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Relation between Self-Stigma Andrecoveryattitude in Schizophrenic Patients.

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Abstract
Background: *Peoplewith schizophrenia have a major obstacle to recovery. It is still morecomplex to manage self stigma than dealing with public stigma, whichgreatly deteriorate self-concept andreduce the likelihood of a good prognosisfor recovery.* ***Aim of study:****to assess therelation between self-stigma and recovery attitude in schizophrenic patient.****Subjects andMethods:****The present study followed a correlation descriptive research design.****Subjects:-*** *A convenient sample of 160 patients with schizophrenia.* ***Tools:*** *The data of this study was collected using the following tools:****Tool I: - Socio-demographic and clinical data sheet.Tool II: The Internalized Stigma of Mental Illness Scale (ISMI) Self-stigma,*** *The ISMI-10 has strong psychometric properties and is a practical, reliable, and valid alternative to the original ISMI-29.****Tool II: Recovery Assessment Scale:*** *Recovery was measured by the 24-item Recovery Assessment Scale, this instrument has good psychometric properties and has good internal consistency.* ***Results:****There was significant negative statistical correlation between internalized stigmawith recovery attitude. In addition, the study results found that the majority of the participants had high level of internalized stigma and the majority of the participants had negative attitude toward recovery from mental illness. Moreover, age,occupation, education level, duration of illness and number of hospital admissions had significant statistical difference with internalized stigma and recovery attitude.****Conclusion and recommendation:****Internalized stigma is related negatively to the recovery. It is essential to tailor internalized stigma reduction interventionsand evaluate the effectiveness of anti-stigma interventionon recovery inthe routine care of schizophrenic patients.*

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I. Introduction

Schizophrenia is one of the main mental disorders that can lead to cognitive disturbances (inability to pay attention, reason, solve problems, learn, etc.) and perceptual and behavioral disturbances with positive symptoms (thoughts and behaviors disorders etc.) and negative symptoms.[(1)] Schizophrenia develops at a young age and is more often in men than women, and more than 21 million people in the world suffering from it. Schizophrenia, a severe mental disorder affecting approximately1% of the population worldwide, isa lifelong illness with little hope of recovery.[(2)] It is a fact that with early diagnosisandregular treatment, 25% of schizophrenic patients show high recoverylevels, and 50% show moderate recoverylevels and maintain independent and socially supported life.[(3,4')]

Stigma is universal and has no boundaries. Stigma towards those with a mental illness is a widespread and evident across all cultures and societies. The World Health Organization definitionof stigma as 'a mark of shame, disgrace, or disapproval that results in being rejected, discriminated against, and excluded from different areas of society' (WHO, 2001).[(5)] It involves labeling, stereotyping, separation, and discrimination.[(6)] Researchers have attempted to conceptualize stigma and why stigma occurs and how it affects on people . ***Corrigan and Watson (2002b)*** [(7)] distinguished between public stigma, the negative stereotypes and discriminatory behaviors held by the public, and self-stigma, the internalization of negative stereotypes, beliefs and discriminatory behaviors'. A recent conceptualization focused in particular on the personal impacts of stigma. ***Brohan et al. (2010)***[(8)]define internalized stigma, which is the sum of negative cognitive, behavioral and

emotional consequences coming from experienced and perceived stigma. These consequences include low self-esteem, self shame, depression, hopelessness, and poor personal recovery. [9, 10]

Internalized stigma is a term used to define the negative thoughts and emotions that people have about them as a consequence of mental illness. ***Corrigan et al. (2009)*** [11] suggest that this occurs when people who are conscious of negative stereotypes about mental illness adopt these devaluing and discriminatory attitudes and use them in self-evaluation. This typically leads to feelings of inferiority, guilt, shame, a desire for secrecy and demoralization that reduces self-esteem, and hinders recovery. On the other hand, it has been suggested that symptoms may be exacerbated by stigma. Studies have shown that internalizing stigma negatively impacts on self-esteem which is known to be related to recovery. [12,13]

Recovery has become an important aspect of mental health care services all over the world. Recovery-oriented practices especially for schizophrenia, which has traditionally been as a condition with an unfavorable outcome. Since recently in the 20th-century care organizations have challenged the assumption that schizophrenic patients can live a productive and satisfying life. Emphasizing that recovery can occur even when psychotic symptoms are persistent. [14] The clinical definition of recovery includes remission of symptomsand functional improvement. The Remission inSchizophrenia defined as improvements in core symptoms to theextent that they are low intensity that they nolonger interfere significantly with behavior. [15]

