TURKISH VERSION OF PERCEIVED DEVALUATION-DISCRIMINATION SCALE: AN ADAPTATION STUDY

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ABSTRACT

TURKISH VERSION OF
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AN ADAPTATION STUDY

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The purpose of this thesis was to adapt Perceived Devaluation-Discrimination (PDD) scale for Turkish language and culture. With this aim, participants for two different samples were included in the study. The first sample consisted of 145 general community residents and the second sample consisted of 85 individuals with chronic psychiatric disorders. Statistical analyses were carried out to test for psychometric properties of the Turkish version of PDD in general community and clinical samples. In this regard, exploratory and confirmatory factor analyses, internal consistency reliability analysis, convergent and discriminant validity analyses were conducted. As a result of exploratory factor analysis, a two-factor structure for PDD emerged in both the general community and clinical samples. These factors were named as *Perceived Discrimination and Negative Evaluation* and *Perceived Acceptance and Non-negative Evaluation* subscales. The two-factor structure was supported with confirmatory factor analysis with good

model-data fit in the general community sample and acceptable data-model fit in the clinical sample. Cronbach's alpha values for PDD were .76 in the general community sample and .79 in the clinical sample. Alpha values of PDD subscales ranged between .72 and .77 in both samples. While convergent and discriminant validity tests provided partial support for construct validity of PDD in the general community sample, the convergent validity tests conducted with the clinical sample provided strong evidence for validity of PDD. The findings and their implications for future research were discussed.

Keywords: mental illness, stigma, perceived devaluation discrimination, Turkish.

ÖZ

ALGILANAN DEĞERSİZLEŞTİRME-AYRIMCILIK ÖLÇEĞİNİN
TÜRKÇEYE UYARLAMA ÇALIŞMASI

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Bu çalışmanın amacı Algılanan Değersizleştirme-Ayrımcılık (ADA) ölçeğinin Türk dili ve kültürüne adaptasyonunu yapmaktır. Bu amaçla, iki farklı örneklemden katılımcılar çalışmaya dahil edilmiştir. İlk örneklem genel toplumdaki 145 bireyden, ikinci örneklem ise kronik psikiyatrik bozukluğu bulunan 85 bireyden oluşmaktadır. Çalışma kapsamında ADA'nın Türkçe versiyonunun psikometrik özellikleri, genel toplum ve klinik örneklemlerde istatistiksel analizlerle test edilmiştir. Bu bağlamda, keşfedici ve doğrulayıcı faktör analizleri, iç tutarlılık güvenirlik analizi, yankınsak ve ayırd edici geçerliliği analizleri yapılmıştır. Keşfedici faktör analizi sonucunda, hem genel toplum hem de klinik örneklemlerde ADA için iki faktörlü bir yapı ortaya çıkmıştır. Bu faktörler *Algılanan Ayrımcılık ve Olumsuz Değerlendirme* ile *Algılanan Kabul ve Olumsuz Olmayan Değerlendirm*e alt ölçekleri olarak adlandırılmıştır. Söz konusu iki faktörlü yapı doğrulayıcı faktör analizinde de desteklenmiş, genel toplum örnekleminde iyi bir veri-model uyuşması göstermiş, klinik örneklemde de kabul edilebilir bir veri-model

uyuşması ortaya koymuştur. ADA ölçeği için Cronbach alfa değeri genel toplum örnekleminde .76, klinik örneklemde ise .79 olarak bulunmuştur. ADA alt ölçeklerinin alfa değerlerinin ise her iki örneklemde de .72 ile .77 arasında değiştiği gözlemlenmiştir. ADA için yapılan yakınsak ve ayırd edici geçerliliği testlerinin genel toplum örnekleminde kısmi olarak geçerlilik desteği ortaya koyduğu görülmüş, klinik örneklem içinse güçlü yakınsak geçerliliği kanıtları ortaya konmuştur. Bulgular, uygulamalar ve gelecek çalışmalar için çeşitli öneriler tartışılmıştır.

Anahtar Kelimeler: ruhsal hastalık, damgalama, algılanan değersizleştirme ayrımcılık, Türkçe.

To Dudu and my precious family…

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CHAPTER 1

INTRODUCTION

1.1. Definition of Social Stigma

It has been more than fifty-five years since the famous sociologist Erving Goffman (1963) introduced his well-known book on social stigma. In his book, he defined stigma as a “deeply discrediting” attribute which reduces its possessor “from a whole and usual” person to a “tainted, discounted one” (p. 3). His work has been very influential for many scholars; consequently, a variety of definitions for the stigma concept have emerged from different disciplines such as psychology, sociology, anthropology and biology. From the traditional psychological perspective, stigma is "some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context" (Crocker, Major, & Steele, 1998, p. 505). It represents a socially constructed *mark* on individuals which is associated with undesirable dispositions and negative evaluations by others (Jones et al., 1984).

Due to the apparent emphasis on attributes and associations in its definition, an effort was made by some scholars to distinguish stigma from a number of social cognitive concepts. For example, stereotype, which refers to a set of beliefs about people’s characteristics and traits (Baron & Branscombe, 2011), has been compared to social stigma. Corrigan and Penn (1999) argued that stereotypes are not always harmful and they can be efficient ways of organizing social information. According to them, it is not the existence of stereotypes but being prejudiced that leads to discriminative behavior. Therefore, in Corrigan and Penn’s view, stigma refers specifically to *negative stereotyping* that leads to *discrimination*. The nuance to be emphasized here is that while stereotypes can be based on both positive and negative traits (Baron & Branscombe,

2011), stigma always implies a negative meaning (Crocker et al., 1998). In fact, the Ancient Greeks used the word *stigma* to refer to bodily signs of burns and cuts which marked their slaves, criminals, and traitors to communicate their lower moral status (Goffman, 1963).

The difference between the definitions of stigma and prejudice, on the other hand, is not so clear. Phelan, Link and Dovidio (2008) made an extensive analysis to compare the two concepts, reviewing a total of 18 models regarding both stigma and prejudice. Their review has shown that prejudice and stigma are largely overlapping constructs without a clear distinction in their components, however, with a difference of foci. First, while prejudice models try to explain the processes related to perpetrators, stigma models emphasizes the processes of the victims. Secondly, the majority of prejudice articles focus on race-related studies, yet most stigma research is about illness and disability-related topics. Nevertheless, it should be noted that stigma studies do not exclude the topics of race and ethnicity altogether. Indeed, Goffman (1963) groups characteristics such as race, nation and religion under a category of "tribal stigma".

In summary, social stigma is a broad concept with several components. It is socially constructed; therefore its properties are subject to change across time and societies (Link & Phelan, 2001). Also, it has no clear boundaries that separates it from other social cognitive constructs such as prejudice. Most basically, stigma is synonymous with negative stereotyping and prejudice, but it reflects a point of view in studying a social phenomenon. It underlines the perspective of those who suffer from stigmatization. Stigma research includes a broad range of topics such as disability, illness, race and substance abuse, while most research focus on disability and illness (Phelan et al., 2008). The current study focused on social stigma of mental illness.

1.2. Conceptualization of Mental Illness Stigma

There are several models and conceptualizations of social stigma. Below is a brief review of the existing models from different disciplines and perspectives. It should be

noted, however, that because the review focused on models with implications for mental illness stigma it is not an exhaustive review of all stigma models.

1.2.1. Psychological approach to stigma

Three important aspects of stigma were emphasized in the psychology literature. These were the dimensions of stigma (Jones et al., 1984), social cognitive processes in stigma (Corrigan, 2000), and the identity-threat model of stigma (Major and O'Brien 2005).

In their influential paper, Jones and his colleagues (1984) described six dimensions for stigma. These dimensions are peril, concealability, origin, disruptiveness, course and aesthetic qualities. *Peril* is about how much the stigmatizing condition is associated with dangerousness, leading to perceptions of threat by others. C*oncealability*, is the dimension focusing on the degree to which a stigmatizing condition can be hidden from others. The more visible a condition is, the higher stigmatization is expected. Third dimension, *origin*, refers to the attributions of responsibility for the acquisition of stigmatized condition. Attributions to genetic endowment, personal failure, or preferences fall under this dimension. Fourth, *disruptiveness*, is the degree to which the stigmatizing condition undermines interpersonal relations, success, and other social interactions. *Course* is the dimension focusing on how much the stigmatizing condition changes over time. Accordingly, reversibility of the stigmatized condition determines the negativity associated with the stigma. The final dimension, *aesthetics*, focuses on how the stigmatizing condition hinders the attractiveness of a person.

In his book, Hinshaw (2007) discussed the ways in which these dimensions can be applied to mental illness stigma. For instance, on *concealability* dimension, he pointed to the dilemma of whether to disclose or hide psychiatric diagnosis history. Although hiding one's psychiatric condition can save the individual from a potential social rejection in the first place, it might still keep the person constantly anxious and vigilant about the possibility of revelation of his or her condition. Therefore, even if a

stigmatizing condition is not visible, stigma can still be damaging for people with mental illnesses.

Hinshaw (2007) also showed that stigma dimensions can help us better understand the stigmatizing nature of the beliefs about mental illness. For example, the belief that severe mental illnesses are untreatable is closely related with the *course* dimension of stigma. Consequently, while chronicity of mental illness might contribute to stigmatization, the recognition that psychiatric disorders can be treated can help reducing stigma. Another belief, that people with mental illness are unpredictable in social interactions, can be understood in terms of the *disruptiveness* dimension and is likely to be connected with dangerousness beliefs, which is directly related to the *peril* dimension. Finally, when we consider the side effects of some psychiatric drugs on motor movements and physical appearance, *aesthetics* can be a determining dimension of stigma strength to the degree that individuals with mental illness deviate from societal standards of attractiveness.

