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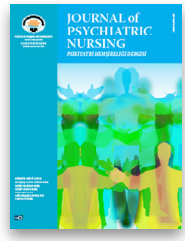

Original Article

Investigation of the relationship between internalized stigmatization and social loneliness in psychiatric inpatients

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Abstract

Objectives: This study aimed to investigate the relationship between internalized stigmatization and social loneliness in psychiatric inpatients.

Methods: The study population consisted of all inpatients treated in the psychiatric ward of a research hospital in a province in the east of Turkey. There was no sample selection from the group of the 77 patients who received inpatient treatment at the psychiatry clinic between March 2017 and February 2018 and complied with the inclusion criteria. The Personal Information Form, Internalized Stigma in Mental Illness Scale, and Loneliness Scale were used to collect data by a face-to-face interview technique; the data were evaluated using the SPSS 23 package program. Percentage, mean, standard deviation, t test, Mann-Whitney U, Kruskal-Wallis, and correlation analysis were used for statistical analysis.

Results: In the correlation analysis of the scales, it was determined that there was a statistically negative relationship between the Stigma Resistance subdimension and loneliness, and a statistically significant positive correlation between the loneliness score, mean scores of Alienation, Approval of Stereotypes, Perceived Discrimination, Social Retraction and Resistance against Stigma.

Conclusion: Psychiatric patients may have a more isolated life because of internalized stigmatization. In this study, it was concluded that the level of loneliness increased as the internalized stigmatization levels of the patients increased, but that loneliness decreased as patients resisted internalized stigmatization. By decreasing the stigma and increasing the resistance to internalized stigma, patients can increase their adaptation to active social life.

Keywords: Individual with psychiatric illness; inpatient; internalized stigma; loneliness.

Stigmatization, which plays an active role in dismissal of individuals or groups for various reasons such as illnesses, substance use, ethnicity, or physical condition, is an undesirable situation.[1] Basically, stigmatization is the exclusion or dismissal of people who frighten an individual or society, are thought to disrupt harmony, and who are appear to be different.[2] Although stigmatization has changed along with differences in culture and beliefs in societies, over time the most commonly stigmatized group ,in many societies were individuals with mental illnesses.[1,3] An individual with mental illness is seen as an incompatible and dangerous person with the potential to do harm at any time and thus is stigmatized and marginalized.[1] Marginalized patients evaluate themselves negatively and accept the stigmatization as time passes and internalize it.[3] Additionally, literature shows that individuals with mental illness stigmatize, trivialize, and blame themselves, withdraw from the community, and experience feelings of exclusion even when they have not been exposed to exclusion or discrimination.[1,4]

Since the beginning of studies on stigmatization, it has been reported that stigmatization causes depression, withdrawal from the community, and feelings of worthlessness in the

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What is known on this subject?

- It is known that individuals with mental illness are stigmatized and isolated by society. This study aims at determining the relationship between internalized stigmatization and loneliness.

What is the contribution of this paper?

- It has been concluded that loneliness levels of patients increased as their stigmatization levels increased and that their loneliness decreased as they showed resistance to stigmatization.

What is its contribution to the practice?

- Methods to fight stigmatization should be increased to ensure that patients do not feel lonely; by carrying out ways to reduce their loneliness, we can help patients to avoid internalizing stigmatization. As a result, it is thought that the facilitation of the patients' adaptation to life will contribute to the practice.

patient; this makes the patient's life more difficult and negatively affects the treatment process.[5,6] More than half of individuals with mental illness state that they feel lonely.[7] Loneliness is a painful universal phenomenon with an evolutionary basis.[8] Loneliness termed perceived social isolation is a subjective experience that occurs when individuals think that they are incapable of finding a sense of belonging, especially in their own relationships.[9] Loneliness leads to the absence of social relationships and a lack of love in existing social relationships.[8]