The patient-based definition of recovery has been developed based on narratives of individuals experiencing mental illness. People with psychosis have the possibility of living a productive and satisfying life, despite persistent symptoms. The most frequently patient-based definitions: "the development of new meaning in one's life, as one grows beyond the catastrophic impacts of mental illness." Recovery from schizophrenia is not a unique process but differamong persons. The personal recovery has been widely used to describe the patient-based definition of recovery. There are similar categories of personal recovery aspects such as connectedness, hope, identity, meaning, and empowerment (also known by the acronym "CHIME"). [16, 17]

Yanos and colleagues (2008)[18] derived a study relating to the impact of internalized stigma on recovery-related outcomes for mentally ill people. They found internalized stigma reduced sense of hope and self-esteem which in turn resulted in negative consequences related to recovery. The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a concise statement of mental health recovery, defined as a journey of reaching one's potential through healing while living a meaningful life in his or her society despite a mental health disability. [19, 20] A growingempirical research studies has examininginternalized stigma and its deleterious impacts on schizophrenic patients. Most of these studieshave found that internalized stigma is correlated with negative outcomes, such as decreasedself-esteem [21, 22], hopelessness and qualityof life, poor socially supported network and social interaction, a reluctance to seek treatment services, poor treatment adherence, impairedsocial skills, and more severe psychotic symptoms. Therefore, it is reasonableto suggest that internalized stigma is one of the biggestobstacles to recovery from severe mental illness (e.g.,Schizophrenia).[23, 24]

For the development of effective clinical interventions, and to improve the course of illness, a full understanding of the mechanisms of self-stigma functions as considered a crucial barrier to recovery. The present study aimed to investigates self-stigma and the recovery attitude in a sample of patients diagnosed with schizophrenia.***Therefore, this study examined the relation of self-stigma and recovery attitude in patients with schizophrenia.***

The study aim:

To examine the relation between self-stigma and recovery attitudein schizophrenic patient.

Research questions:

Is there a relation between self-stigma and recovery attitude in schizophrenic patient.

Subjects and Method

Research design

The present study followed a correlation descriptive research design.

Subjects:-

A convenient sample of 160 patients with schizophrenia will be calculated according to the (Epi- Info software).

Inclusion criteria:-

- Aged from 18 years and above.
- Both sexes.
- Having a diagnosis of schizophrenia based on DSM5 Criteria (with a duration of illness ≥ 2 years.
- Having insight into his/her mental illness.
- Being in remission (as defined by the termination of the patient's treatment in the hospital, and the absence of signs of active periods of schizophrenia.
- Having no education and/or language barrier to prevent the psychiatric interview.

Exclusion criteria:-

- Patients diagnosed with mental retardation, or substance use disorder or other co-morbid psychiatric disorder.
- Patients with physical disability.

Setting

The study was carried out at two settings:

- The psychiatric outpatient clinic of Tanta University Hospital. This hospital is affiliated to Tanta University.

Tools

The data of this study was collected using the following tools:

Tool I: - Socio-demographic and clinical data sheet.

It was developed by the researcher to elicit socio-demographic data about patients as "age, sex, marital status, level of education, occupation, place of residence, co-habitation and income", as well as patient clinical data as "age at disease onset, duration of the illness, and number of previous psychiatric hospitalizations".

Tool II: The Internalized Stigma of Mental Illness Scale (ISMI) Self-stigma, or internalized stigma, was measured with the 'Internalized Stigma of Mental Illness Scale'.

The ISMI-10 has strong psychometric properties and is a practical, reliable, and valid alternative to the original ISMI-29.[25] Respondents rate on a four-point Likert scale whether they strongly disagree(1),disagree(2),agree(3),or strongly agree(4)with the given first person statements. Although the ISMI-10 covers all five dimensions of internalizedStigma measured by the ISMI-29, it was not our intention to create five two-item subscales. Thus, it was recommended using the total ISMI-10 score rather than dividing it into subscales. The ISMI has shown a good internal consistency; the ISMI-10 had an alpha of 0.75 (Cronbach's α0.75).

Interpretation of Scores

Scoring Key

The ISMI-10 contains 10 items which produce a total score. Reverse-code items 2 and 9 before calculating the total score. Add the item scores together and then divide by the total number of answered items. The resulting score should range from 1-4. For example, if someone answers 8 of the 10 items, the total score is produced by adding together the 8 answered items and dividing by 8.

