge period regarding the use of medication and managing the ongoing disease symptoms (Table 3a).

Treatment and Care

In this dimension, the use of medication, problems met while using the medication, and their solution methods, non-medical treatments, and support from family and outside of the family were determined. Among the participants, 87.1% stated that they used medication, 45.2% had problems with "side effects", 25.8% had trouble resulting from "wrong use of medication"; it was determined that of the individuals who had problems, only 31.8% stated that they tried to refer to a physician to solve these issues. 54.8% of them stated that they did not use non-medical treatment; 61.3% stated that they received moral and material support from their families (Table 3b).

Self-care

This dimension included findings regarding the daily self-care

Table 3b. Care requirements of the participants after discharge

	n	%		n	%
Treatment and care			Self-care		
Use of medication (n=31)			Able to Practice Daily Self-care (n=31)		
Yes, I use	27	87.1	Doing without any problem	14	45.2
No, I do not use	4	12.9	Doing despite problems	12	38.7
Problems met while using the medication (n=31)			Not able to do	5	16.1
Side effects of medication	14	45.2	Problems met during the daily self-care (n=31)		
Do not have any problems	9	29.0	There is no problem	14	45.2
Wrong use of medication	8	25.8	Fatigue and unwillingness	13	41.9
The way to solve these problems (n=22)			Stubborn symptoms	4	12.9
By their own methods	8	36.4	The way to handle these problems (n=31)		
By consulting their physician	7	31.8	There is no problem	14	45.2
Do nothing	7	31.8	Exert oneself, no able to be effective	12	38.7
Non-medical treatment methods (n=31)			Get assistance	5	16.1
There is no other method	17	54.8	Sleep		
Self-relaxation	11	35.5	Changes in sleeping pattern (n=31)		
Advices of relatives	3	9.7	No change in sleeping pattern	12	38.7
Family support for treatment (n=30)			It has been regulated	7	22.6
Material aid and spiritual support	18	61.3	Hard and uncomfortable sleep	8	25.8
Help to maintain treatment	7	22.6	Sleep much	4	12.9
Do not receive any support	5	16.1	Reasons of this change (n=17)		
Support sources out of family* (n=31)			Positive influence of hospital order	6	35.3
No other support	16	51.6	Stress and negative influence of disease	7	41.2
Friends	9	29.0	Drugs and medicines	4	23.5
Relatives	5	16.1	The way of sleep regulation* (n=21)		
Healthcare professionals	3	9.7	Doing nothing	10	47.6
			Non-pharmacological methods	8	38.1
			Medicines subscribed by the doctor	4	19.0

*Individuals' answers could be more than one. Therefore, the percentages were calculated over the number of respondents.

abilities of individuals, the problems they met during their daily care, and the way they solved these problems. Among the participants, 38.7% had problems doing their daily care: 41.9% stated that these problems resulted from some reasons such as "fatigue and unwillingness". Most of the individuals who had problems maintaining daily self-care activities stated that they were unable to solve these problems (Table 3b).

Sleep

The sleep dimension covered findings about changes in sleeping habits after discharge from hospital, reasons for this change, and the way to regulate the sleep. Among them, 25.8% of the individuals who stated that there was a change in their sleeping habits indicated that hardly slept, and then only uncomfortably, but 47.6% of the study subjects did not do anything to regulate their sleeping patterns (Table 3b).

Role and Relations

In this dimension, findings about the participants' in-fam-

ily roles, relations with their spouses, children, relatives, and friends, and the status of their sex life after being hospitalized were evaluated. Among them, 61.3% expressed that in-family roles were negatively affected for the following reasons: "they were forced into the treatment, their family had intense fear and sadness, and they fell into disfavor". Of the married patients, 58.3% stated that their relationship with their spouses and 41.7% of the patients who had children, stated that their relationship with their children was negatively affected. Also, 58.1% stated that "their relatives knew about their disease and they had a good relationship with them, whereas 29% stated that "their relatives stayed away from them because of the disease". 35.5% of the participants stated that "their friendships did not deteriorate", whereas 22.6% stated that "they did not have any friends". Almost half of the participants thought that the disease negatively affected their sex life (Table 3c).