In addition to stigma dimensions, psychological models were also created to describe stigmatization through social cognitive processes. To understand these models, stigmatization should be viewed in terms of the cognitive, affective, and behavioral terms. Corrigan (2000) integrated these aspects in a model with three distinct components, namely, stereotyping, prejudice, and discrimination. According to Corrigan, signals such as labels, psychiatric symptoms, and skill deficits that are associated with mentally ill people function as *discriminative stimuli* for those who stigmatize mental illness. Occurrence of these signals activate cognitive mediators like stereotypes and prejudices. Finally, these mediators create the basis of discriminative behavior. To explain this process with a simple example, Corrigan (2000) depicted a scene where a person notices someone speaking to himself in a public area. He concludes that the person talking to himself is crazy. This observation (speaking to oneself) and the subsequent labeling (crazy) activate the stereotype that crazy people are dangerous. As a result, the observer decides not to allow this dangerous person move into his

neighborhood and, thus, show discriminative behavior (p. 49). At this point, emotional reactions play an in important role in predicting behavior. If the stigmatizer person experiences fear emotion, then avoidance behavior might follow; however, if the person experiences pity as a result of his or her attributions, then helping behavior can be expected (Corrigan, 2002).

While the above-mentioned example focused solely on the stigmatizer's perspective, Corrigan and Watson (2002) explained that stereotyping, prejudice, and discrimination can be used to understand both stigmatizer and stigmatized people's perspectives. From the stigmatizer's perspective, stereotypes target a group of people as an out-group, creating public stigma. From the perspective of the stigmatized individual, on the other hand, the stereotypes can be directed to the person's very self, which leads to self-stigma. Prejudice and agreement with the negative beliefs about mentally ill people might create reactions of anger and fear among stigmatizer people, which lead them to adopt avoidant behaviors. Self-stigma may result in reactions of low self-esteem and low self-efficacy for the stigmatized, which in turn may lead to failure in pursuing social and economic opportunities.

To increase our understanding of stigmatization from the perspective of the stigmatized people, it is useful to consider the identity-threat models, which constitute another psychological approach to conceptualization of stigma. In 2005, Major and O'Brien integrated the previous identity-threat models of stigma (see Crocker et al., 1989) with Lazarus and Folkman's (1984) stress and coping model. According to Major and O'Brien's (2005) integrated identity-threat model, the degree to which stigma-related stressors are seen as threatening to self-identity by the stigmatized people depends on a number of variables. These variables are the collective representations of devalued social identities, immediate situational cues, and personal characteristics.

Major and O'Brien's (2005) integrated identity-threat model posits that individuals will differ in their understanding of *collective representations* of their stigmatized social identities. Understanding of collective representations include

knowledge on the dominant culture's stereotypes for their stigmatized identity and awareness of being a target of devaluation and discrimination by the others. Understanding of collective representations affects how the stigmatized people perceive the *situational cues* in various social contexts; that is, whether they assign a negative meaning to these cues with attributions of discrimination, devaluation and negative stereotyping. At this point, *personal characteristics* such as stigma sensitivity, group identification, and personal goals and motives affect whether a stigma-related stressor is appraised as threatening to the self or not. If a threatening appraisal is made as exceeding the stigmatized person's resources for coping, the person will form reactions that are both involuntary, such as emotional and physiological stress reactions, and voluntary, such as conscious coping attempts in modifying the threatening situation. These reactions predict various outcomes such as health, academic success, and well-being for stigmatized people.

Public transportation can be a good example to explain the integrated identity-threat model for mental illness stigma. An individual with mental illness who is aware of the negative stereotypes (*collective representations*) of his social identity might feel threatened upon entering an environment of public transportation, where he or she is most likely out-numbered by the non-stigmatized group (*situational cues*). Depending on a number of *personal characteristics* such as how vigilant this individual is for stigma-related threats and how much this person wants to be protected against the stigma threat, he or she will make *identity-threat appraisals* for the situations during transportation. For example, he or she might appraise an empty seat as "Nobody wants to sit near me, they are rejecting me." Such an appraisal will then lead to emotional, physiological and behavioral consequences as stress and various coping reactions.

To summarize, psychological conceptualizations help us understand the factors contributing to stigma by describing stigma dimensions. Also, they describe how the actual stigmatization process take place in daily social interactions by using social cognitive concepts such as stereotypes, prejudice, and discrimination. Finally they

predict possible emotional, physical and behavioral consequences of stigma for people with mental illness. Although, psychological conceptualizations provide in-depth descriptions of cognitive processes, they do not provide a very broad perspective on how various social variables contribute to stigmatization. Therefore, it is important to consider sociological explanations for a more complete picture.

1.2.2. Sociological approach to stigma

Following Erving Goffman, sociological work on stigma continued developing in symbolic interactionist tradition, particularly through the labeling approach in deviance literature. According to the labeling theory, deviant identities are formed not because of deviant behavior or motivations but through a process of labeling (Becker, 1963). Lemert (1972) helped us better understand this process with the concepts of primary and secondary deviance. Primary deviance refers to the initial act of deviant behavior, which is often normalized by others and does not lead to a deviant self-identity. If this initial act is not normalized, however, the actor becomes labeled by the others which, subsequently, leads the actor to form a deviant self-identity conveyed by the label itself. When this deviant identity becomes central to self, newer and repeated transgressions start to be performed by the labeled person. This state constitutes the secondary deviance (Giddens, 2009).

In this line of thought, Scheff (1966) extended the labeling approach to a theory of mental illness. In his work, he claimed that the labeling of initial psychiatric symptoms is the most important cause of the subsequent chronic mental illness. However, this etiological claim has drawn a lot of criticism. These criticisms rejected labeling as an etiological variable for mental illness and linked the deviant identities and the negative reactions of society to the deviant behavior itself (Gove, 1975; Gove, 1982).

While the criticisms on Scheff's etiological claim continued, Bruce Link (1982) extended the debate, focusing on other effects of labeling on mental illness. He suggested that labels can have detrimental consequences for labeled individuals in terms of housing,

mate selection, economic gains, friendship, and family relationships. Based on these claims, Link (1987) made additions to Scheff's original formulation and created the Modified Labeling Theory (MLT) of mental illness (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). According to this theory, people in the society internalize the conceptions of what it means to be a person with mental illness through a socialization process. Numerous variables during the socialization process determine how much a person believes that a mentally ill person will be devalued and discriminated against in the society. When a person develops mental illness and seeks treatment contact, he becomes labeled with an official diagnosis. This makes socially-acquired conceptions of mentally ill person relevant for the individual. At this point, the individual may or may not adopt coping strategies such as keeping his condition hidden from others, social withdrawal, and trying to educate others on the misconceptions about mentally ill people. Nevertheless, based on the degree of perceived devaluation and discrimination, the individual might face negative social and psychological consequences such as lower self-esteem, unemployment, and reduced social network, all of which might make the person more vulnerable to new disorders and maintain the existing disorder (Link et al., 1989).

In order to test the hypotheses of MLT, Link created the Perceived Devaluation-Discrimination (PDD) scale (Link, 1987) and applied this scale to different groups of people with or without psychopathology and psychiatric diagnosis. As a result, Link and other researchers have shown that the labeling associated with official diagnoses leads to many negative outcomes in terms of various sociological and psychological variables for patients such as unemployment (Link, 1987), reduced social networks (Link et al., 1989), deteriorated self-esteem (Wright, Gronfein, & Owens, 2000), depressive symptoms (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997), and decreased quality of life (Rosenfield, 1997).

Later on, Link and Phelan (2001) suggested a sociological conceptualization for stigma with four interconnected components, which are labeling, stereotyping, separating, and status loss and discrimination. A fifth component, *emotional reactions*,

was added later (Link, Yang, Phelan, & Collins, 2004). According to this conceptualization, stigma occurs, in the first place, as the social selection of a salient human difference. The salience of the selected difference and its attributes can change across time and space in societies; however, the human difference that is singled out, such as skin color, becomes labeled at that time and the label is taken for granted in daily interactions. This process is accompanied by the second component, that is, association of negative attributes with the labeled human difference. Here, the social-cognitive mechanisms such as stereotyping operate and create the devalued social identity for stigmatized person. Third component, separating, is where the categories of *us* versus *them* become clear. The separation results in emotional reactions for both the stigmatizer and the stigmatized, which affect the interaction of the two groups. While the stigmatizers can react with anger, irritation, pity and fear; the stigmatized might feel embarrassment, shame, fear, alienation, and anger. The outcome of stigmatization is the final component, that is, a status loss for the stigmatized in the social hierarchy and discrimination on individual and structural levels. The critical point in this model is that, for stigmatization to occur, all of these five components should take place in a power relationship between the stigmatizer and the stigmatized. The stigmatizers always hold the social, cultural, economic and political power.

In summary, the sociological conceptualization of mental illness stigma was initially developed as an extension of the literature regarding deviance. This initial work was based on studying the relationship between stigma and deviant behavior of individuals. Following the criticisms of the etiological inferences of this work, scholars changed their focus in order to understand the meaning of mental illness stigma and the negative effects of it on people with mental illness. Eventually, scholars developed comprehensive conceptualizations including both sociological and psychological knowledge, paying specific attention to the power relationship between the stigmatizers and the stigmatized. Perspectives on stigma conceptualization, however, are not limited to psychological and sociological ones.