4-category method (following the method used by Lysaker et al., 2007):

1.00-2.00: minimal to no internalized stigma
2.01-2.50: mild internalized stigma
2.51-3.00: moderate internalized stigma
3.01-4.00: severe internalized stigma

2-category method(following the methodused by Ritsher [Boyd] & Phelan, 2004).
1.00-2.50: does not report high internalized stigma
2.51-4.00: reports high internalized stigma

Tool II: Recovery Assessment Scale:

- Recovery was measured by the 24-item Recovery Assessment Scale [26,27], covering five dimensions of recovery: personal confidence and hope (e.g. "I am hopeful about my future"), willingness to ask for help (e.g. "I ask for help when I need it"), goal and success orientation (e.g. "I have goals in life that I want to reach"), reliance to others (e.g. "I have people I can count on") and no domination by symptoms (e.g. "My symptoms interfere less and less with my life"). Total mean scores from 1 to 5 were calculated. Higher scores indicated a more positive attitude toward recovery.

- This instrument has good psychometric properties and has been translated into many different languages. According to a recent review of quantitative studies using the RAS, this measure continues to have good internal consistency. The RAS is negatively corrected with public and self-stigma in individuals with mental illness in previous studies and has been identified as a barrier to recovery. Cronbach's alpha is 0.93.

II. Methods

Official permission to conduct the study was obtained from Tanta University hospital. Approval fromethical committee in facultyof nursingto conductthe study. Throughout the study process the following ethical points were considered: Participation in the study was voluntary and informed consent was obtained from the studied care giver to participate in the study. Explanationthe purpose of thestudyand emphasizingthe right to withdraw at any point during the study. Assuring studied caregiver about their privacy and confidentiality of the obtained data. Orienting the participantsabout date, timeandplaceofdata collection. Orienting the participants that collected data will be used only for the purpose of scientific research.

Actual study

A written consent was obtained from each selected caregiver according to their willingness for participation in the study after explaining the aim of the study, establishing rapport and trusting relationship with each participant. The form of the study tools was distributed and explained to patients (n = 160) and they were reassured that all information will be confidential and used only for the purpose of the study and they were individually interviewed for keeping their privacy.

Tools of the study were implemented by the researcher using the interview questionnaire sheet to determine relation between internalized stigma and recovery attitude. Each interview was implemented on an individual basis and lasted for about 40-50 minutes according to participants' attention and willing to cooperate or talk with the researcher. Data were collected over a period of about seven months.

Statistical analysis:

The collected data were organized, tabulated and statistically analyzed using SPSS software (Statistical Package for the Social Sciences, version 19, SPSS Inc. Chicago, IL, USA). For quantitative data, the range, mean and standard deviation were calculated. For qualitative data, which describe a categorical set of data by frequency, percentage or proportion of each category, comparison between two groups and more was done using Chi-square test ($\chi 2$). For comparison between means of two groupsof parametric data of independent samples, student t-test was used. For comparison between more than two means of parametric data, F value of ANOVA test was calculated. Correlation between variables was evaluated using Pearson's correlation coefficient (r). Significance was adopted at $p<0.05$ for interpretation of results of tests of significance.

Table (1): Basic characteristics of the studied patients from outpatient clinic in Tanta University Hospital (n=160).

	N	%
Age		
<20	48	30.0
20-40	56	35.0
40-60	48	30.0
>60	8	5.0
Gender		
Male	88	55.0
Female	72	45.0
Marital status		
Married	88	55.0
Unmarried	72	45.0
Occupation status		
Employed	32	20.0
Unemployed	128	80.0
Level of Education		
Illiterate	8	5.0
Read and write	24	15.0
Secondary	120	75.0
University and higher	8	5.0
Family income		
Enough and saving	48	30.0
Just enough	104	65.0
Not enough	8	5.0

Table (1): shows basic characteristics of the studied patients from outpatient clinic in Tanta University Hospital. It was observed that the highest frequency of them were (35.0 %) aged more than 20-40 years and 80% of them were unemployed. Majority (75.0%) of them were secondary education. Three quarters of study participants (75%) were rural residents. The majority of study participants were married (55%) and the majority of them declared to have enough income (65%). Also, it was observed that nearly all the studied patients (85%) were living in cohesive families and the majority (60%) of them had duration of illness less than five years and frequency of hospitalization(60%),less than three times in year.

	N	%
Living arrangement		
With family	136	85.0
Dorm/mess	24	15.0
History of cigarette smoking (current or ex-smoker)		
Yes	48	30.0
No	112	70.0
family history of drug addiction		
Yes	40	25.0
No	120	75.0
Residence		
Rural	80	50.0
Urban	80	50.0
History of Other Psychiatric Illness		
Present	48	30.0
Absent	112	70.0
Family History of Other Psychiatric Illness		
Present	40	25.0
Absent	120	75.0
Frequency of hospitalization		
Less than three times	96	60.0
Three times and more	64	40.0
duration of illness		
Less than 5 years	96	60.0

5 years and more	64	40.0
Drug adherence		
Regular	88	55.0
Irregular	72	45.0
Insight with mental illness		
Yes	80	50.0
Weak	64	40.0
No	16	10.0
Age at the onset of the disease		
18-30.	72	45.0
30-40.	80	50.0
More than 50	8	5.0

Table (2) Score of self stigma among the studied patient from outpatient clinic in Tanta University Hospital(n=160).