In addition to individuals isolated because of mental illness, loneliness has increased in the entire society compared to the past, which is perhaps the reason that studies carried out on loneliness have increased in the last twenty years. Among studies on stigmatization, those that examine stigmatization against individuals with mental illnesses are seen in the majority.[10–12] From the patient's point of view, it can be said that the number of existing studies is limited. Studies also show that patients experiencing stigmatization are socially isolated and that they experience serious incompatibilities during the treatment process.[1–3] However, no studies to date have examined the relationship between internalized stigmatization of individuals with mental illness and loneliness. The present study suggests that methods to fight stigmatization can be increased by considering the factors affecting stigma and loneliness in psychiatric patients, and thereby the sense of loneliness experienced by those patients can be reduced. In addition, to protect and maintain the mental treatment, it can be noted that the issue of loneliness and coping with loneliness is also important in individual and group therapies. It is believed that social programs and training, increasing social support systems, and studies focused on the issue will contribute to overcoming stigmatization.

In the light of that information, this study was carried out to examine the relationship between internalized stigmatization and levels of loneliness of inpatient psychiatric patients.

For this purpose, the answers to the following questions were sought.

- What are the descriptive characteristics that affect internalized stigmatization in psychiatric patients?
- What is the level of loneliness of psychiatric patients?
- What are the descriptive characteristics that affect loneliness in psychiatric patients?

Materials and Method

The study was carried out with a descriptive and cross-sectional pattern. The proposed study population consisted of all 275 patients that had been treated between March 2017 and February 2018 in the psychiatric ward of a research hospital located in an eastern province of Turkey. No sample selection was made; 77 patients (28%) who fit the inclusion criteria and had been treated in the psychiatric ward in that period were included in the study. Inclusion criteria were as follows: agreeing to participate in the study, being in the stage of discharge from the hospital due to remission period, and at least 18 years old. Exclusion criteria were not wanting to participate in the study (I don't want to participate, I feel tired, I don't understand, etc.), having an additional diagnosis of mental retardation, and not being able to communicate.

Data Collection: Data were collected using the Personal Information Form, the Internalized Stigma in Mental Illness Scale (ISMI), and the UCLA Loneliness Scale.

The data were collected during a physician visit with patients at the stage of discharge as the disease entered the remission period, i.e., the time when the physician deems the patient appropriate for discharge during the visit because the disease is no longer active or acute and because the patient shows a favorable prognosis. The data were collected by one of the researchers using a face-to-face interview technique in an interview room. The forms were introduced to the patients while explaining the purpose of the study. Patients were given the choice to either fill in the forms by themselves, during which a researcher stood by for possible questions, or to have the questions read to them by a researcher—in which case the researcher filled in the forms. Each patient was given approximately 20 minutes.

Date Collection Tools

Personal Information Form: The form was created by the researchers in line with published literature to determine the patients' descriptive characteristics (age, sex, marital status, educational status, working status, family type, people they live with), their clinical diagnosis, duration of illness, and duration of hospitalization.[1–3,13]

Internalized Stigma in Mental Illness Scale (ISMI): This self-report scale evaluating internalized stigma developed by Ritsher et al.; it consists of 29 items and is a 4-point Likert-type scale. The items are evaluated as follows: 1= I absolutely disagree (1 point); 2 = I do not agree (2 points); 3 = I agree (3 points); 4 = I absolutely agree (4 points). The ISMI scale score varies from 29 to 116 points and has no cut-off points. High scores achieved from the scale indicate increased perceived stigmatization. Ersoy and Varan[13] (2007) conducted the validity and reliability study of the ISMI scale with 203 psychiatric

patients. The internal consistency coefficient obtained for the entire scale was 0.93, and the two-half reliability of the scale was 0.89. The Cronbach alpha value obtained in the present study was 0.86. The scale evaluates the subjective stigmatization experiences of people within the following five subdimensions: alienation, approval of stereotypes, perceived discrimination, social retraction, and resistance against stigma. The items of the resistance against stigma subdimension are scored in reverse numerically.

UCLA Loneliness Scale: The UCLA Loneliness Scale was developed by Russel, Peplau, and Ferguson in 1978 and edited in 1980. The scale consists of 20 items, of which 10 are scored in order and 10 in reverse. A high score is accepted as a sign that loneliness is experienced more intensely. The points to be achieved from each item range from 1 to 4. The highest score that can be obtained is 80, and the lowest, 20. The scale does not have a fixed cut-off score or subdimensions. The higher the score on the scale, the higher the level of perceived loneliness. The validity and reliability study of the UCLA Loneliness Scale was conducted by Demir (1989).[14] The test-retest reliability of the scale was found to be significant (r=0.73). Findings related to the reliability of the scale show that the alpha internal consistency coefficient determined as 0.96 is sufficient.[14] The Cronbach alpha value in this study was 0.84.