1.2.3. Evolutionary approach to stigma

From an evolutionary perspective, Kurzban and Leary (2001) elaborated on a model focusing on the adaptive and functional aspects of stigma, such as operations contributing to reproductive success of human species. They compared a number of ways humans and nonhuman animals such as fish and primates perform social exclusion among their species. They noted three important evolutionary mechanisms in stigmatization process of humans: dyadic cooperation, coalitional exploitation, and parasite avoidance.

In *dyadic cooperation*, humans engage in reciprocal altruism where they share their excess resources with social exchange partners in expectation of a later gain. These resources can include anything from tangible goods to skills, efforts and information (Neuberg & Cottrell, 2008). Unpredictability in terms of likelihood of reciprocation, interaction partner's lack of resources, and exploitation of resources with evidence of cheating form the basis for stigma with a function of social exclusion. The role that unpredictability plays in this model is particularly related to the mental illness stigma in terms of stigmatizers' expectations about dangerousness and untrustworthiness (Kurzban & Leary, 2001).

The second mechanism, *coalitional exploitation* refers to the group level behavior of social exclusion and cooperation for attaining better resources and the means to reach those resources. The tendency is to include those who are highly cooperative as ingroup members, and exploit the others by excluding them as outgroup. The final mechanism, *parasite avoidance*, reflects avoidance from infested members of a group. Kurzban and Leary (2001) reviewed the way parasitic predators such as bacteria, viruses, worms, and insects cause physical and behavioral anomalies such as asymmetry, lesions, and muscle damage. Then they explained the role that aesthetic preferences of humans play in avoiding possible infested members. Although parasite avoidance is thought to be relevant for the stigmatization of physical disability and some mental illnesses (Hinshaw, 2007), the idea has been criticized for lacking evidence (Phelan et al., 2008).

One important point in the evolutionary perspective is that it makes specific predictions for behavioral and emotional reactions of the stigmatizers based on each of the mechanisms described. Those who don't conform to the dyadic reciprocation are expected to generate anger and receive punishment. Targets of coalitional exploitation are expected to be hated, feared, exploited, and dominated. Finally, parasite suspects are expected to face fear, disgust, and avoidance by stigmatizers (Hinshaw, 2007; Kurzban & Leary, 2001).

1.2.4. Anthropological approach to stigma

Yang et al. (2007) introduced an anthropological and ethnographic perspective to stigma by providing a moral dimension to the concept. The word *moral* here refers to people's values that determine what matters most to them when engaging in their everyday practices (Kleinman, 2006). With this definition, Yang et al. (2007) proposed that stigma threatens "the loss or diminution of what is most at stake" (p.1530) for the stigmatized people in their social world of daily interactions. For example, for a North American person, stigma might be felt with its threats on individualistic aspects of daily life such as self-reliance; or for a young adult, stigma can be experienced most strongly with its negative impact on romantic relationships. In fact, Yang and Kleinman (2008) showed the effects of stigma on moral experience in the Chinese culture with the experience of *losing face* and its subsequent negative impact on most valued cultural achievements such as getting married and continuing the family lineage. As a result, Yang et al. (2007) proposed that stigma threatens what matters most in an individual's social world; it operates both in social and subjective spheres; and it can be affective and somatic, because the status loss and social devaluation can be physically felt and manifested.

1.3. Research Findings on Mental Illness Stigma

As stated previously, the majority of studies in the stigma literature focused on illness and disability topics (Phelan et al., 2008). Moreover, Phelan and her colleagues found that 38% of stigma research is directly related to mental illness stigma, making it the most frequently studied topic in the stigma literature. When viewed historically, it is possible to classify mental illness stigma research in two categories. The initial group of studies focused on public attitudes toward mental illness and a subsequent attempt at reducing public stigma (e.g., Cumming & Cumming, 1957). The latter group, on the other hand, focused on the internalization of mental illness stigma, the negative consequences of such internalization, and prevention of these negative consequences for patients (e.g., Drapalski et al., 2013). A brief review of the findings of these studies is presented in this section.

Early studies that were conducted in 1950s and 1960s on general public populations demonstrated that people with mental illness were feared, ignored, distrusted, and disliked by the general public and they were considered dangerous, unpredictable and dirty (Cumming & Cumming, 1957; Nunnally, 1961). Vignette studies designed by Star (1955) have been methodologically very influential on the subsequent stigma research. Using these vignettes experimentally, Philips (1966) has shown that labeling can have negative effects such as social distancing and rejection of stigmatized individuals. Various attempts at reducing public stigma with public intervention studies and policy initiatives in Western countries followed these findings (Hinshaw & Cicchetti, 2000; Stuart, 2016).

The changes in public stigma of mental illness have been tracked for decades (e.g. Angermeyer, Matschinger, Carta, & Schomerus, 2014; Pescosolido et al., 2010). According to a meta-analysis published in 2012, however, although the public understanding of biological correlates of mental disorders has increased, this did not lead to a decrease in stigmatization and discrimination, nor did it lead to an increase in social acceptance of individuals with mental disorder (Pescosolido, 2013; Schomerus et al.,

2012). Nevertheless, the picture is not all bleak. In another meta-analysis, contact and education were found to have a positive effect in reducing the public stigma for mental illness (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012).

The second generation of studies in mental illness stigma adopted the perspective of the patients and elaborated on the concept of internalized stigma (or self-stigma). Defined briefly, internalized stigma refers to the process with which the stigmatized individuals, first, become aware of public conceptions of mental illness, then start agreeing with the related negative stereotypes and prejudice, and finally, make these negative evaluations a part of their self-concept (Corrigan & Rao, 2012; Link et al. 1989; Muñoz, Sanz, Pérez-Santos, & Quiroga, 2011). Internalized stigma is rather common among psychiatric patients. In fact, according to an international study of 14 European countries conducted with a sample of 1229 psychiatric patients, 41.7% of the participants had moderate or high levels of self-stigma (Brohan, Elgie, Sartorius, & Thornicroft, 2010).

The concept of internalized stigma has been studied extensively and has been associated with many negative consequences for psychiatric patients. Negative consequences include reduction in self-esteem, self-efficacy, quality of life, social integration, empowerment, hope, and an increase in symptom severity (Drapalski et al., 2013; Livingston & Boyd, 2010). Moreover, it leads to treatment discontinuation and poorer treatment adherence among patients (Fung, Tsang, & Chan, 2010; Sirey et al., 2001), creating an important barrier for the treatment of psychiatric disorders (Yanos, Roe, & Lysaker, 2010).

A few variables were pointed out with possible beneficial effects on perceived and internalized stigma. For example, being employed, having social contacts, and receiving social support during the onset of illness were associated with lower self-stigma (Brohan et al., 2010; Mueller et al., 2006). Recent reviews and meta-analyses of the intervention studies targeting internalized and perceived stigma, however, are inconclusive and there is a lack of evidence for an effective method in reducing

internalized stigma (Bütcher & Messer, 2017; Griffiths, Carron-Arthur, Parsons, & Reid, 2014).

1.4. Measurement of Mental Illness Stigma

As explained earlier, the conceptualization of stigma and perspectives of mental illness stigma research vary considerably across studies. This variation has also been reflected in measurement of mental illness stigma, with a high number of measures covering several different areas in the study area. A brief review of these areas, measurement approaches, target populations, and examples of measurement instruments are presented in this section.

To begin with, many researchers utilized an explicit measurement approach in their tools, that is, the tools with which they measured participants' responses in self-report format. Often, these were used in non-experimental survey designs with or without vignette components (Link, et al., 2004). The problem with this measurement style, however, is that it is vulnerable to social desirability. To deal with this problem, an implicit approach to measuring stigma has been suggested (Yang, Link, & Phelan, 2008). Consequently, there has been a recent trend in conducting studies with implicit measurement tools, namely, Implicit Association Tests (e.g. Mannarini & Boffo, 2014; Stull, McGrew, Salyers, & Ashburn-Nardo, 2013). Some of these studies documented evidence for the validity and reliability of the implicit measurement tools for stigma (e.g. Denenny, Bentley, & Schiffman, 2014).

In their review, Yang and Link (2016) categorized numerous mental illness stigma measures into two different groups. These groups are general community attitudes, and mental health consumer and family stigma. In the general community studies, social distance scales comprised the first of the stigma measurement areas. These scales aim to measure the willingness of participants to engage in different social interactions and relationships with stigmatized individuals. Although social distance, as a measurement area, was first introduced in 1925 to measure race and ethnicity distance

(Bogardus, 1925), it is also used in many large-scale survey-type studies in mental illness stigma research (e.g. Pescosolido, Medina, Martin, & Scott, 2013). Another area in general community studies is the measurement of stereotyping with Semantic Differential (Osgood, Suci, & Tannenbaum, 1957). The measures pertaining to this area targeted the association between stigma related concepts (e.g. psychiatrist, schizophrenia) and pairs of adjectives such as cold-warm, dangerous-safe (Nunnally & Kittross, 1958). Such measures are advantageous for allowing direct study of stereotyping, but they are vulnerable to social desirability bias as any other explicit measurement tool. Yet another measurement area in general community studies includes public attitudes and opinions on mental illness. Examples of measures that investigate public attitudes and opinions are Community Attitude Towards the Mentally Ill (Taylor & Dear, 1981), community perception of mental illness stigma (e.g. PDD), attributions of responsibility (e.g. Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003), and emotional reactions towards mentally ill (Angermeyer & Matschinger, 1996).