	ISM.10	
	N	**%**
Mild	24	15.0%
Moderate	96	60.0%
Severe	40	25.0%
Total	160	100.0%
Range	17-32	
Mean+SD	23.55±4.795	

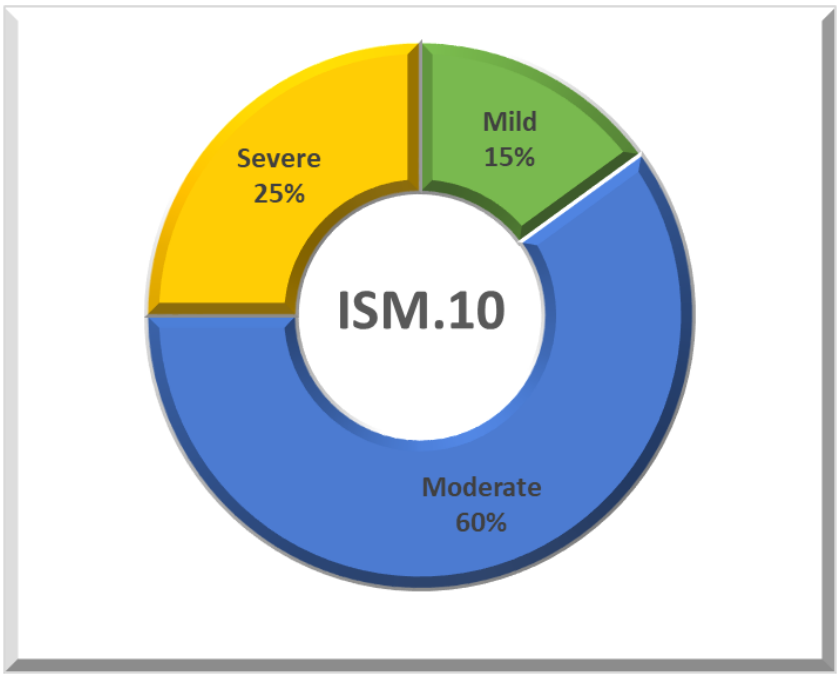

Table (2): shows scores of stigma rating Scale among the studied patients.

Regarding the total stigma Rating ScaleScore, it was found the majority (60%) of studied patients reported moderate stigma mean score of (23.55±4.795), 25% of them reported severe stigma and 15% of them had mild stigma.

Table (3): scoresof recovery attituderatingScaleamongthe studied patients from outpatient clinic in Tanta UniversityHospital.

RAS	Negative		Positive		Score	
	N	%	N	%	Range	Mean±SD
Self confidence	88	55.0%	72	45.0%	6-24.	13.2±4.482
Goal, success orientation and hope	88	55.0%	72	45.0%	3-14.	8.05±2.523
Help seeking behavior	80	50.0%	80	50.0%	14-42.	25.25±7.177
Control on symptoms	96	60.0%	64	40.0%	4-20.	10.9±4.348
Dependence on others	144	90.0%	16	10.0%	5-11.	9.05±1.435
Total RAS	88	55.0%	72	45.0%	44-108.	66.45±16.5912