Safe Environment

In this dimension, findings about on feeling safe in the living environment and actions to provide this condition were eval-

Table 3c. Care requirements of the participants after discharge

	n	%		n	%
Roles and relationships			Safe environment		
The disease influence on family roles* (n=31)			Feeling safe (n=31)		
No influence	10	32.3	Feel safe	19	61.3
Positive influence	4	12.9	Do not feel safe	12	38.7
Negative influence	19	61.3	Practices to feel safe (n=31)		
The disease influence on husband-wife relationship (n=12)			Doing nothing	20	64.5
No influence	5	41.7	Using mental relaxation	11	35.5
Had influence	7	58.3	Spiritual dimension		
The disease influence on the relationship with children (n=12)			Health definition* (n=30)		
No influence	7	58.3	Mental peace	20	66.7
Had influence	5	41.7	Physical health	10	33.3
The disease influence on relationship with relatives (n=31)			Self-reliance	7	23.3
They know the disease, they have good relationships	18	58.1	Significant people in the life* (n=31)		
They become distanced because of the disease	9	29.0	Family	31	100.0
They live away, they do not know the disease	4	12.9	Relatives	5	16.1
The disease influence on relationship with friends (n=31)			Friends	3	9.7
No influence	11	35.5	Leisure time evaluation (Recreation)* (n=31)		
Had influence, they become distanced	10	32.3	Domestic activities	24	77.4
Do not have any friend	7	22.6	Outdoor activities	11	35.5
Made new friends	3	9.7	Doing nothing, sleep	6	19.4
The disease influence on sexual life (n=24)			The disease influence on spiritual beliefs* (n=31)		
No influence	10	41.7	No negative influence	19	61.3
Had influence	12	50.0	Weakened religious belief and prayer	11	35.5
Other	2	8.3	Decrease in their love of humanity	6	19.4
			Social view on mental disease (n=28)		
			Social exclusion, pity	19	67.9
			Try to understand and help	9	32.1
			Future plans* (n=31)		
			Have a hobby, profession	19	61.3
			Establish a family and extend it	13	41.9
			There is no future plan	6	19.4
			Other (getting healthier, etc.)	4	12.9

*Individuals' answers could be more than one. Therefore, the percentages were calculated over the number of respondents.

uated. Among the participants, 61.3% felt safe within their living environment, whereas 38.7% of them stated that they did not; their reasons included "suspecting, fear of being murdered, afraid to be alone, fear of re-hospitalization". Of the participants, 64.5% did not take any action to feel safe, whereas others stated that they applied "mental relaxation techniques" by "keeping themselves busy with something, trying to avoid bad things, always keeping a family member with themselves, thinking about what nurses and doctors told them, trying to establish good communication, providing family peace" (Table 3c).

Spirituality

In this dimension, findings about individuals' health perceptions, important people in their lives, their spare time activities, their religious and spiritual actions after the disease, the

way they perceived the social understanding of mental illness, and their future plans were included. Among the participants, 66.7% defined health as "having mental peace". All individuals stated that their families are the most important people in their lives, and they mostly spend their leisure time on in-house activities; whereas 61.3% stated that the disease did not have any negative effect on their spiritual beliefs, 19.4% stated that "there is a decrease in their love of humanity". Among the participants, 67.9% faced "social exclusion and pity" and stated their future plans included "to have a profession, property" (61.3%) and "to establish a family and extend it" (41.9%) (Table 3c).

Discussion

Schizophrenia is a chronic disease; it results in progressive loss of social and functional abilities and increases the burden of

care on patients' families.^[19,20] In chronic diseases, the objective of healthcare providers is not only to cure the individuals, but also to help them to adapt to the ongoing issues from their condition. Therefore, the role of nurses in the healthcare has changed: they have mainly focused on the "self-care" concept.^[11] This study was conducted to determine the study subjects' ability for early-period self-care and schizophrenia patients' care requirements after discharge.

It was determined that the point average of participants' self-care ability was at medium levels. In a study conducted with 21 non-acute schizophrenia patients, Çorçem and Partlak-Günüşen (2010) also found that the point average of self-care ability was at a medium level (88.42 ± 25.09); these authors determined that economic status and self-care ability are positively correlated.^[5] Çiftçi et al.^[11] (2015) found that the point average of self-care ability among schizophrenia patients (77.0 ± 23.0) was lower than that of the individuals with anxiety disorder and depression. The lack of some qualities that maintain self-care, such that lack of physical energy, awareness, decision-making, motivation, self-respect and confidence, can decrease the self-care ability of schizophrenic patients.^[21] Therefore, studies where those factors that can affect the self-care ability of individuals are taken under consideration are required.