In the second body of stigma research, where mental health consumers were targeted, the studies frequently focused on measuring internalized stigma. However, the stigma measurement areas targeted by the tools used in these studies reflect a wide range of differences in patient experiences, perceptions, and behavior. Some examples of measurement areas here include alienation, stigma resistance (e.g. Ritsher, Otilingam, & Grajales, 2003), stereotype awareness, stereotype agreement (e.g. Corrigan, Watson, & Barr, 2006)**,** perception of discrimination and devaluation (e.g. PDD), experiences of discrimination (e.g. Brohan et al., 2013), and stigma coping strategies (e.g. Link, Struening, Neese-todd, Asmussen, & Phelan, 2002). It should be noted that many scales measure multiple areas with different subscales and are not restricted to only one area. In fact, PDD can be used both in general community populations as a measure of public perception of mental illness (e.g. Angermeyer et al., 2014), and in mental health consumer populations as an internalized stigma measure (Livingston & Boyd, 2010). It should be noted, however, that while many tools target multiple stigma measurement

areas, this does not mean that one-fits-for-all approach is a valid way of choosing the right tool for measuring stigma. It is very important to consider not only the population characteristics but also the compatibility of research questions and the stigma measurement areas targeted by specific tools when deciding to use a stigma scale (Yang & Link, 2016).

1.5. Mental Illness Stigma in Turkey

1.5.1. Research findings in Turkey

In Turkey, initial studies about mental illness stigma were conducted in 1970s focusing on public attitudes toward the mentally ill. These studies, in general, documented socially restrictive, avoidant and punitive attitudes of community members towards people with mental illness (for a detailed chronological review in Turkish see Taşkın, 2007). Although it was mentioned that the community knowledge of psychiatric disorders and their etiology has increased substantially since 1970s (Taşkın, 2007), the negative beliefs and attitudes associated with mental illness seem to persist. In fact, according to a relatively recent study conducted on 516 university students in Ankara, University students were found to hold high levels of dangerousness belief for individuals with mental illness (Ünal, Hisar, Çelik, & Özgüven, 2010). Another study, making use of vignettes, showed that people in the rural areas of Western Turkey believe that schizophrenia patients are aggressive and should not be allowed to be free in the community (Taşkın et al., 2003).

The negative beliefs regarding people with mental illness were also investigated among health professionals. It was found that the majority of physicians and nurses hold the belief that individuals with mental illness are dangerous (Bağ & Ekinci, 2005). In addition, it was reported that some emergency service personnel are negligent when treating physical symptoms of psychiatric patients, which might reflect an institutionalized stigma (Saillard, 2010). A review of studies focusing on attitudes of mental health professionals showed that the findings are inconclusive regarding mental

health professionals' stigmatizing beliefs and attitudes towards individuals with mental illness (Çam & Bilge, 2013). Nevertheless, some studies with successful anti-stigma interventions targeting mental health professionals, such as an Internet-based intervention to reduce mental illness stigma among psychiatry residents and specialists, have also been reported (Bayar, Poyraz, Aksoy-Poyraz, & Arıkan, 2009).

As in the North American and Europen literatures, initial stigma studies that targeted the general community were followed by the second generation of studies that focused on the perspective of the stigmatized individuals. For example, one qualitative study showed that individuals with mental illness feel stigmatized by their families, mental health professionals, and the society, which leads to many negative effects such as difficulties in daily social interactions and treatment non-adherence (Yüksel, Bingöl, & Oflaz, 2013). Quantitative studies supported these findings, showing that internalized stigma is negatively associated with variables such as social functioning, hope, and income (Doğanavşargil-Baysal, Özkan, & Gökmen, 2013; Sarıkoç & Öz, 2015). As a result, fighting mental illness stigma has been pointed as an important direction to follow in Turkey. In their review of Turkish mental illness studies, Çam and Bilge (2013) reported that several studies provided suggestions to fight mental illness stigma, such as educating public about mental illness, enriching the curriculum of mental health professionals, and adopting an interdisciplinary approach for interventions**.**

1.5.2. Measurement tools in Turkish

In Turkey, the initial work in introducing mental illness stigma measures has developed through translation and adaptation of the existing measures in the literature. Examples of these measures include Internalized Stigma of Mental Illness Scale (Ersoy & Varan, 2007; Ritsher et al., 2003), Beliefs Toward Mental Illness Scale (Bilge & Çam, 2008; Hirai & Clum, 2000), Community Attitude Towards the Mentally Ill (Bağ & Ekinci, 2006; Taylor & Dear, 1981), Perceptions of Stigmatization by Others for Seeking Help (Sezer & Kezer, 2013; Vogel, Wade, & Ascheman, 2009), and Stigma Scale for

Receiving Psychological Help (Komiya, Good & Sherrod, 2000; Topkaya, 2011). With the number of these measures growing, the diversity of tools, which is vital for capturing various stigma measurement areas in Turkish context, has been improving.

In addition to the translation/adaptation approach, researchers expressed a need for culturally-sensitive stigma scales for the Turkish context. For example, the Self-Stigma Inventory for schizophrenia patients (Yıldız, Kiras, İncedere, & Abut, 2018) and the Self-Stigma Inventory for families of schizophrenia patients (Yıldız et al., 2018) have been recently introduced as reliable and valid measures developed for the Turkish culture. In these two studies, researchers conducted focus groups with schizophrenia patients and their families in order to capture cultural aspects of stigmatization in Turkey. Later, they integrated their focus group findings in developing scale items in order to optimize cultural sensitivity and comprehensibility of their instruments. The researchers demonstrated that the two stigma measures have excellent psychometric properties. Unfortunately, such studies are rare and an increase in the number of instruments developed for the Turkish cultural context is needed, because although the stigmatization of mental illness appears to be universal, the manifestations, meanings, and experiences of stigma differ widely across cultures (Koschorke, Evans-Lacko, Sartorius, & Thornicroft, 2016; Yang et al., 2007).

1.6. Perceived Devaluation-Discrimination

1.6.1. Uses of the Perceived Devaluation-Discrimination scale

Originally, Bruce Link developed the PDD to test the Modified Labeling Theory (MLT) which focuses on the negative consequences of labeling associated with entering psychiatric treatment (Link, 1987). In the most basic description, MLT predicts a set of negative psychological (e.g. low self-esteem) and social outcomes (e.g. reduced social network) for people who receive a psychiatric label but not for those who don't receive such a label (Link et al., 1989). Because receiving an official diagnosis holds a key point in MLT, it is vital to compare various groups of people that differ in their diagnostic

status and psychopathology level. PDD is especially useful, at this point, as a measurement tool which facilitates inter-group comparisons. In fact, in earlier studies, PDD has been used to compare stigma perceptions of the following five groups: (1) psychiatric patients who are contacted for their first treatment, (2) psychiatric patients who are contacted for repeated treatments, (3) former patients who no longer receive psychiatric treatment, (4) untreated community members with psychopathology, and (5) community members without psychopathology (Link, 1987; Link et al., 1989). Therefore, one important aspect of PDD is that it can be used on both clinical and general community populations to make comparisons between the two.

PDD's utilization, however, is not limited to patient and non-patient comparisons. In clinical studies, for example, PDD was also used as a measure of perceived stigma and internalized stigma. In fact, in a meta-analysis, Livingston and Boyd (2010) reported PDD as one of the most frequently used internalized stigma measures. Moreover, it is possible to find examples of research in which PDD was used to evaluate the effectiveness of anti-stigma interventions on patients (see Link et al., 2002). In the studies targeting community populations, on the other hand, PDD was used to measure public stigma of mental illness. Researchers in some of these studies make regional comparisons for public stigma (e.g. Schomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006; Zieger et al., 2016) and track its changes over time (e.g. Angermeyer et al., 2014).

1.6.2. Research findings on Perceived Devaluation-Discrimination

Previous studies have shown that PDD is related to various psychological variables for people with mental illness. For example, it was shown that PDD predicted self-esteem of psychiatric patients as measured by Rosenberg Self-Esteem Scale (Rosenberg, 1965) in 6 and 24-month follow-ups of a stigma coping program (β = -.32, p < .001; and β = -.45, p < .001 respectively; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Also, PDD predicted low self-efficacy for psychiatric patients (β = .40,

$p < .001$), explaining 14% of the variance in self-efficacy measured by Self-efficacy Scale (Kleim et al., 2008; Schwarzer, 1999). Moreover**,** PDD predicted psychological demoralization for patients with psychiatric diagnoses ($\beta = .23$, $p = .001$; Link, 1987). As correlational findings, PDD was reported to be positively related to depressive symptoms measured by Center of Epidemiological Studies Depression Scale ($r = .32$, $p < .01$; Link et al., 1997; Radloff, 1977), and positively related to internalized stigma measured by Internalized Stigma of Mental Illness Scale among psychiatric patients ($r = .56$, $p < .001$; Brohan et al., 2010).

According to MLT, PDD would be unrelated to stigma-related negative outcomes among people who have not been labeled with a psychiatric diagnosis (Link, Mirotznik, & Cullen, 1991; Link et al., 2004). Indeed, it was shown that although PDD predicted demoralization among people with a psychiatric diagnosis, it did not predict demoralization for people without a psychiatric label (Link 1987; Link et al., 1991). Consequently, general public studies mostly focused on associations of PDD with sociodemographic variables instead of psychological variables that were investigated in clinical studies. For example, in a study conducted with Indian general public sample, it was reported that education predicted PDD scores in a negative direction ($\beta = -.20$, $p = .001$; Zieger et al., 2016). In another study which was conducted with North Korean defectors who live in South Korea, it was shown that married people had significantly higher levels of PDD scores than those who have never been married (Ahn et al., 2015). In yet another study that was conducted in South Korea, researchers reported that a late adult cohort above the age of 60 was more likely to have higher PDD scores than younger cohorts (Park et al., 2014). On the other hand, in a North American college student sample, it was shown there was a positive correlation between PDD and Perceptions of Stigmatization by Others for Seeking Psychological Help scale ($r = .20$, $p < .001$; Vogel et al., 2009), both of which measure various aspects of perceived stigma.