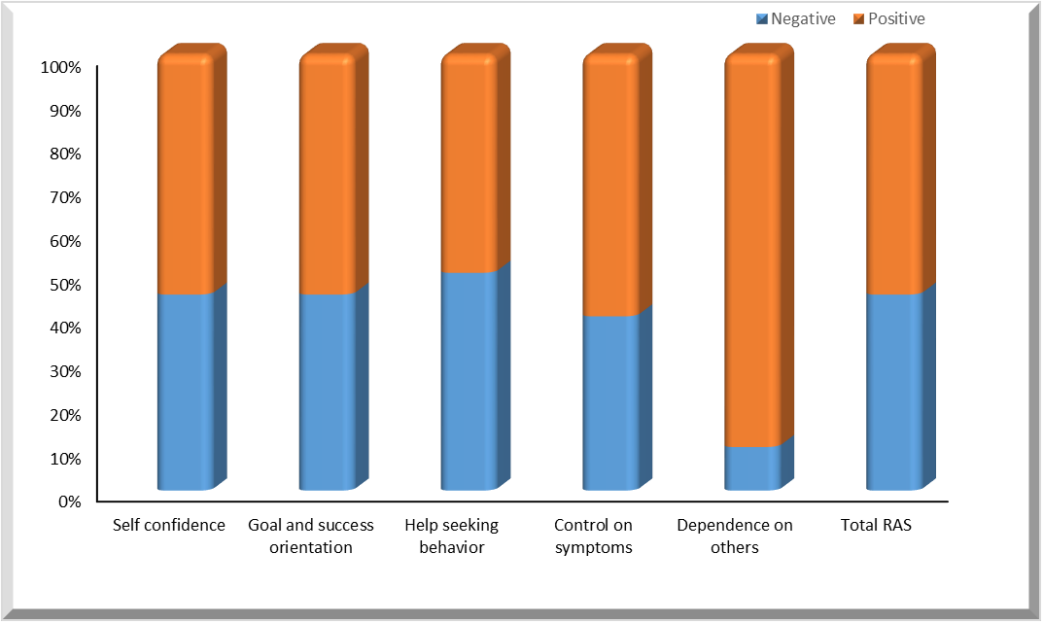

Table (3): Shows scores of recovery attitude rating Scale among the studied patients from outpatient clinic in Tanta University Hospital. Regarding the total recovery attitude rating ScaleScore, it was found the majority of studied patients reported negative attitudemean score of (66.45±16.5912) with first rank for Help seeking behavior followed by Self confidence and goal and success orientation and hope respectively.

Table (4): the relation betweentotal stigma rating Scale score and socio-demographic of study group (n=160)

Demographic data		N	ISMI-10	F or T	ANOVA or T-test	
			Mean ± SD		test value	P-value
Age	**<20**	56	23.143 ± 4.897	F	9.053	<0.001*
	20-40	48	26.167 ± 5.486			
	40-60	48	21.500 ± 2.843			
	>60	8	23.000 ± 0.000			
Gender	**Male**	88	23.455 ± 4.008	T	-0.278	0.782
	Female	72	23.667 ± 5.637			
marital status	**Married**	88	22.636 ± 4.876	T	-2.718	0.007*
	Unmarried	72	24.667 ± 4.478			
Occupation status	**Employed**	32	20.500 ± 3.968	T	-4.231	<0.001*
	Unemployed	128	24.313 ± 4.692			
Level of Education	**Illiterate**	8	23.000 ± 0.000	F	8.657	<0.001*
	Read and write	24	20.000 ± 0.000			
	Secondary	8	20.000 ± 5.132			

	University and higher	120	24.583 ± 0.000			
Family income	**Enough and saving**	48	27.167 ± 3.844	T	25.849	<0.001*
	Just enough	104	21.923 ± 4.467			
	Not enough	8	23.000 ± 0.000			
Living arrangement	**With family**	136	23.294 ± 4.841	T	-1.746	0.090
	Dorm/mess	24	25.000 ± 4.334			
History of cigarette smoking (current or ex-smoker)	**Yes**	48	21.833 ± 3.423	T	-3.549	<0.001*
	No	112	24.286 ± 5.114			
family history of drug addiction	**Yes**	40	20.400 ± 1.516	T	-8.081	<0.001*
	No	120	24.600 ± 5.052			
Residence	**Rural**	80	24.500 ± 4.682		2.549	0.012*
	Urban	80	22.600 ± 4.746			
History of Other Psychiatric Illness	**Present**	48	20.167 ± 1.478	T	-9.334	<0.001*
	Absent	112	25.000 ± 4.994			
Family History of Other Psychiatric Illness	**Present**	40	24.200 ± 5.060	T	0.954	0.343
	Absent	120	23.333 ± 4.705			
Frequency of hospitalization	**Less than three times**	96	24.667 ± 5.542	T	4.263	<0.001*
	Three times and more	64	21.875 ± 2.640			
duration of illness	**Less than 5 years**	96	23.250 ± 4.944	T	-0.985	0.326
	5 years and more	64	24.000 ± 4.563			
Drug adherence	**Regular**	88	21.636 ± 3.543	T	-6.204	<0.001*
	Irregular	72	25.889 ± 5.101			
Insight with mental illness	**Yes**	80	24.700 ± 5.268	F	7.707	<0.001*
	Weak	64	23.000 ± 4.246			
	No	16	20.000 ± 0.000			
Age at the onset of the disease	**18-30.**	72	25.333 ± 5.433	F	11.154	<0.001*
	30-40.	80	22.300 ± 3.740			
	More than 50	8	20.000 ± 0.000			

Table (4): the relation between total self stigmaratingscore and socio-demographic of study group, it was found that there is a significant relation between total self stigmarating Scoreand age group (20-40) , unmarried patients , unemployment, secondary educational level,low income, living alone and age of disease onset between 18-30 ($p<0.05$).