Ethical Aspects of the Study: Ethics committee approval (Date: 06/02/2017, Protocol No: 2017/01/07) was obtained to conduct the research. For the collection of the data, informed consent was read to each patient, and verbal consent was obtained.

Data Evaluation: The obtained data were evaluated in SPSS 23 (Scientific Package for Social Statistics) package program with a 95% confidence interval and $p<0.05$ significance level. The normal distribution analysis of the data was done with the Kolmogorov-Smirnov test: the scores of the scales showed normal distribution for some variables but abnormal distribution for others. Therefore, when comparing groups, parametric comparison tests were used for groups with normal distribution and nonparametric comparison tests were used in groups with abnormal distribution. Number percentage, mean, standard deviation, t test, Mann Whitney U, Kruskal Wallis analysis and correlation analysis were used for the data analysis.

Limitations of the Study: Because the study was conducted with patients who were about to be discharged, the results can be generalized only for that group. In addition, not knowing how patients perceive the scale questions constitutes a limitation of this study.

Results

Descriptive characteristics of the participants are shown in Table 1. Among the patients, 36.4% were 25 to 34 years old, 66.2% were men, and 36.4% were high school graduates. In addition, 80.5% were unemployed, and 35.1% had been forced to leave work previously due to their mental illness. It was determined that no clear medical diagnoses were made for 19.5% of the patients, that 35.1% were suffering from depression, and that 24.7% were schizophrenic.

The correlation analysis between the ISMI and loneliness scale mean scores of the participants are shown in Table 2. A positive relationship was determined between the total ISMI score, the subdimensions alienation, approval of stereotypes,

Table 1. Percentage distribution of patients' descriptive characteristics

Descriptive characteristics	n	%
Age		
18–24 years	21	27.3
25–34 years	28	36.4
35–44 years	17	22.1
45 years and older	11	14.3
Sex		
Female	26	33.8
Male	51	66.2
Educational status		
Illiterate	7	9.1
Literate	4	5.2
Primary school	24	31.2
High school	28	36.4
University	14	18.2
Family type of growing up		
Elementary family	43	55.8
Extended family	32	41.6
Broken family	2	2.6
Marital status		
Married	30	39.0
Single	47	61.0
Children		
Yes	31	40.3
No	46	59.7
Employment status		
Employed	15	19.5
Unemployed	62	80.5
Having to leave a job due to mental illness		
Yes	27	35.1
No	50	64.9
Clinical diagnosis		
No diagnosis yet	15	19.5
Depression	27	35.1
Bipolar	4	5.2
Schizophrenia	19	24.7
Anxiety disorder	6	7.8
Psychosis	5	6.5
Dissociative disorder	1	1.3
Time since diagnosis (years)	6.49±7.67	
Times hospitalized	3.78±4.17	

Table 2. Correlation analysis between ISMI and UCLA mean scores

	Internalized Stigma in Mental Illness Scale (ISMI)					
	Alienation	Approval of stereotypes	Perceived discrimination	Social retraction	Resistance against stigma	ISMI Total
UCLA	r=0.511 p=0.001	r=0.570 p=0.001	r=0.562 p=0.001	r=0.577 p=0.001	r=-0.307 p=0.007	r=0.704 p=0.001

perceived discrimination and social retraction, and the mean UCLA score ($p<0.001$). A negative relationship was determined between the ISMI subdimension resistance against stigma and the mean UCLA score ($p<0.001$). As the mean scores of internalized stigma increased, the loneliness mean scores also increased; and that as resistance against stigma mean scores increased, the loneliness mean scores decreased.