1.6.3. Why translate Perceived Devaluation-Discrimination?

Creating the Turkish version of PDD can be important and beneficial for several reasons. First of all, as a stigma measure, PDD can be applied to diverse populations since the item wording of it is not exclusive to any patient or non-patient group's perspective. This unique characteristic of PDD makes it possible to compare various clinical and public samples in stigma research. Currently, Turkish literature on mental illness stigma seems to be lacking a measure that is capable of making such comparisons. Turkish version of PDD can fill this gap in the literature.

Second, as mentioned earlier, there are many different stigma measurement tools which are associated with different models and conceptualizations of the stigma concept. Consequently, researchers can pick the correct measurement tools based not only on their methodological approaches and sample characteristics, but also based on their stigma models, theoretical approaches and even research questions (Yang et al., 2007; Yang & Link, 2016). Yet, there are limited number of stigma measures in Turkish literature. Therefore, Turkish version of PDD will contribute to measurement diversity in stigma research and allow for tests of MLT in the Turkish context of mental illness stigma.

In PDD scale, participants' opinions regarding "what most people" think are asked, rather than asking their opinions directly. Link and Cullen (1983) aimed to reduce social desirability bias of the participants by doing this. In fact, an early study showed that while 75% of the participants reported that *other people* would have negative opinions about psychiatric patients, only 17% of participants personally acknowledged having negative opinions of patients (Elinson, Padilla & Perkins, 1967). In a more recent study, researchers utilized question structures with the expression "most people" in order to measure perceived stigma in their vignette study (Griffiths et al., 2006). They reported that participants demonstrate higher levels of stigma scores when responding to perceived stigma items (what most people think) as opposed to personal stigma items which question personal opinions toward mentally ill individuals. This gap between perceived and personal stigma was underlined as a possible indicator of social

desirability bias (Gaebel, Baumann, Witte, & Zaeske, 2002; Griffiths et al., 2006). As a result, having a Turkish version of PDD might provide researchers with a tool to collect less biased data on public stigma in the Turkish context.

Finally, PDD is utilized widely across the world both as an internalized stigma measure (Livingston & Boyd, 2010) and public stigma measure. In fact, it has been translated to many other languages such as Swedish, Spanish, German, and Chinese (Björkman, Svensson & Lundberg, 2007; Martinez-Zambrano et al., 2016; Matschinger, Angermeyer & Link, 1991; Yin et al., 2014). Therefore, creating the Turkish version of PDD can make it possible to compare mental illness stigma across Turkey and all of these other countries.

1.7. Aims and Hypotheses

The purpose of the current study was to translate and adapt the Perceived-Devaluation Discrimination scale into Turkish language and culture. Another aim was to demonstrate the reliability and validity of the Turkish version of PDD scale in general community and clinical populations. Therefore, it was hypothesized that;

H_1: Turkish version of PDD will be positively and significantly correlated with the Turkish version of Internalized Stigma of Mental Illness (ISMI) scale in the clinical sample.

H_2: Turkish version of PDD will be positively and significantly correlated with the Turkish version of Beliefs Toward Mental Illness Scale (BMI) in the general community sample.

H_3: Turkish version of PDD will be positively and significantly correlated with the Turkish version of Perceptions of Stigmatization by Others for Seeking Psychological Help (PSOSH) scale in the general community sample.

H_4: Turkish version of PDD will have a two-factor structure in the general community sample.

H$_5$: Turkish version of PDD will have a two-factor structure in the clinical sample.

H$_6$: Turkish version of PDD and Turkish version of Rosenberg Self-Esteem Scale (RSES) will have differing relationships across clinical and general community samples. More specifically, after controlling for demographic variables, the Turkish version of PDD will be positively and significantly correlated with the Turkish version of RSES in the clinical sample (H_{6a}). However, in the general community sample, there will be only a weak correlation below .30 between the Turkish version of PDD and the Turkish version of RSES (H_{6b}).

H$_7$: After controlling for demographic variables, the Turkish version of PDD will positively and significantly predict the Turkish version of RSES in the clinical sample.

H$_8$: There will be only a weak correlation below .30 between Turkish version of PDD and Turkish version of Beck Depression Inventory (BDI) in general community sample.

CHAPTER 2

METHODS

2.1. Participants

Data was collected from two different samples, one community and one clinical sample, to demonstrate the psychometric properties of the Turkish version of PDD. In the community sample, the only inclusion criterion was to be at the age of 18 or above. For this group, no pre-determined exclusion criteria existed. In the clinical sample, the inclusion criteria were: (1) to be at least 18 years old and (2) to have a chronic psychiatric disorder. The exclusion criteria were (1) to be at the acute phase of the disorder and (2) to have severe cognitive impairments that cause an inability to fill out the survey forms.

Hundred and fifty people who live in Ankara's various neighborhoods were invited to participate in the study using a snowball sampling technique. Out of these 150 people, 1 participant did not return the survey package, and data from 4 participants were excluded from the final data set for being incomplete. Therefore, data from 145 community sample participants were included in final analysis. The mean age for the community sample was 44.90 (*SD* = 14.74). Of the community sample, 48.25% were male and 51.75% were female. The majority of the participants (64.83%) had bachelor's degree and only 2.07% had a degree lower than high school graduation. When it comes to mental health treatment history, 83.45% of the participants in the community sample reported that they have never received any mental health services and only 2.07% reported that they currently receive mental health services. Finally, 17 participants (11.72%) reported that they have received psychiatric diagnoses in the past. Please see Table 1 for the demographic information regarding the community sample.

Table 1

General Community Sample Demographic Information

	M	*SD*	*N*	%	Min-Max
Age	44.90	14.74	143		18-86
Household population	3.04	1.14	143		1-6
Household income (TL/month)	5570.36	2598.96	138		1500-15000
Gender					
Male			69	48.25	
Female			74	51.75	
Marital Status					
Single			51	35.66	
Married			92	64.34	
Education					
Primary school			1	.69	
Middle school			2	1.38	
High school			33	22.76	
Bachelor's			94	64.83	
Master's			13	8.97	
Doctorate			2	1.38	
Worked (within last year)					
Yes			92	65.25	
No			13	9.22	
Retired			36	25.53	

Table 1 (continued)

	M	*SD*	*N*	%	Min-Max
Previous Psychiatric Diagnosis					
Yes			17	11.72	
No			128	88.28	
Previous Mental Health Service					
Yes			24	16.55	
No			121	83.45	
Current Mental Health Service					
Yes			3	2.07	
No			142	97.93	
Previous Hospitalization					
Yes			2	1.38	
No			143	98.62	
Family Member with Diagnosis					
Yes			20	14.08	
No			122	85.92	

For the clinical sample, data from 85 individuals with various chronic psychiatric disorders was obtained. The participants were contacted via community mental health service centers and non-profit organizations serving patients diagnosed with schizophrenia and their families, including: Dr. Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital Community Mental Health Service, Dr. Nafiz

Körez Sincan State Hospital Community Mental Health Service (Ankara), Nazilli State Hospital Community Mental Health Service (Aydın), Ankara Association for Learning and Supporting to Live with Schizophrenia (Ankara Şizofreni ile Yaşamayı Öğrenme ve Destekleme Derneği - AŞDER), and Ankara Schizophrenia Patients and Relatives Solidarity Association (Ankara Şizofreni Hastaları ve Yakınları Dayanışma Derneği - Mavi At). The clinical sample consisted of 67 male (78.82%) and 18 female individuals. The mean age in this sample was 41.36 (*SD* = 10.71). Almost half of the participants had high school degree (48.2%) and the majority of the participants (69.41%) were diagnosed with schizophrenia according to diagnosis information reported by the participants. Demographic and diagnostic information for the clinical sample were presented in Table 2 and Table 3.

Table 2

Clinical Sample Demographic Information

	M	*SD*	*N*	%	Min-Max
Age	41.36	10.71	85		22-71
Gender					
Male			67	78.82	
Female			18	21.18	
Marital Status					
Single			64	75.29	
Married			21	24.71	

Table 2 (continued)

	M	*SD*	*N*	%	Min-Max
Education					
Primary school			14	16.47	
Middle school			16	18.82	
High school			41	48.24	
Bachelor's			14	16.47	
Worked (within last year)					
Yes			14	16.47	
No			53	62.35	
Retired			16	18.82	
Previous Hospitalization					
Yes			74	87.06	
No			11	12.94	

Table 3

Psychiatric Diagnoses of the Participants in the Clinical Sample

Diagnosis	*N*	%
Schizophrenia	59	69.41
Schizoaffective Disorder	5	5.88
Bipolar Affective Disorder	11	12.94
Chronic Psychotic Disorder (Not specified)	6	7.06
Diagnosis not known	4	4.71
Total	85	100

2.2. Instruments

2.2.1. Perceived Devaluation-Discrimination

PDD scale was first created by Bruce G. Link in 1987 in order to measure the extent to which a person believes that "most people will devalue or discriminate against a psychiatric patient" (Link, 1987, p.102). Originally, it was designed as a 12-item survey measured on a 6-point Likert-type scale with responses ranging from "strongly agree" to "strongly disagree." Later in 2002, the wording of PDD was revised and a 13th item was added to the scale (Link et al., 2002). This latter version utilized a 4-point Likert format. It has 6 reverse items and the final score is computed by dividing total score to 13. Higher scores indicate stronger perception of devaluation and discrimination towards people with mental illness.