Table (5): The relation between total recovery attitude rating Scale score and socio-demographic of study group (n=160).

Demographic data		**N**	Total RAS	**F or T**	**ANOVA or T-test**	
			Mean ± SD		**test value**	**P-value**
Age	**<20**	48	60.500 ± 12.820	F	8.139	<0.001*
	20-40	56	74.571 ± 23.006			
	40-60	48	63.667 ± 4.274			
	>60	8	62.000 ± 0.000			
Gender	**Male**	88	65.636 ± 16.371	T	-0.685	0.495
	Female	72	67.444 ± 16.918			
marital status	**Married**	88	61.636 ± 6.189	T	-4.272	<0.001*
	Unmarried	72	72.333 ± 22.488			
Occupation status	**Employed**	32	59.500 ± 6.834	T	-2.701	0.008*
	Unemployed	128	68.188 ± 17.833			
Level of Education	**Illiterate**	8	62.000 ± 0.000	F	1.987	0.118
	Read and write	24	65.667 ± 5.297			

	Secondary	120	67.733 ± 18.677			
	University and higher	8	54.000 ± 0.000			
Family income	**Enough and saving**	48	83.333 ± 18.912	T	63.740	<0.001*
	Just enough	104	59.000 ± 8.444			
	Not enough	8	62.000 ± 0.000			
Living arrangement	**With family**	136	67.353 ± 17.719	T	3.228	0.002*
	Dorm/mess	24	61.333 ± 5.297			
History of cigarette smoking (current or ex-smoker)	**Yes**	48	58.333 ± 8.388	T	-5.555	<0.001*
	No	112	69.929 ± 17.995			
family history of drug addiction	**Yes**	40	62.200 ± 2.963	T	-3.171	0.002*
	No	120	67.867 ± 18.890			
Residence	**Rural**	80	73.200 ± 20.568		5.619	<0.001*
	Urban	80	59.700 ± 6.220			
History of Other Psychiatric Illness	**Present**	48	58.833 ± 3.270	T	-5.916	<0.001*
	Absent	112	69.714 ± 18.813			
Family History of Other Psychiatric Illness	**Present**	40	77.200 ± 17.192	T	4.722	<0.001*
	Absent	120	62.867 ± 14.803			
Frequency of hospitalization	**Less than three times**	96	65.083 ± 16.763	T	-1.287	0.200
	Three times and more	64	68.500 ± 16.244			
duration of illness	**Less than 5 years**	96	59.500 ± 9.664	T	-6.686	<0.001*
	5 years and more	64	76.875 ± 19.232			
Drug adherence	**Regular**	88	61.909 ± 9.341	T	-4.004	<0.001*
	Irregular	72	72.000 ± 21.278			
Insight with mental illness	**Yes**	80	72.100 ± 21.444	F	10.437	<0.001*
	Weak	64	60.500 ± 6.047			
	No	16	62.000 ± 0.000			
Age at the onset of the disease	**18-30.**	72	72.000 ± 22.667	F	10.388	<0.001*
	30-40.	80	60.800 ± 5.244			
	More than 50	8	73.000 ± 0.000			

Table (5): Shows the relation between total recovery attituderating Scalescore and socio-demographic of study group, it was found a significant relation between totalrecovery attitude scores and the same variables of study group, it was found that there is a significant relation between total recovery attitude scores and age group (highest mean score of recovery attitude among 20-40) , unmarried, unemployment(unemployed patients were hadhighest recovery attitude mean score) , secondary educational level,high income (highest mean score recovery attitude among high income), living with family and age of disease onset between 30-40 years old ($p<0.05$).

Table (6) Relationship between participants' internalized stigma and recovery attitude toward mental illness (n=160).

	ISM.10	
	r	**P-value**
Self confidence	-0.566	<0.001*
Goal and success orientation	-0.342	<0.001*
Help seeking behavior	-0.111	0.160
Control on symptoms	-0.698	<0.001*
Dependence on others	-0.040	0.617
Total RAS	-0.440	<0.001*

Table (6): shows correlation between self stigmatotal score andrecovery attitude score (domains and total scores)among the studiedoutpatient clinic in Tanta university hospital. There was negative significant correlation between self stigma total score andrecovery attitude score (domains and total scores) (r=0.440).