Comparison of the participants' mean scores according to their descriptive characteristics is shown in Table 3. No statistically significant difference was found between age, sex, educational status, family type, marital status, or number of children and the ISMI or UCLA loneliness mean scores ($p>0.05$). However, a statistically significant difference was found between the variable of having to quit a job due to mental illness and the UCLA loneliness mean score ($p<0.05$); however, there was no statistically significant difference between that variable and the mean ISMI score ($p>0.05$). According to the diagnosis of the patients, no statistically significant difference was found between the diagnosis and ISMI or UCLA loneliness mean scores ($p>0.05$). It was determined that the patients were coping with their disease for 6.49±7.67 years on average, and that there was a positive significant relationship between the duration of the disease and the ISMI and UCLA loneliness mean scores ($p<0.05$). As the duration of the disease increased, the level of perceived stigmatization and loneliness of the patients increased.

Discussion

Individuals can be diagnosed with various physical diseases. However, the situation changes somewhat when it comes to psychiatric diagnoses: patients face discrimination and exclusion due to social prejudice and negative thoughts against psychiatric patients.[15] The correlation analysis in the current study conducted between the UCLA loneliness scale and ISMI scale showed that internalized stigma and loneliness are connected, and that mean loneliness scores increased significantly in parallel with mean stigmatization scores (Table 2). Arabacı, Başoğul and Büyükbayram[16] reported that stigmatization effects social functionality and sociality, and Yanos et al.[17] reported that stigmatization affects social relationships and interpersonal relationships in individuals with mental disorders. It was reported that as patients' interpersonal life deteriorates, they withdrew more into themselves and led a more isolated life as they felt stigmatized. This study also determined that as the patients' resistance against stigmatization increased, their loneliness levels decreased (Table 2). As psychiatric patients learn to resist stigmatization and negative words and social behaviors, they are more able to cope with mental illness. This, on the other hand, contributes to their social functionality and interpersonal relations, leading to a decrease in loneliness. In short, it can be stated that as the internalized stigmatization levels increase in patients, their loneliness levels also increase.

This study determined that age, sex, educational status, family type while growing up, marital status, presence of children, employment status, having to leave work because of the disease, clinical diagnosis, number of hospitalizations and duration of hospitalization had no effect on stigmatization ($p>0.05$). These results are similar to those in other published studies on stigmatization.[16,18–20] Beyazyüz et al.[21] and Kök and Demir[18] reported that age had no effect on internalized stigma; Picco et al.[22] said that sex and marital status had no effect; and Arabacı et al.[16] reported that neither age, sex, number of hospitalizations, nor duration of hospitalization had an effect on internalized stigma. In the current study, it was determined that the time passed since diagnosis had an effect on internalized stigmatization (Table 3, $p<0.05$). Thus, the internalized stigmatization level increases in parallel with the time that passed since diagnosis. This is also an indication of the patient's acceptance of the disease and the corresponding behavior of society.

As marital status was examined in terms of internalized stigmatization, some studies reported that marital status had an effect on internal stigmatization;[11,21,23,24] however, other studies, including our study, found that marital status has no effect on internalized stigmatization.[25,26] Therefore, the individual who is already lonely due to the disease and who is stigmatized by society is stigmatized and lonely in every way whether or not he/she is married.

In this study's results, age, sex, educational status, family type while growing up, marital status, employment status, clinical diagnosis and number of hospitalizations had no effect on loneliness (Table 3, $p>0.05$). When the relationship between various descriptive characteristics and loneliness was examined in the relevant published literature, similar results were found. Alkan[27] reported in their study with hospitalized adult patients that sex did not have an effect on loneliness, and Yıldırım[28] reported in their study with schizophrenic patients that age, sex, and marital status did not have an effect. Howev-

Table 3. Comparison of patients' descriptive characteristics and mean scores obtained from the scales (n=77)