Schizophrenic patients face with many emotional, social, economic problems, and they require the support and cooperation of others to cope with these problems.^[22] In this study, "self-concept, coping, need of knowledge, treatment and care, self-care, sleep, role and relationships, safe environment and spiritual dimension" were analyzed as the self-care requirement areas for schizophrenic patients: it was found that these patients need assistance in the early discharge period for each of these dimensions.

The self-concept affects individuals' emotional and physical self-care to a large extent,^[23] and a person's prominent characteristics should be taken into consideration to understand their self-concept. In this study, participants defined themselves socially, physically, and particularly spiritually, in many ways that indicated their self-awareness and where they needed support; they asserted that increasing self-awareness is the primary objective that improves their self-concept. If individuals think about themselves in a more realistic and positive way, they can cope with problems in a more effective way.^[24] Deterioration in social relations, loss of work, and self-care requirements in schizophrenia patients may be a result of deterioration in self-perception.^[25] Our findings suggest that individuals want to make some changes in their lives, indicating that they are aware of the negative outcomes that result from the loss of skills and try to manage them. In that case, we believe that supporting these patients in their efforts to make these changes will be helpful toward developing a more positive self-concept.

Only a limited number of Turkish studies have examined the coping behaviors of schizophrenia patients. Özcan et al.^[26]

(1999) notified that schizophrenic patients used at least one coping method among "cognitive control, change medication dose, increase relationship with others, acting symptomatically, passive behavior tendencies and substance use" to manage stressing events, but they mostly preferred religious activities. That finding is similar to our: in the present study, individuals stated that they mainly received help and support from their families to solve their problems, which in turn supported the finding that they mostly need emotional support to cope with their disease. Uğurlu (2011) asserted that patients with schizophrenia who received social support to manage the disease did not have any side effects from the treatment.^[27] Yalvaç et al.^[28] (2015) indicated that schizophrenic patients were advised to consult a psychiatrist by their family members. Family interventions for schizophrenia such that education, support, and consultancy have positive influences on these patients.^[29-31] All our findings exhibit the necessity for strengthening the family. Patients with schizophrenia can apply coping methods to become healthier; if they are motivated to use active coping methods, they would obtain better mental health outcomes.

In the need-for-knowledge dimension, patients with schizophrenia explained their disease using negative statements and psychotic symptoms. Güner^[32] (2014) indicated that schizophrenic patients defined their disease as "a frightening, undefinable pain, a lost life, a mystery and a secret", which shows similarities to those statements our study. In the present study, some individuals considered their disease as a temporary condition, which may indicate that they did not accept the illness, because perceiving the disease as chronic increases the adaptation to the disease.^[33] As disease perception defines the ways the affected individuals cope, the mental health team should learn the individual patients' views of their disease.^[32,33] Although most of the participants in this study had been diagnosed with schizophrenia for more than six years and had had at least two hospitalizations for it, they still needed to learn more information about the disease. We assume that individuals were unable to receive sufficient information from the healthcare professionals they had consulted. Similarly, Duran and Gürhan^[34] (2012) found that patients in psychiatry clinics were not regularly being informed about discharge from the hospital; they did not receive information about their disease and diagnosis; therefore, they did not feel ready to be discharged. Hätönen et al.^[35] (2008) determined the most important educational areas for discharged psychiatric patients were effects of their medicine and their side effects, which was similar to results in the present study. Participants thought about providing information to healthcare professionals, which is an important indication that they perceive them as the main authority on their condition. Yılmaz^[36] (2011) stated that schizophrenic patients were informed mostly by physicians, nurses, and psychologists among healthcare professional. Taken all of these findings into the consideration, it is necessary to provide an integrated education and consultancy for schizophrenic patients, both during their hospitaliza-

tion and after their discharge from hospital. Mental education and telepsychiatry have positive influences on schizophrenic patients after they are discharged from hospital and are recommended for observation of in-home patients.^[37]

Outpatients with schizophrenia have a lower level of adaptation to the therapeutic process than do hospitalized patients.^[38] However, most of the patients in our study stated that they used their medication, which may be an indication that these patients were at the early discharge period. But, as they had problems when they were using their medication and they were unable to solve them, it can be assumed that they might develop some inconsistencies in the future. Another study shows that medication alone is not effective to prevent re-hospitalization: in addition to medication, supportive psychosocial interventions are also important.^[39] Tatar Yüksel and Oflaz^[40] (2012) determined that application of a medication management module focused on a social skills training program in short term hospitalization of psychiatric patients using antipsychotic medicine is effective in improving knowledge and use of medication; that indicates similar practices before discharge will be useful for the patients. In the present study, we determined that schizophrenic patients used self-relaxation methods and asked their relatives for advice. Other studies also confirm that a high percentage of schizophrenia patients refer to their religion to cope with the disease.^[28,41] Most participants in the present study stated that they receive material and spiritual support from their families, but they do not have any other support. This is important because a supportive family environment is a preventive factor against recurrence in schizophrenic patients.^[42] Studies that addressing individuals along with their families could be effective to develop convenient coping methods with the disease.