Regarding correlation between self stigmatotal scores and recovery attitude subscales scores; a significant negative correlation between self stigma total scoreand recovery attitude subscales scores namely self confidence, Goal and success orientation and Control on symptoms (-r=-0.566 and -0.342 and -0.698 respectively) and $p<0.001$*. On the other hand, no significant correlation between total self stigma score and help seeking behavior and dependence on others (r= -0.111and -0.040 respectively.

III. Discussion

Internalizationof stigma affects the life of the person in an adverse way,as well as it affects indirectly a great number of related variables. Among those consequences we find that internalized stigma contains adeterioration of interpersonal relationships, quality of life, and a decrease of the attainment ofvital goals. Additionally,internalized stigma would also entailan increase of symptoms severity, a decrease oflikelihood of recovery.[28]

Theprimaryaimofthestudywastoexamine the relation between internalized stigma and recovery attitude. It was found internalized stigma had negative effect on recovery attitude.This come in agreement with previousresearch that has suggestedthat these findings throughanumberofpathways, for example decreased help-seeking, reducedsocialfunctioning and engagementand reducedlifeopportunities. However, whilst it is clearthat internalized stigma influences anumberofaspects ofrecovery' [29 , 30] Another recent study on self-stigma's effect on recovery in patients with mental illnessover 2 years, controlling for age, gender, symptoms andrecovery at baseline measured by the Recovery AssessmentScale. Increased self-stigma was associated with asignificant decrease in recovery after 1 year. Interventionsthat reduce self-stigma could therefore improverecovery.[31]

In the same line, previous cross-sectional studies found self-stigma to be negatively associated with recovery. Self-stigma was also associated with recovery-related variables, such as low self-esteem, hopelessness and increased psychiatric symptoms. One longitudinal research found baseline stigma levels to predict recovery. By interventions, self-stigma could be addressed to fosterrecovery.Also, this come in agreement with cross-sectional study was to determine the internalized stigma effect on recovery in with schizophrenic patients.From the findings, it was found that the level of internalized stigma was high and the level ofrecovery was low with schizophrenicpatients.[32,33]

Regarding stigma level, it was found the majority of schizophrenic patients experienced highly moderate level of self stigma. This study supports previous studies that a relatively high percentage of peoplewith severe mental illness has internalized stigma. Thus, regardless of the used approach, elevated internalized stigma appears to be aclinical issue that affects a great number of persons with severe mental illness. This duetowhenpatients diagnosed with psychiatric illness, they intentionally or unintentionallysee themselves as inadequate and excluded when labeled bysociety with stigma. Additionally,patients isolatingthemselves from community withnegativeemotionssuchasworthlessness andguilt. Asa conclusion, internalized stigma result inlowself-esteem,shame,isolation,and self-exclusion. In a study Yılmaz and Okanlı[23]conducted onschizophrenic patients, internalized stigma was high in patients. Similarly, in a study Assefa et al.[34] onschizophrenic patients, it was found that internalized stigma was highin the patients.

Regarding the total recovery attitude Score, it was found the majority of studied patients reported negative attitude Score with first rank for Help seeking behavior followed by Self confidence and goal and success orientation and hope respectively. Regarding relation between self stigma and self-confidence andhope subscales, it was found negative correlation between them and the difference was significant. Self- confidence andhopelessness were found to playthemediating significant role in recovery process;theywouldhaveto influence the symptoms. This in agreement with study stated that lowself-esteemhasbeenidentified asa risk factorfor developing psychosis.[35] A recentreview explored that hopelessnessasamajorbarriertorecovery. Hence, that onepathwaythroughwhichstigmamightaffectbothobjectiveandsubjective recovery outcomes wouldbethroughself-esteemand hopelessness.[36, 37]

Regarding the relation betweentotal recovery attitudescore and socio-demographic of study group, it was found a significant relation between totalrecovery attitude scores and the same variables of study group, it was found that there is a significant relation between total recovery attitude scores and age group (highest mean score of recovery attitude among middle age of 20-40) , unmarried, unemployment, andhigh income (highest mean score recovery attitude among high income), living with family and age of disease onset between 30-40 years old ($p<0.05$). In the same line, Erol et al[38]found that the level of recovery is higher for the

employed patients than for the unemployed. Unemployed patients' negative symptoms and functioning were worse in comparison to the employed. This due to the employed schizophrenic patients had higher functionalities compared to the unemployed patients, thereby increasing his or her level of functionality and social skills which in turn increasing like hood of recovery.