Descriptive characteristics	ISMI Total		UCLA	
	Mean±SD	Test and p value	Mean±SD	Test and p value
Age				
18–24 years	61.71±12.81	KW=3.914	41.76±10.25	KW=3.109
25–34 years	67.10±10.53	p=0.271	44.71±11.14	p=0.375
35–44 years	70.00±12.50		48.47±12.29	
45 years and older	70.63±12.05		47.09±10.33	
Sex				
Female	66.34±13.42	MW-U=652.00	43.92±10.92	MW-U=601.50
Male	67.00±11.49	p=0.906	45.66±11.29	p=0.507
Educational status				
Illiterate	67.00±8.94	KW=4.476	45.14±10.49	KW=3.811
Literate	66.50±5.97	p=0.345	51.50±2.64	p=0.432
Primary school	70.83±12.55		46.91±11.03	
High school	63.71±12.70		43.14±11.57	
University	65.92±12.02		43.92±12.23	
Family type of growing up				
Elementary family	64.62±12.23	KW=5.802	45.09±11.39	KW=3.165
Extended family	70.37±11.21	p=0.055	46.00±10.60	p=0.205
Broken family	55.50±7.77		30.00±0.00	
Marital status				
Married	68.43±11.86	t=0.958	46.40±11.87	t=0.831
Single	65.72±12.25	p=0.341	44.23±10.67	p=0.409
Children				
Yes	70.03±10.60	t=1.974	47.16±11.89	t=1.356
No	64.58±12.64	p=0.052	43.67±10.48	p=0.179
Employment status				
Employed	64.80±10.94	MW-U=401.00	40.66±10.78	MW-U=361.50
Unemployed	67.25±12.39	p=0.410	46.14±11.03	p=0.182
Having to leave a job due to mental illness				
Yes	70.51±12.46	MW-U=504.50	48.51±12.02	MW-U=470.50
No	64.76±11.51	p=0.068	43.22±10.26	p=0.029
Clinical diagnosis				
No diagnosis yet	65.53±13.01	KW=5.396	47.66±10.45	KW=7.349
Depression	67.74±11.62	p=0.494	45.77±10.33	p=0.290
Bipolar	55.75±7.54		33.75±8.09	
Schizophrenia	68.94±12.27		46.36±12.70	
Anxiety disorder	65.50±15.64		43.50±12.02	
Psychosis	68.60±10.54		42.60±9.39	
Dissociative disorder	61.00±0.00		30.00±0.00	
Time since diagnosis (years)	r=0.239		r=0.295	
	p=0.036		p=0.009	
Times hospitalized	r=0.090		r=0.141	
	p=0.439		p=0.226	

MW-U: Mann-Whitney U test; KW: Kruskal Wallis test; t: t test in independent groups; r: correlation analysis; SD: Standard deviation.

er, those studies reported that educational status and the people that the patients live with did have an effect on loneliness. These results differ from the current study's findings, possibly due to the regional and cultural differences in Turkey.

The mean loneliness scores of patients who had to leave their job due to their illness was found to be significantly higher ($p<0.05$), whereas loneliness scores of employed patients were determined to be significantly lower. It can be postulated that

the participation of working individuals in the business life leads them to see themselves as beneficial to society and to be more interactive with society in the work environment, which, on the other hand, reduces loneliness levels. It was also determined that not only employment status but also the time that has passed since diagnosis affected loneliness levels. The longer the time since the diagnosis, the lonelier the patients felt. Sevil et al.[29] and Friedman et al.[30] reported that the duration of disease increases the level of loneliness. Contrary to these results, Fukui et al.[31] and Deckx et al.[32] reported in their studies that as the disease duration progressed, the level of loneliness decreased. It is possible that this result may be related to the prognosis, type, and perception of the disease. The results obtained from the current study suggest that patients who have been diagnosed with the disease for a longer period of time or have been unemployed longer, were forced to leave their jobs and thus experienced more loneliness. It can also be stated that increasing loneliness due to stigmatization is an inevitable result.

Conclusion

Based on the results of the present study, the duration of the disease was effective on internalized stigmatization and loneliness levels but that the other descriptive characteristics did not affect internalized stigmatization. As the patients' internalized stigmatization levels decreased, their loneliness also decreased, and as their internalized stigmatization levels increased, their loneliness levels also increased.

The psychiatric nurse plays an important role in reducing internalized stigmatization. Nurses working in psychiatry are of great importance in many areas such as the mental illness, patient approach, physical and psychological competencies of the patient, as well as training the patient's relatives, healthcare professionals, and especially, society. To reach a larger audience of both sick and healthy individuals, it can be recommended to use technology and mass media.