Internal consistency reliability of PDD ranged from .82 to .88 (Link et al., 2004; Kleim et al., 2008) in samples of mental health service consumers. PDD also showed high internal consistency in general public samples. For example, the German version of PDD was reported to demonstrate an alpha value of .86 in public survey study (Angermeyer et al., 2014).

Two-factor and single factor structures were reported for PDD. An exploratory factor analysis that was conducted on a psychiatric sample showed that positively and negatively-worded items grouped under separate factors (Interian et al., 2010). These two factors were named as *Perceived Discrimination and Negative Evaluation* and *Perceived Acceptance and Non-negative Evaluation*. In the same year, a different two-factor structure was suggested in a study that utilized a modified version of PDD for specific use on alcohol stigma (Smith, Dawson, Goldstein, & Grant, 2010). In the latter study, it was hypothesized that the items that depict beliefs represent *Perceived Devaluation* factor and the items that depict behaviors represent *Perceived Discrimination* factor. Glass, Kristjansson, and Bucholz (2013) tested this two-factor (Perceived Devaluation and Perceived Discrimination) and single factor structures for alcohol-stigma PDD in their study with confirmatory factor analysis. Their study showed

support for both structures. The same factor structures were also tested in a general public sample of Chinese people for original PDD items using confirmatory factor analysis (Yin et al., 2014). Again, both single factor and two-factor structures (Perceived Devaluation and Perceived Discrimination) were supported.

PDD was one of the early measures to target clinical population areas in stigma research, therefore, the main evidence for PDD's validity came in the form of construct validity rather than concurrent validity. In particular, PDD has been found to be associated with less self-esteem, demoralization (Link, 1987; Link et al., 1989), depressive symptoms (Link et al., 1997), reduced social networks (Link et al., 1989), decreased quality of life (Markowitz, 1998; Rosenfield, 1997), low self-efficacy, poor coping (Kleim et al., 2008), unemployment, and less income (Link, 1982; Link 1987) among clinical populations.

Although validity of the original PDD was not directly tested by comparing it to other stigma scales, researchers developing self-stigma and perceived stigma measures within the last two decades reported associations with PDD. For example, PDD is positively associated with Internalized Stigma of Mental Illness scale ($r = .35$, $p < 0.01$; Ritsher et al., 2003) and with Perceptions of Stigmatization by Others for Seeking Help scale ($r = .20$, $p < 0.001$; Vogel et al., 2009). In conclusion, PDD has been recognized as a valid and reliable measure to utilize in general public and clinical samples. In the current study, psychometric properties of the Turkish version of PDD were tested in both clinical and public populations. A copy of the Turkish version of the PDD scale can be found in Appendix D.

2.2.2. Rosenberg Self-Esteem Scale (RSES)

Developed by Rosenberg (1965), RSES is a 10-item survey that measures self-esteem of respondents on a 4-point scale. Half of the items (item 1, 2, 4, 6 and 7) are reverse-coded. The Turkish version of this instrument was created by Çuhadaroğlu (1986) with a study using an adolescent sample. In this version, the total score is

computed on Guttman scale and it ranges between 0 and 6 points. Points 5 and 6 indicate low self-esteem, the range between 2 and 4 indicate moderate self-esteem, and points 0 and 1 indicate high self-esteem. Validity of this scale was reported to be .71 as it was demonstrated by correlations between RSES and interview scores, where self-esteem of participants were coded as low, moderate or high by interviewer (Çuhadaroğlu, 1986). Internal consistency reliability of this measure was reported in different studies with Chronbach's alpha values ranging between .76 and .82 (Çeçen, 2008; Güloğlu & Karaırmak, 2010; Tuğrul, 1994). Finally, test-retest reliability was reported to be .75 (Çuhadaroğlu, 1986). In the current study, RSES was used to test for discriminant validity of PDD in the public sample, and for convergent validity of PDD in the clinical sample. Cronbach's alpha coefficient for RSES was found .86 in community sample and .79 in clinical sample. A copy of RSES can be found in Appendix G.

2.2.3. Perceptions of Stigmatization by Others for Seeking Help (PSOSH)

PSOSH is a perceived stigma measure that is developed by Vogel et al. (2009). It is translated and adapted to Turkish by Sezer and Kezer (2013) with a study conducted on university students. The survey asks respondents to imagine a scenario where they decide to receive professional psychological help for a problem in their lives. Then, the respondents are asked to rate 21 possible reactions to this decision by the people in their environment. Each reaction is rated on 5-point Likert-type scale based on how much the participants agree that the people in their environment would show a particular reaction. Sezer and Kezer (2013) reported PSOSH scale's Cronbach's alpha coefficient as .93, test re-test reliability as .80 and concurrent validity as .72 as it was tested with correlations between PSOSH and Stigma Scale for Receiving Psychological Help (Komiya et al., 2000; Topkaya, 2011). In the current study, PSOSH was used to test for convergent validity of PDD in the general community sample. The Cronbach's alpha value for the

general community sample was .96. A copy of the PSOSH scale can be found in Appendix H.

2.2.4. Beliefs Toward Mental Illness Scale (BMI)

BMI was developed by Hirai and Clum (2000) in order to measure cross-cultural differences in beliefs toward mental illness and to predict health seeking behavior. It provides a set of statements that reflect stigmatizing beliefs about mental illness. Participants are asked to rate these statements based on how much they agree with each of the statements. BMI was translated and adapted to Turkish by Bilge and Çam (2008). The Turkish version of BMI consists of 21 items that are measured on a 6-point Likert format. It has 3 subscales that were supported by factor analysis. These three subscales are: Incurability and Disturbance in Interpersonal Relationships, Dangerous, and Shame. Cronbach's alpha coefficient for the entire scale was .82 and alpha values of its subscales ranged between .69 and .80 (Bilge & Çam, 2008). The same study also reported small significant correlations of BMI with Community Mental Health Ideology (r = .18) and Fear/Exclusion (r = .-17) subscales of Community Attitudes Toward Mentally Ill scale (Bağ & Ekinci, 2006; Taylor & Dear, 1981). In the current study, BMI was used to test for convergent validity of PDD in the general community sample. Cronbach's alpha coefficient for full scale was .90 and alpha coefficients of its subscales ranged between .69 and .87. A copy of the BMI scale can be found in Appendix I.

2.2.5. Beck Depression Inventory (BDI)

BDI is a 21-item survey that measures depression symptoms (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Each item consists of 4 statements and the respondents are asked to choose the statement that describes how they have felt over the past week. Every item is scored between 0 and 3 points. BDI was translated and adapted to Turkish by Hisli (1988). In her study, the concurrent validity was reported as .50 as it was measured by the correlation between BDI and Minnesota Multiphasic Personality

Inventory Depression subscale. Internal consistency reliability was .74. BDI was used, in the current study, to test for discriminant validity of PDD in the general community sample. Its Cronbach's alpha coefficient was found to be .83. A copy of BDI form can be found in Appendix J.

2.2.6. Internalized Stigma of Mental Illness Scale (ISMI)

ISMI was developed by Ritsher et al. (2003) as a 29-item survey that aims to measure internalized mental illness stigma on a 4-point Likert-type scale. The scale consists of 5 subscales: Alienation, Stereotype Endorsement, Discrimination Experience, Social Withdrawal, and Stigma Resistance. A total of 5 items in the Stigma Resistance subscale are reverse-coded (items 7, 14, 24, 26, and 27). The adaptation of Turkish version, as created by Ersoy and Varan (2007), conserved the 5-factor structure. Cronbach's alpha for the Turkish version was .93 and alpha values of its subscales ranged between .63 and .87. Convergent validity of this measure was demonstrated through correlations with various scales including RSES (r = -.68), BDI (r = .70), and Brief Symptom Inventory (r = .59). In the current study, Cronbach's alpha value of ISMI was .89 and it was used to test for convergent validity of PDD in the clinical sample. A copy of the ISMI scale can be found in Appendix K.

2.3. Procedure

2.3.1. Translation

The 13-item version of PDD (see Appendix B for original items in English) was translated to Turkish using a double translation and reconciliation approach. This approach involves two independent translators or translator groups creating their own translated forms in the target language. Then a third independent person or group (reconciler) reviews the two translated versions and reconciles the differences to create the final version of the translated form. According to the International Test Commission's (2017) adaptation and translation guidelines, this approach is an effective

translation method to spot possible idiosyncrasies that could be overlooked when translated with a single translation approach.

The translation of the Turkish version of PDD was carried out by the author of the current paper and a senior researcher. Both translators are knowledgeable in psychological measurement methods, advanced statistics in social sciences, and the concept of mental illness stigma, and are fluent in both English and Turkish. After two independent translations had been created, another senior researcher reconciled the two Turkish forms of PDD (see Appendix C for Turkish version of PDD after reconciliation). The reconciler is a bilingual psychologist who is experienced in the area of cross-cultural equivalence of measures, and who has lived both in the United States and Turkey.

After the two translations were reconciled into a third form, the Turkish version of PDD was administered to 6 people from the community. The educational level of six participants ranged between middle school and university degree and their ages ranged between 23 and 54. Following the administration of translated PDD, short structured interviews were conducted with these 6 people (see Appendix A for interview questions) and their comments were noted. The same procedure was repeated with 3 people who are diagnosed with a chronic psychiatric disorder (2 schizophrenia and 1 chronic depression patients). Based on the comments from a total of 9 people, the wording and sentence structures were revised and the final version of the Turkish version of PDD was created (Appendix D).