Saruç and Kaya Kılıç^[43] (2015) conducted a study on self-care in schizophrenia patients and determined that only 34.7% of the registered patients in the Community Mental Health Center performed their self-care without receiving any help and support. This finding is similar to that of our study, which also determined that the individuals had problems mostly resulting from negative conditions such that "fatigue and unwillingness". These negative symptoms of the patients are main determinants of the objective burden for the caregivers.^[44] The Çetin et al.^[45] (2013) study found that difficulties experienced by the caregiving family members and their levels of expressed emotion decreased as the schizophrenic patient's independency in the instrumental activities of daily life increased. The stress on caregivers of schizophrenic patients should be reduced to decrease the negative impacts of the disease on the family environment; some interventions such that organizing family education, family support groups, crisis management, and consultancy could be effective.^[44,46] In the present study, some schizophrenia patients / did not receive any help despite their difficulties in their self-care. To increase these individuals' motivation for self-care maintenance, it is suggested that psychiatric nurses use motivational interview method in clinics and community health centers.^[47]

Sleep disorders are common in schizophrenic patients, particularly after their discharge from hospital. Yetkin et al.^[48] (2011) found that compared to a control group, the schizophrenic patients had less total sleep time, lower sleep efficiency, longer sleep latency, more awakenings, and increased duration of awakenings after falling asleep. Before discharge, patients should be provided relaxation techniques among self-coping methods, and they should adopt correct habits through education about regulating their sleep patterns.^[49]

In the role and relationship dimension in this study, as is also stated in the literature, it was determined that their domestic role, sexuality, and their relationships with spouses and children, relatives and friends have been negatively affected.^[50-55] Another study found that schizophrenic patients attempted to hide their illness from their spouses, and when the truth was learned the marriages ended in divorce.^[55] As the marriage brings a sense of safety and responsibility to affected individuals,^[56] it is also considered to increase their self-care ability. Therefore, improving the coping behaviors of spouses and children alongside those of the patients is required as a nurses' responsibility to protect and maintain the family. Saruç and Kaya Kılıç^[43] (2015) found, similar to this study, that most schizophrenic patients do not have any friends and do not see their neighbors. Lack of emotional expression and deterioration in perception of others' emotions can prevent the socialization of schizophrenia patients.^[54] However, negative beliefs and attitudes of society towards the schizophrenic patient may affect interpersonal relationships as well. In this study, about one-half of the participants thought that the disease influenced their sex life. A study that examined the sexual problems of schizophrenic patients reported that schizophrenic patients taking antipsychotic medications have problems in the frequency of sexual intercourse, and in areas of sexual communication, satisfaction, avoidance, and touching.^[53] Doğu et al.^[52] (2012) stated that sexual dysfunction reduces patients' quality of life and may be a cause of treatment non-compliance; thereby, it negatively affects an individual's self-care ability.

In the dimension of safe environment, it was determined that individuals had lack of confidence derived from "fear of being murdered, suspecting of everything, fear of re-hospitalization by force". We observed that individuals mainly used mental methods to provide a safe environment. Another study that examined hallucination types and fear elements of schizophrenic patients found that those individuals mostly have delusions of persecution, being poisoned and being followed, being stalked, and talked about behind their backs.^[57] These problems result from the nature of the disease and may increase the individual's requirement for a sense of safety. The transformation of care from hospital to society has also increased nurses' responsibilities to provide a therapeutic environment for their patients during this time. Within the social mental health understanding, the inclusion of patients to the daily part-time treatment programs in the Community Mental Health Centers will provide them a safe environment.^[10]