In addition to educating society to reduce both internalized stigmatization and loneliness levels of patients, it can be recommended to implement interventions and programs that will increase the coping of patients with feelings of stigma and loneliness in society. Organizations can be joint efforts of nurses and psychiatric patients; various institutions and organizations can be contacted to plan larger-scale events. Individuals who have been coping with the illness for a longer period of time should be the first priority in planning activities, and initiatives should be concurrently formed that include newly diagnosed patients in various activities and social programs before internalized stigmatization and loneliness can develop. Finally, another suggestion is to carry out qualitative studies in which internalized stigmatization and loneliness are examined in depth and to make plans for larger studies or projects with the joint participation of nurses working in both clinical and academical fields.

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References

1. Çam O, Çuhadar D. Ruhsal bozukluğu olan bireylerde içselleştirilmiş damgalanma. Anadolu Psikiyatri Derg 2009;10:84–5.
2. Coşkun S, Güven Caymaz N. Bir Kamu ve Özel Psikiyatri Hastanesine Başvuran Hastaların İçselleştirilmiş Damgalanma Düzeyi Yönünden Karşılaştırılması. J Psychiatric Nurs 2012;3:121–8.
3. Yıldırım E, Akyıl Sokullu D, Köknel Ö. Alkol Bağımlılığında İçselleştirilmiş Damgalanma: Depresif Belirtilerle İlişki. Psikoloji Çalışmaları 2012;32:1–12.
4. Yılmaz E. Şizofreni hastalarında içselleştirilmiş damgalanmanın tedaviye uyuma etkisi. [Yayınlanmamış yüksek lisans tezi] Erzurum: Atatürk Üniversitesi Sağlık Bilimleri Enstitüsü; 2012.
5. Mickelson KD, Williams SL. Perceived stigma of poverty and depression: Examination of interpersonal and intrapersonal mediators. Journal of Social and Clinical Psychlogy 2008;27:903–30.
6. Cavelti M, Kvrgic S, Beck EM, Rüsch N, Vauth R. Self-stigma and its relationship with insight, demoralization, and clinical outcome among people with schizophrenia spectrum disorders. Compr Psychiatry 2012;53:468–79.
7. Prince JD, Oyo A, Mora O, Wyka K, Schonebaum AD. Loneliness Among Persons With Severe Mental Illness. J Nerv Ment Dis 2018;206:136–41.
8. Mushtaq R, Shoib S, Shah T, Mushtaq S. Relationship between loneliness, psychiatric disorders and physical health ? A review on the psychological aspects of loneliness. J Clin Diagn Res 2014;8:WE01–4.
9. Lim MH, Gleeson JFM, Alvarez-Jimenez M, Penn DL. Loneliness in psychosis: a systematic review. Soc Psychiatry Psychiatr Epidemiol 2018;53:221–38.
10. Batinic B, Lemonis E, Opacic G. Effects of ınternalized stigma of mental disorder on quality of life and self-esteem in panic disorder patients. J Clinic Res Bioeth 2014;5:5.
11. Kamışlı S, Dil S, Daştan L, Eni N. Özgürlük duygusu ve içselleştirilmiş damgalanma: ayaktan ve yatarak psikiyatrik tedavi alan hastaların karşılaştırılması. Türk Psikiyatri Derg 2016;27:251–6.
12. Tanabe Y, Hayashi K, Ideno Y. The Internalized Stigma of Mental Illness (ISMI) scale: validation of the Japanese version. BMC Psychiatry 2016;16:116.
13. Ersoy MA, Varan A. Ruhsal hastalıklarda içselleştirilmiş damgalanma ölçeği Türkçe formunun güvenirlik ve geçerlilik çalışması. Türk Psikiyatri Derg 2007;18:163–71.
14. Demir A. UCLA yalnızlık Ölçeğinin Geçerlik ve Güvenirliği. Psi-