2.3.2. Data collection

The ethical approval for this study was obtained from the Human Subjects Ethics Committee of the Middle East Technical University, Ankara and Aydın Provincial Health Directorates, and ethical committees of the Ankara Sincan, Ankara Oncology, and Aydın Nazilli hospitals. For schizophrenia associations, no official ethical approval procedure existed. Therefore, verbal permissions from the management of these associations were obtained to contact their members within the association buildings.

After receiving all of the necessary approvals and permissions, participants from the community population were invited to participate using a snowball sampling method. Those who accepted to participate were given an informed consent form, a survey package, and an envelope to ensure the privacy of the responses. The author recruited the clinical sample participants by visiting community mental health service and schizophrenia association centers. Each participant in this population was informed verbally about the entire content of the informed consent form. Those who were willing to participate were provided with the survey package.

Two different survey packages for the two populations were composed in printed format. The community sample survey package consisted of 6 forms and included the following: Demographic form, Perceived Devaluation-Discrimination scale, Rosenberg Self Esteem Scale, Perceptions of Stigmatization by Others for Seeking Help scale, Beliefs Toward Mental Illness Scale, and Beck Depression Inventory. The second survey package, which was composed for the clinical sample, consisted of 4 forms: Demographic form, Perceived Devaluation-Discrimination scale, Rosenberg Self Esteem Scale, and Internalized Stigma of Mental Illness scale. The order of the measurement instruments in each package was counter-balanced. These instruments and the informed consent form can be found in the Appendices D to K.

2.4. Statistical Analyses

Before the main analyses, the accuracy of data entry was ensured and missing data were detected using descriptive statistics and frequencies for every variable. No outliers were detected and missing data were replaced with series mean. However, no replacement was done for missing data caused by missing pages in survey package. After data set cleaning, Cronbach's alpha coefficients were calculated to test internal consistency reliability of PDD in the community and clinical samples. Then, for construct validity testing, convergent and discriminant validity of PDD were analyzed using Pearson's correlation coefficients between PDD and various other measures. In the

community sample, correlations between PDD, BMI and PSOSH scales were analyzed to test for convergent validity. For discriminant validity in this sample, correlations between PDD, RSES and BDI were analyzed. In the clinical sample, convergent validity was checked with correlations between PDD, ISMI and RSES. To further evaluate construct validity, exploratory and confirmatory factor analyses were conducted. Finally, a hierarchical multiple regression analysis was run to test whether PDD predicts RSES in clinical sample after controlling for demographic variables. All analyses except confirmatory factor analysis were conducted using the Statistical Package for Social Sciences (SPSS) version 20.0 for Windows. The confirmatory factor analysis, on the other hand, was carried out using EQS version 6.1 for Windows.

CHAPTER 3

RESULTS

3.1. Preliminary Analyses

As preliminary analysis, in the first place, descriptive statistics for composite scores of PDD, ISMI, BMI, PSOSH, BDI and RSES were computed for community and clinical samples (see Table 4). Secondly, a series of one-way ANOVAs and correlation analyses were conducted to check for possible relations between demographic variables and scale total scores. For the community sample, a significant effect of marital status on self-esteem was found, $F(1, 136) = 7.17$, $p < .01$. Accordingly, married people ($M = .73$, $SD = .76$) reported significantly lower RSES scores than single people ($M = 1.25$, $SD = 1.51$), which indicated that married people have higher self-esteem than single people in the community sample. Also, age was correlated with PDD in both community ($r = -.22$, $p < .01$) and clinical ($r = .24$, $p < .05$) samples, yet with different directions. Additionally, in the clinical sample, no correlations between PDD and time since initial diagnosis date, and between PDD and time since last hospitalization date was found.

To continue, all stigma scales, including PDD, ISMI, BMI and PSOSH, were checked for neutrality of responses using one-sample t-tests against mid-point values. The results showed no neutral response tendency based on composite scores. Finally, mean scores of PDD and RSES were compared across samples. The results from t-tests have shown that while there is no significant difference between general community and clinical samples for PDD scores, there was a significant difference in terms of RSES scores. Specifically, participants in the general community sample demonstrated significantly lower RSES scores ($M = .91$, $SD = 1.10$) than those in the clinical sample

(M = 2.31, SD = 1.52). This suggests that participants in the community sample had higher self-esteem than the participants in the clinical sample; $t(223) = 8.22$, $p < .000$.

Table 4

Descriptive Statistics for Composite Scores of Instruments

	M	*SD*	*N*	Skewness	Kurtosis
Community					
Sample					
PDD	2.75	.38	144	-.40	1.43
BMI	2.30	.84	145	.44	.57
PSOSH	2.10	.78	144	.59	-.03
BDI	7.93	6.37	142	.83	-.03
RSES	.91	1.10	140	1.94	5.08
Clinical Sample					
PDD	2.66	.55	85	.01	.59
ISMI	65.81	15.79	85	.12	-.40
RSES	2.31	1.52	85	.51	-.10

Note. PDD: Perceived Devaluation-Discrimination scale, ISMI: Internalized Stigma of Mental Illness scale, BMI: Beliefs Toward Mental Illness scale, PSOSH: Perceptions of Stigmatization by Others for Seeking Help scale, BDI: Beck Depression Inventory, RSES: Rosenberg Self-Esteem Scale.

3.2. Exploratory Factor Analysis

Previous studies with exploratory and confirmatory factor analyses provided evidence for one-factor and two-factor structures of PDD (Glass et al., 2013; Interian et al., 2010; Yin et al., 2014). In these studies, one-factor structure of perceived devaluation-discrimination, two-factor structure of positively and negatively-worded items, and two-factor structure with perceived devaluation and perceived discrimination subscales were investigated. To the author's knowledge, there is no previous Turkish

adaptation of PDD. Therefore, for the current study, exploratory factor analyses were conducted for PDD using clinical and community samples separately before proceeding with confirmatory factor analysis.

3.2.1. General community sample

Initially, an exploratory factor analysis (EFA) using principle axis factoring method was conducted with direct oblimin rotation for community sample. Kaiser-Meyer-Olkin (KMO) test of sampling adequacy was .73, and Bartlett's test of sphericity was significant χ^2 (78) = 444.30, $p < .001$, suggesting factorability of PDD items. The analysis yielded a four-factor structure with eigenvalues of 3.54, 1.98, 1.19 and 1.01. The four-factor structure accounted for 59.46% of total variance. However, taking into account the inflection point in scree plot (Figure 1) and the previous studies reporting two-factor structures (e.g., Glass et al., 2013; Interian et al., 2010; Yin et al., 2014), the author decided to reduce the number of factors to 2. Therefore, the analysis was repeated with 2 forced factors. The new solution explained 42.48% of variance. Loadings in the factor structure matrix (Table 5) has shown that 7 items (item 5, item 6, item 7, item 9, item 11, item 12, and item 13) loaded on the first factor and 6 items (item 1, item 2, item 3, item 4, item 8, and item 10) loaded on the second factor.

When the item loadings in suggested factor structure is examined, it becomes evident that the first factor is composed of negatively-worded items and the second factor is composed of positively-worded and reverse-coded items. Item 8 ("Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job") loaded on both factors equally, yet the author preferred to keep this item under the second factor as it is one of the positively-worded items. A similar factor structure was reported previously by Interian et al. (2010), where the negatively-worded items comprised *Perceived Discrimination and Negative Evaluation* factor and the positively-named items comprised *Perceived Acceptance and Non-negative Evaluation*

factor. For the current analysis, these names were adopted for factor 1 and factor 2, respectively.

In the literature, conventionally accepted cut-off point for factor loadings was reported as .40 (Matsunaga, 2010). Based on this cut-off point, item 5 and item 8 can be considered to have poor loadings with .35 and .38 values, respectively. However, the fact that their loadings are above .30 leaves a window for interpretability (Comrey & Lee, 1992; Tabachnick & Fidell, 2007). At this point, it was decided to keep the original number of total items and retain a similar structure as the one in clinical sample in order to facilitate maximum comparability between clinical and general community uses of PDD. Therefore, no item was deleted from general community version of this scale.

3.2.2. Clinical sample

In the clinical sample, a similar pattern to that of community sample was observed. First of all, an EFA using principle axis factoring method was conducted with direct oblimin rotation. Factorability of PDD items in the clinical sample was supported with KMO test of sampling adequacy (KMO = .74) and Bartlett's test of sphericity (χ^2 (78) = 308.60, $p < .001$). The analysis yielded a four-factor structure with eigenvalues of 3.77, 2.20, 1.23 and 1.01. The four-factor structure accounted for 63% of total variance. On the other hand, as in the community sample, the author decided to keep two-factor structure based on inflection point of scree plot (Figure 2) and previous studies. In consequence, the analysis was repeated with 2 forced factors. The two-factor solution explained 45.88% of variance. Loadings in the factor structure matrix suggested that item loadings were identical to the loadings in the general community sample: 7 items (item 5, item 6, item 7, item 9, item 11, item 12, and item 13) loaded on the first factor and 6 items (item 1, item 2, item 3, item 4, item 8, and item 10) loaded on the second factor. Again, factor 1 and factor 2 were named *Perceived Discrimination and Negative Evaluation* (DNE) and *Perceived Acceptance and Non-negative Evaluation* (ANNE), respectively. As seen in Table 6, factor loadings of all items in this sample were above

conventional cut-off point of .40 (Matsunaga, 2010) and above .45, which was suggested as a fair factor loading degree by Comrey and Lee (1992).