In the spiritual dimension, health perception was defined as “finding mental peace”. There has been no Turkish study of the health perceptions of psychiatric patients. Health perception affects an individual’s health behaviors; therefore, it is important to provide protectionist interventions.^[58] The love and support of a family plays an important role in the life of schizophrenia patients. Most patients with chronic mental illness live with their families or interact with their family members, and the quality of care will increase with the inclusion of family members in the rehabilitation program.^[59] Most of the participants stated that they spend their leisure time for indoor activities. In a study similar to ours, it was found that almost 65% of the schizophrenic patients spent their time watching television.^[43] “Recreation therapy” as a nursing intervention that utilizes leisure time productively should be considered by nurses, particularly for those individuals who have experienced a deterioration in their social interactions and social isolation like that in schizophrenia patients.^[60] The present study indicated that schizophrenia negatively impacts religious and spiritual beliefs for some patients. Even though spirituality in persons diagnosed with schizophrenia gives meaning and aim to their life,^[61,62] it is sometimes ignored in nursing care.^[63–65] Spiritual beliefs are important in helping individuals to accept the problems associated with their diseases and to carry out plans for their future.^[66] Most mentally disordered people stated that they experienced “exclusion and pity” from the society. Many mentally ill people are aware of the social stigmatization of mental disorders, which then lead to self-stigmatization—one of the biggest barriers to recovery. Education should be the main focus to fight against internalized stigma and to resist against social stigma.^[67] Patients’ future plans that were asked as the other aspect of their spiritual dimension indicated that they had some future plans to establish living conditions that they were not able to achieve due to the nature of their disease, such as a profession and a family life. As their life purposes are effective for their motivation to adapt and participate in a treatment program, healthcare teams should also take individuals’ own purposes under consideration.^[68]

Limitations of the Study

The study participants were discharged schizophrenic patients after their hospitalization in Akdeniz University Hospital Psychiatry Clinic; therefore, study results could only be generalized within the research sample.

Conclusion

This study indicated that schizophrenic patients require help and support to maintain their independence in daily life during the early period after discharge. Therefore, this study provides significant data to shape nursing care provided by psychiatric clinics. Self-care abilities of the schizophrenia patients in the early period after discharge was found to be only at a medium

level. Individuals had significant requirements in at least one of the following dimensional areas: self-concept, coping, need for knowledge, sleep, roles and relationships, treatment and care, safe environment, self-care, and spirituality. We believe that the evaluation of care requirements for each of these dimensions will provide the significant integrative understanding for psychiatric patients’ recovery. Although these findings were obtained from only a few research participants, each experience is unique and valuable for an integrative and phenomenological approach to nursing care. Discharge planning of psychiatric nursing, with the cooperation of the mental health team, their inclusion in the post-discharge care and the importance of self-care ability level as discharge criteria of psychiatric patients will contribute to the maintenance of care within society outside the treatment facility.

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

Peer-review: Externally peer-reviewed.

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

References

1. Gerson LD, Rose LE. Needs of persons with serious mental illness following discharge from inpatient treatment: patient and family views. *Arch Psychiatr Nurs* 2012;26:261–71. [\[CrossRef\]](#)
2. Loch AA. Discharged from a mental health admission ward: is it safe to go home? A review on the negative outcomes of psychiatric hospitalization. *Psychol Res Behav Manag* 2014;7:137–45. [\[CrossRef\]](#)
3. Irmirer C, McCarthy JF, Barry KL, Soliman S, et al. Reinstitutionalization following psychiatric discharge among VA patients with serious mental illness: a national longitudinal study. *Psychiatr Q* 2007;78:279–86. [\[CrossRef\]](#)
4. Sönmez EU. Şizofreni Hastalarında Dönerkapı Fenomeni Değişkenlerinin İncelenmesi. [Yayımlanmamış Uzmanlık Tezi]. İstanbul: Bakırköy Ruh ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi; 2008.
5. Çörçem P, Partlak Günüşen N. Şizofreni hastalarının öz-bakım gücü ve etkileyen faktörlerin incelenmesi. IV. Ulusal Psikiyatri Hemşireliği Kongresi (24–26 Haziran 2010) Özet Kitabı. Sam-sun: 2010. s.176–7.
6. Holmberg SK, Kane C. Health and self-care practices of persons with schizophrenia. *Psychiatr Serv* 1999;50:827–9. [\[CrossRef\]](#)
7. Fortinash KM, Holoday Worret PA. *Psychiatric Mental Health Nursing*. 4th ed. Missouri: Elsevier; 2008.
8. Buldukoğlu K. Values in Psychiatric Care. *Türkiye Klinikleri J Psychiatr Nurs-Special Topics* 2015;1:9–15.
9. George JB. *Nursing Theories*. 6th ed. New Jersey: Pearson; 2010.
10. Varcarolis EM. *Essentials of Psychiatric Mental Health Nursing*:

- A Communication Approach to Evidence-Based Care. 2nd ed. Missouri: Elsevier Saunders; 2013.
11. Çiftçi B, Yıldırım N, Şahin Altun Ö, Avşar G. What level of self-care agency in mental illness? The factors affecting self-care agency and self-care agency in patients with mental illness. *Arch Psychiatr Nurs* 2015;29:372–6. [CrossRef]
 12. Cornwell P, Dicks B, Fleming J, Haines TP, et al. Care and support needs of patients and carers early post-discharge following treatment for non-malignant brain tumour: establishing a new reality. *Support Care Cancer* 2012;20:2595–610. [CrossRef]
 13. Driscoll A. Managing post-discharge care at home: an analysis of patients' and their carers' perceptions of information received during their stay in hospital. *J Adv Nurs* 2000;31:1165–73. [CrossRef]
 14. Nahcivan NO. A Turkish language equivalence of the Exercise of Self-Care Agency Scale. *West J Nurs Res* 2004;26:813–24.
 15. Bakoğlu E, Yetkin A. Hipertansiyonlu hastaların öz-bakım gücünün değerlendirilmesi. *CÜ Hemşirelik Yüksekokulu Dergisi* 2000; 4:41–9.
 16. Stuart GW, Laraia MT. Principles and Practice of Psychiatric Nursing. 8th ed. St. Louis: Elsevier Mosby; 2005.
 17. Gamble C, Brennan G. Working With Serious Mental Illness: A Manual For Clinical Practice. 2nd ed. Philadelphia: Elsevier; 2006.
 18. Carpenito-Moyet LJ. Hemşirelik Tanıları El Kitabı. Erdemir F, çev ed. İstanbul: Nobel Tıp Kitabevleri; 2005.
 19. Kocal Y, Karakuş G, Tamam L. Sociodemographic and Clinical Characteristics of inpatients with Schizophrenia in Psychiatry Clinics. *Klinik Psikiyatri* 2017;20:104–13. [CrossRef]
 20. Elder R, Evans K, Nizette D. Psychiatric and Mental Health Nursing. Australia: Elsevier; 2013.
 21. Cutler C. Assessing patients' perception of self-care agency in psychiatric care. *Issues Ment Health Nurs* 2003;24:199–211.
 22. Babacan Gümüş A. Şizofrenide Hasta ve Ailelerin Yaşadığı Güçlükler, Psikoeğitim ve Hemşirelik. *Hemşirelikte Araştırma Geliştirme Dergisi* 2006;8:23–34.
 23. Potter PA, Perry AG. Basic Nursing: Theory and Practice. St. Louis: Mosby; 1995.
 24. Hiçdurmaz D, Öz F. Benliğin Bilişsel Yaklaşımla Güçlendirilmesi. *Hacettepe Üniversitesi Hemşirelik Fakültesi Dergisi* 2011;18:68–78.
 25. Bulut A. Şizofren Hastalarında İştisel Varsanıları İle İlgili İnanışlarının Benlik Saygısı İle İlişkisi. [Yayımlanmamış Uzmanlık Tezi] İstanbul: Bakırköy Prof. Dr. Mazhar Osman Ruh Sağlığı ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi 6. Psikiyatri Birimi; 2012.
 26. Özcan ME, Gürgen F, Türkeş C. Şizofrenili Hastalarda Başa Çıkma Davranışları. *Düşünen Adam Dergisi* 1999;12:35–40.
 27. Uğurlu N. Şizofreni Tanısı Konan Hastalarda Bir İşte Çalışmanın ve Derneğe Üye Olmanın İşlevsel İyileşme, Tedaviye Uyum ve Stresli Durumlarla Baş Etme Üzerine Etkisi. [Yüksek Lisans Tezi] Ankara: Gazi Üniversitesi Sağlık Bilimleri Enstitüsü; 2011.
 28. Yalvaç HD, Kotan Z, Ünal S. Help seeking behavior and related factors in schizophrenia patients: a comparative study of two populations from eastern and western Turkey. *Düşünen Adam: Psikiyatri ve Nörolojik Bilimler Dergisi* 2015;28:154–61.