koloji Derg 1989;7:14–8.
15. Overton SL, Medina SL. The Stigma of Mental Illness. Journal of Counseling & Development 2008;86:143–51.
16. Arabacı BL, Başoğul C, Büyükbayram A. Adli Psikiyatri Hastalarının İçselleştirilmiş Damgalanma ve Sosyal İşlevsellik Düzeyleri. Anadolu Psikiyatri Derg 2015;16:113–21.
17. Yanos PT, Roe D, Lysaker PH. Narrative enhancement and cognitive therapy: a new group-based treatment for internalized stigma among persons with severe mental illness. Int J Group Psychother 2011;61:577–95.
18. Kök H, Demir S. Şizofreni ve bipolar bozukluğu olan hastalarda içselleştirilmiş damgalanma, benlik saygısı ve algılanan sosyal destek. Çukurova Medikal Derg 2018;43:99–106.
19. Kim WJ, Song YJ, Ryu HS, Ryu V, Kim JM, Ha RY, Lee SJ, Namkoong K, Ha K, Cho HS. Internalized stigma and its psychosocial correlates in Korean patients with serious mental illness. Psychiatry Res 2015;225:433–9.
20. Lee S, Lee MT, Chiu MY, Kleinman A. Experience of social stigma by people with schizophrenia in Hong Kong. Br J Psychiatry 2005;186:153–7.
21. Beyazyüz M, Beyazyüz E, Albayrak Y, Baykal S, Göka E. Bir Eğitim Araştırma Hastanesi Psikiyatri Polikliniğine Başvuran Hastalarda İçselleştirilmiş Damgalanma Düzeylerinin Bazı Tanı Grupları, Sosyodemografik Özellikler ve Benlik Saygısı ile Ilişkisi. Yeni Symposium 2015;53:2–12.
22. Picco L, Abdin E, Chong SA, Pang S, Vaingankar JA, Sagayadevan V, et al. Beliefs About Help Seeking for Mental Disorders: Findings From a Mental Health Literacy Study in Singapore. Psychiatr Serv 2016;67:1246–53.
23. Podogrodzka-Niell M, Tyszkowska M. Stigmatization on the way to recovery in mental illness - the factors associated with social functioning. Psychiatr Pol 2014;48:1201-11.
24. Verhaeghe M, Bracke P, Bruynooghe K. Stigmatization and self-esteem of persons in recovery from mental illness: the role of peer support. Int J Soc Psychiatry 2008;54:206–18.
25. Tel H, Ertekin-Pınar Ş. Ayaktan Izlenen Psikiyatri Hastalarında Içselleştirilmiş Damgalama ve Benlik Saygısı. J Psychiatric Nurs 2012;3:61–6.
26. Üstündağ MF, Kesebir S. İki uçlu bozuklukta içselleştirilmiş damgalanma: Klinik özellikler, yaşam kalitesi ve tedaviye uyum ile ilişkisi. Türk Psikiyatri Derg 20132;24:231–39.
27. Alkan S. Hastanede yatan bireylerde yalnızlık. [Yayınlanmamış yüksek lisans tezi] Sivas: Cumhuriyet Üniversitesi Fen Bilimleri Enstitüsü; 1996.
28. Yıldırım T. Şizofreni hastalarında içselleştirilmiş damgalanma ile yalnızlık arasındaki ilişki. [Yayınlanmamış yüksek lisans tezi] Malatya: İnönü Üniversitesi sağlık Bilimleri Enstitüsü; 2018.
29. Sevil U, Ertem G, Kavlak O, Coban A. The loneliness level of patients with gynecological cancer. Int J Gynecol Cancer 2006;16:472–7.
30. Friedman G, Florian V, Zernitsky-Shurka E. Theexperience of loneliness among young adult cancer patients. Journal of Psychosocial Oncology 1989;7:1–15.
31. Fukui S, Koike M, Ooba A, Uchitomi Y. The effect of a psychosocial group intervention on loneliness and social support for Japanese women with primary breast cancer. Oncol Nurs Forum 2003;30:823–30.
32. Deckx L, Daniels L, Nelissen K, Van Abbema D, Stinissen P, Bulens P, et al. Quality of life and loneliness in older cancer patients. Preliminary results of KLIMOP, a cohort study on the wellbeing of older cancer patients in Belgium and the Netherlands. European Journal of General Practice 2013;19:41.