In relation to total self stigmarating scalescore and socio-demographic of study group, it was found that there is a significant relation between total self stigmascore and age group (20-40) , unmarried patients , unemployment, secondary educational level,low incomeand age of disease onset between 18-30 ($p<0.05$).Similarly, another study foundthat individuals in the middleage (35–54 years) had higher mean scale scores than younger and older patients. It is possible that individuals in midlife are more likely to be affected byinternalized stigma as they consider their personal aspirations, and barriers that may existtoward achieving them; while both younger and older individuals may be less concernedwith these issues. [(39)] However, another study found that a negative significant correlationbetween internalized stigma and age; the stigma decreasedwith increasing age. An explanation for this is that as patients' ageincreased, patients were less exposed to stigma because they weremore accustomed to societal attitudes and started to have a more isolatedlife by withdrawing from society. [(40)]

In the current study, it was found that the difference between thepatients' perception of their income level is enough and that of the recovery wasstatistically significant. This result comes in agreement with previous study that found that recovery was foundto be high in patients who had a good income level. Itcan be said that patients who feel well from a material point of vieware able to participate more easily in their social environment and enabling them to continue their daily life activitiesand increase their level of recovery.[(41)]

In relation to their educational levels, a statistically significantdifference was found between the educational level and recovery total mean score. As the educational levels increased, the recovery levels increased. In line with this, Xiang et al. in theirstudy on schizophrenic patients found that as the educational statusof the patients increased, their negative symptoms were seen less andtheir functional recovery were higher. [(42, 43)] Whenthe ISMIS total mean scoreswas compared with the educational level of patients, a statisticallysignificant difference was found between educational level andthe ISMIS total mean scores. This in line with previous study that found high stigma level as educational levels increased. This is understandable,as the increased education levels allowed the patients toresearch more about the cause, course, and treatment of the illnessand find a lot of information about the illness. This increased knowledgecould lead to increased stigma.[(44)]

Regarding employment status, it was found that working individuals feltmore stigmatized than those who did not work. The fact that workingschizophrenic patients interact more with society, and that society is exposed to them more stigmatized wordsand behaviors. Regarding income level,, the difference between the internalized stigma and income levelwas statistically significant. The level of stigmatization was found to be lower in those who see their income level as good. It can be said that as patients feel better in material terms and the patients are then exposed toless stigma and do not see themselves as a burden on society.

Moreover,thelevel ofthe self-stigmatotalscore wasalso significantly correlated with the age of onset of the disorder.This finding is consistent with the results of Holubova et al[(45)]found that self stigma negatively correlated with the age at the onset of the disorderinoutpatients with schizophrenia spectrum disorders.That explained by early onset of the disorder feel that they are stigmatized more than the individuals with later onset. Early onset of schizophrenia may impair the development of personality and the social roles before learning how to manage these situations. Earlier onset of schizophrenia is also related with low self-esteem.Hence, Recovery and self stigma give different perspectivesregarding the experienceof persons withmental illness, and it are should be taken into consideration in the field of psychiatric nursing care and recovery-oriented practice. The strategies of stigma coping andinterventions could be incorporated inprograms to enhance recovery.

IV. Conclusion

The current study concluded that,there were significant negative statistical correlation between internalized stigma and recovery attitude. In addition, the study results found that more the majority of the participants had moderate level of internalized stigma and the majority of the participants had negative attitude toward recovery from mental illness. The study also revealed that, regarding age, marital status and occupation

had significant statistical difference with internalized stigma and recovery attitude. Moreover education level, duration of illnesshad significant statistical difference with internalized stigma.

V. Recommendations

[1]. Normalizing strategies include providing information about the wide spread prevalence of psychotic experiences and famous people who have been successful despite experiencing psychosiswith the aim of reducing the patient's perception of being different from others.

[2]. Hence, psychiatric services need to consider practical ways of reducing patient'ssocial exclusion, for example by encouraging self-help groups and advisors, and by developing robust anti-stigma policies.

[3]. Illness and stigma psycho education of recovery to break the association between the diagnosis and the threatening image of stereotype, the rejection of cultural stereotypes and discrimination of mental illness.

[4]. Highly recommend interventions aimedat building positive self-concept of schizophrenic patients, reducingself-stigmatizing attitudes and thoughts, and strengthening positiveviews of one´s self.

[5]. Counseling initiatives related to the psychiatry nurse's effective coping interventions with internalized stigma may reduce the negative consequences of internalized stigma. Psychiatric nurses can contribute to the functional improvement of patients by reassembling patients, cooperating with the family and community, encouraging psychiatric patients and giving those responsibilities inthe home environment and community.

[6]. Psychiatric nurses' attitudes toward stigma prevention, along with their attitudes toward mental illness, are most important to bridge all health professionals and the public. For this reason, psychiatric nurses should first assess their own attitudes and evaluate how individuals with mental illness are affected by their attitudes.

[7]. Mass media should play a crucial role in the de-stigmatization of mentally ill patients and mental illness as well.

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