 29. Soygür H, Çelikel B, Aydemir Ç, Bozkurt S. Hasta yakınları ile gerçekleştirilen psikodrama yönelimli destekleyici-eğitici grup psikoterapisinin kronik şizofreni gidişi üzerinde etkisi. *Düşünen Adam: Psikiyatri ve Nörolojik Bilimler Dergisi* 1998;11:5–11.
 30. Bademli K, Çetinkaya Duman Z. Family to Family Support Programs for the Caregivers of Schizophrenia Patients: A Systematic Review. *Türk Psikiyatri Derg* 2011;22:255–65.
 31. Chien WT, Yip AL, Liu JY, McMaster TW. The effectiveness of manual-guided, problem-solving-based self-learning programme for family caregivers of people with recent-onset psychosis: A randomised controlled trial with 6-month follow-up. *Int J Nurs Stud* 2016;59:141–55. [CrossRef]
 32. Güner P. Illness perception in Turkish schizophrenia patients: a qualitative explorative study. *Arch Psychiatr Nurs* 2014;28:405–12. [CrossRef]
 33. Yılmaz Karabulutlu E, Okanlı A. Hemodiyaliz Hastalarında Hastalık Algısının Değerlendirilmesi. *Anadolu Hemşirelik ve Sağlık Bilimleri Dergisi* 2011;14:25–31.
 34. Duran S, Gürhan N. Psikiyatri hastalarının taburculuk eğitimi alma durumunun değerlendirilmesi. *FÜ Sağ Bil Tıp Derg* 2012;26:39–44.
 35. Hätönen H, Kuosmanen L, Malkavaara H, Välimäki M. Mental health: patients' experiences of patient education during inpatient care. *J Clin Nurs* 2008;17:752–62. [CrossRef]
 36. Yılmaz S. Şizofreni Tanılı Hasta ve Ailelerinin Eğitim Gereksinimleri. [Doktora Tezi], İstanbul: İstanbul Üniversitesi Sağlık Bilimleri Enstitüsü; 2011.
 37. Özkan B, Erdem E, Demirel Özsoy S, Zararsız G. Şizofreni hastalarına verilen ruhsal eğitim ve telepsikiyatrik izlemenin hasta işlevselliği ve ilaç uyumuna etkisi. *Anadolu Psikiyatri Derg* 2013;14:192–9.
 38. Dikeç G, Kutlu Y. The Determination of Treatment Adherence and Affecting Factors Among a Group of Patients with Schizophrenia. *J Psy Nurs* 2014;5:143–8. [CrossRef]
 39. Gültekin BK, Güler J, Kesebir S, İrmak Ç, et al. Rehospitalization Rates of Patients with Schizophrenia Discharged on Typical, Atypical Antipsychotics, Electroconvulsive Therapy or Combination Treatment During Six Months. *Klinik Psikiyatri Dergisi* 2013;16:206–13.
 40. Tatar Yüksel Ç, Ofraz F. Assessing Medicine Management Education in Psychiatric Inpatients Who use Antipsychotic Medicine. *J Psy Nurs* 2012;3:67–74. [CrossRef]
 41. Yazıcı E, Yazıcı AB, İnce M, Erol A, et al. The search for traditional religious treatment amongst schizophrenic patients: the current situation. *Anadolu Psikiyatri Derg* 2016;17:174–80.
 42. Baştug S, Karancı AN. The impact of caregivers' expressed emotion and the patients' perception of expressed emotion on the positive and negative symptoms of patients with schizophrenia in a sample from Turkey. *Düşünen Adam: The Journal of Psychiatry and Neurological Sciences* 2015;28:127–39. [CrossRef]
 43. Saruç S, Kaya Kılıç A. Social Profile of Patients Receiving Service from Community Mental Health Center and Provided Servi-

- ces in the Center. *Toplum ve Sosyal Hizmet* 2015;26:53–71.
44. Arslantaş H, Adana F. The Burden of Schizophrenia on Caregivers. *Current Approaches in Psychiatry* 2011;3:251–77.
 45. Çetin N, Demiralp M, Oflaz F, Özşahin A. The relationship between daily life activity levels of schizophrenia patients and care burden and expressed emotion statuses of their family members. *Anadolu Psikiyatri Derg* 2013;14:19–26. [CrossRef]
 46. Bademli K, Çetinkaya Duman Z. Caregivers of Schizophrenia Patients. *Current Approaches in Psychiatry* 2013;5:461–78.
 47. Çetinkaya Duman Z, Ertem M. Why Motivational Interviewing Important for Patients with Schizophrenia? *DEUHFED* 2016;9:148–52.
 48. Yetkin S, Aydın H, Özgen F, Sütcigil L, et al. Şizofreni Hastalarında Uyku Yapısı. *Türk Psikiyatri Dergisi* 2011;22:1–9.
 49. Alptekin K, Yıldırım E. Şizofreni hastalığında İlgörü Eksikliği: “Hasta değilim, Yardıma İhtiyacım Yok”. *Kronik Ruhsal Hastalıklarda Tedavi İşbirliği - Uzman Görüşleri*; 2011.
 50. Vaz FJ, Béjar A, Casado M. Insight, psychopathology, and interpersonal relationships in schizophrenia. *Schizophr Bull* 2002;28:311–7. [CrossRef]
 51. Pinkham AE, Penn DL. Neurocognitive and social cognitive predictors of interpersonal skill in schizophrenia. *Psychiatry Res* 2006;143:167–78. [CrossRef]
 52. Doğu B, Güler J, Çıtak S, Altunkaynak Y, et al. Şizofreni hastalarının cinsel yaşama ilişkin öznel düşüncelerinin cinsiyetler arası karşılaştırması. *Klin Psikiyatr Derg* 2012;15:238–47.
 53. Çakmak S. Şizofrenik Bozuklukta Cinsel İşlev Bozuklukları: Kesitsel Bir Değerlendirme. [Yayınlanmamış Uzmanlık Tezi] Adana: Çukurova Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı; 2010.
 54. Ünal S. Şizofrenide öznel yaşantılar ve duyguların ifadesi. *Klin Psikiyatr Derg* 2000;3:131–6.
 55. Loganathan S, Murthy RS. Living with schizophrenia in India: gender perspectives. *Transcult Psychiatry* 2011;48:569–84.
 56. Pehlivan K. Marriage and Parenthood in Female Psychiatric Patients: A Review. *Düşünen Adam* 2006;19:143–54.
 57. Özen Ş, Özmen S. The type of delusions, fear contents and negative life events in a group of patients with schizophrenia. *Anadolu Psikiyatri Derg* 2010;11:133–8.
 58. Araz A, Harlak H, Meşe G. Health Behaviors and Alternative Medicine Use. *TAF Prev Med Bull* 2007;6:112–22.
 59. Yıldız M. Psikiyatrik Rehabilitasyon. Bireyden Topluma Ruh Sağlığı. Işık Sayıl, editor. İstanbul: Erler Matbaacılık; 2004.
 60. Johnson M. Nursing Diagnoses, Outcomes and Interventions: NANDA, NOC, And NIC Linkages. 2nd ed. St. Louis: Mosby; 2006.
 61. Mohr S, Brandt PY, Borrás L, Gilliéron C, et al. Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. *Am J Psychiatry* 2006;163:1952–9. [CrossRef]
 62. Huguelet P, Mohr S, Borrás L, Gillieron C, et al. Spirituality and religious practices among outpatients with schizophrenia and their clinicians. *Psychiatr Serv* 2006;57:366–72. [CrossRef]
 63. Yılmaz M, Okyay N. Views Related to Spiritual Care and Spirituality of Nurses. *Hemşirelikte Araştırma Geliştirme Dergisi* 2009;11:41–52.
 64. Kostak MA, Çelikkalp Ü, Demir M. Hemşire ve ebelerin maneviyat ve manevi bakıma ilişkin düşünceleri. *Maltepe Üniversitesi Hemşirelik Bilim ve Sanatı Dergisi Sempozyum Özel Sayısı* 2010;218–25.
 65. Sis Çelik A, Özdemir F, Durmaz H, Pasinlioğlu T. Determining the Perception Level of Nurses Regarding Spirituality and Spiritual Care and the Factors that Affect their Perception Level. *Hacettepe Üniversitesi Hemşirelik Fakültesi Dergisi* 2014;1:1–12.
 66. Kostak M. Hemşirelik bakımının spiritüel boyutu. *Fırat Sağlık Hizmetleri Dergisi* 2007;2:105–15.
 67. Çam O, Çuhadar D. Stigma Process and Internalized Stigma among Individuals with Mental Illness. *J Psy Nurs* 2011;2:136–40.
 68. Sivaraman Nair KP. Life goals: the concept and its relevance to rehabilitation. *Clin Rehabil* 2003;17:192–202. [CrossRef]