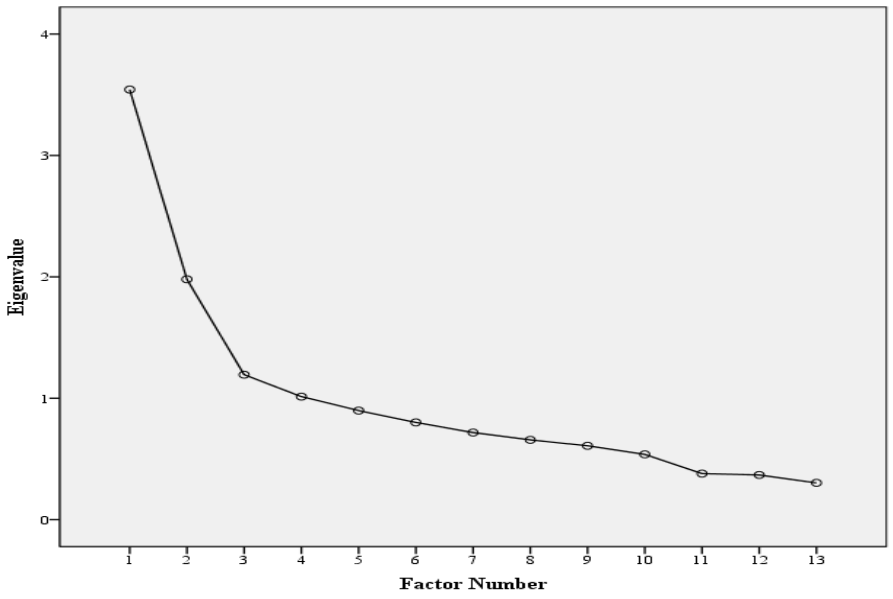

Figure 1. Scree plot for factors suggested by EFA for PDD in general community sample

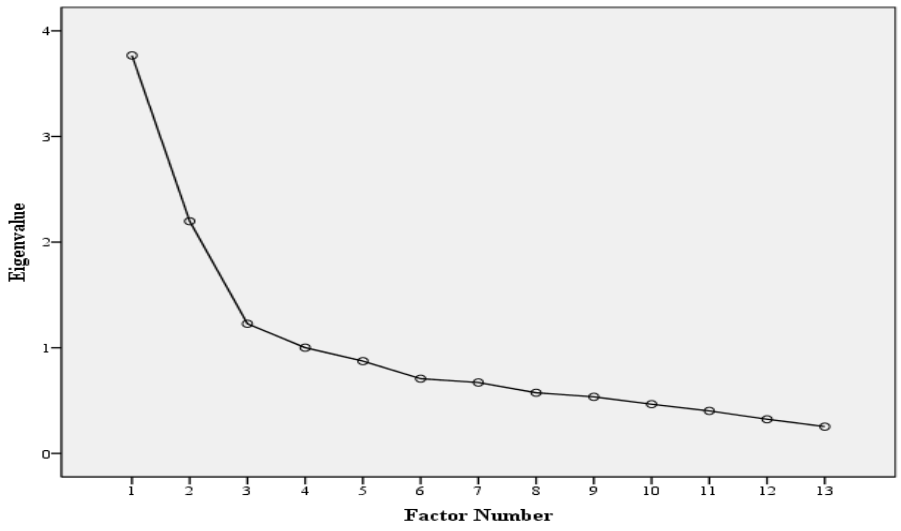

Figure 2. Scree plot for factors suggested by EFA for PDD in clinical sample

Table 5

Factor Structure of PDD in General Community Sample (n = 144)

Perceived Devaluation-Discrimination Items	Factor	
	Perceived Discrimination and Negative Evaluation	Perceived Acceptance and Non-negative Evaluation
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental illness.	**.72**	
13. Most people think that a person who has been hospitalized for serious mental illness is dangerous and unpredictable.	**.63**	
12. Once they know a person was in a psychiatric hospital, most people will take his or her opinions less seriously.	**.60**	
9. Most employers will pass over the application of a person who has been hospitalized for mental illness in favor of another applicant.	**.59**	.34
7. Most people think less of a person who has been in a psychiatric hospital.	**.55**	
6. Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.	**.41**	

Table 5 (continued)

5. Most people believe that entering a psychiatric hospital is a sign of personal failure.	**.35**	
3. Most people believe that a person who has been hospitalized for serious mental illness is just as trustworthy as the average citizen.		**.72**
2. Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.		**.68**
4. Most people would accept a person who has made a full recovery from serious mental illness as a teacher of young children in a public school.		**.57**
1. Most people would accept a person who once had a serious mental illness as a close friend.		**.52**
10. Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.		**.40**
8. Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.	.38	**.38**

Note. Bold characters indicate items loaded to factors in respective columns.

Table 6

Factor Structure of PDD in Clinical Sample (n = 85)

Perceived Devaluation-Discrimination Items	Factor	
	Perceived Discrimination and Negative Evaluation	Perceived Acceptance and Non-negative Evaluation
13. Most people think that a person who has been hospitalized for serious mental illness is dangerous and unpredictable	**.72**	
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental illness.	**.68**	
7. Most people think less of a person who has been in a psychiatric hospital.	**.59**	
6. Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.	**.53**	
9. Most employers will pass over the application of a person who has been hospitalized for mental illness in favor of another applicant.	**.49**	

Table 6 (continued)

5. Most people believe that entering a psychiatric hospital is a sign of personal failure.	**.48**	-.37
12. Once they know a person was in a psychiatric hospital, most people will take his or her opinions less seriously.	**.45**	
3. Most people believe that a person who has been hospitalized for serious mental illness is just as trustworthy as the average citizen.		**-.81**
2. Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.		**-.64**
1. Most people would accept a person who once had a serious mental illness as a close friend.		**-.62**
4. Most people would accept a person who has made a full recovery from serious mental illness as a teacher of young children in a public school.	.33	**-.55**
8. Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.	.37	**-.50**
10. Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.		**-.49**

Note. Bold characters indicate items loaded to factors in respective columns.

3.3. Internal Consistency Reliability

Reliability of PDD was measured with internal consistency reliability using Cronbach's alpha coefficient and ranged from .72 to .79. Deletion of no item resulted in an improvement for alpha value. Therefore, the original item number was conserved. For community and clinical samples, Cronbach's alpha coefficients of PDD and its subscales were provided in Table 7.

Table 7

Internal Consistency Reliability of PDD and PDD Subscales

Sample	Cronbach's alpha coefficient	*N*
General community sample		
PDD	.76	144
PDD-DNE	.74	144
PDD-ANNE	.72	144
Clinical sample		
PDD	.79	85
PDD-DNE	.76	85
PDD-ANNE	.77	85

Note. PDD: Perceived Devaluation-Discrimination scale, PDD-DNE: Perceived Discrimination and Negative Evaluation subscale, PDD-ANNE: Perceived Acceptance and Non-negative Evaluation subscale.

3.4. Confirmatory Factor Analysis

3.4.1. General community sample

To test for two-factor structure of PDD in the general community sample, a confirmatory factor analysis (CFA) using EQS 6.1 was conducted. Items 5, 6, 7, 9, 11, 12, and 13 were entered as indicators of the DNE factor. The remaining items (1, 2, 3, 4, 8, and 10) were entered as the indicators of the ANNE factor. The results showed that *Mardia's Z* was 15.93. Based on this finding, normality assumption was not met.

Therefore, robust statistics were taken into account instead of the maximum likelihood model. The average off-diagonal absolute standardized residual was found .07. When the percentage of residuals were examined, it was seen that 36.26% of residuals fall between z scores of -0.1 and 0, and 42.86% of residuals fall between z scores of 0 and 0.1. Robust statistics showed that the model did not fit the data well, *Satorra-Bentler* χ^2 (64) = 105.06, $p < .001$, *CFI* = .84, *RMSEA* = .07, *CI* [.04, .09]. In fact, Hu and Bentler (1999) argued that for a good model fit, Root Mean Square Error of Approximation below .06 and incremental fit indices around .95 should be sought. Therefore, post-hoc modifications were considered to improve the model.

In order to improve the initial model, four post-hoc modifications were conducted. Based on the suggestions of Lagrange Multiplier (LM) test, an error covariance was added between error terms of the indicators of ANNE (item 2 and item 3, item 2 and 8) and DNE (item 6 and item 11, item 9 and 12). Each modification was conducted separately. The model improved gradually and significantly after each modification ($\Delta\chi^2(1) = 15.71$, $p < .001$; $\Delta\chi^2(1) = 7.11$, $p < .01$; $\Delta\chi^2(1) = 4.11$, $p < .05$; $\Delta\chi^2(1) = 7.29$, $p < .01$). The final model fit the data very well, *Satorra-Bentler* $\chi^2(60) = 70.80$, $p > .05$, CFI = .96, RMSEA = .04, *CI* [.00, .07], supporting H_4. Figure 3 shows path diagram of the Turkish version of PDD in the general community sample.

3.4.2. Clinical sample

Two-factor structure of the Turkish version of PDD was also tested in clinical sample with CFA using EQS 6.1. Similar to the structure in community sample, items 5, 6, 7, 9, 11, 12, and 13 were entered as indicators of DNE factor. The remaining items (1, 2, 3, 4, 8, and 10) were entered as the indicators of ANNE factor. The results showed that *Mardia's Z* was 5.41. This value suggests a slight non-normality for the data. Therefore, robust statistics were considered instead of the maximum likelihood

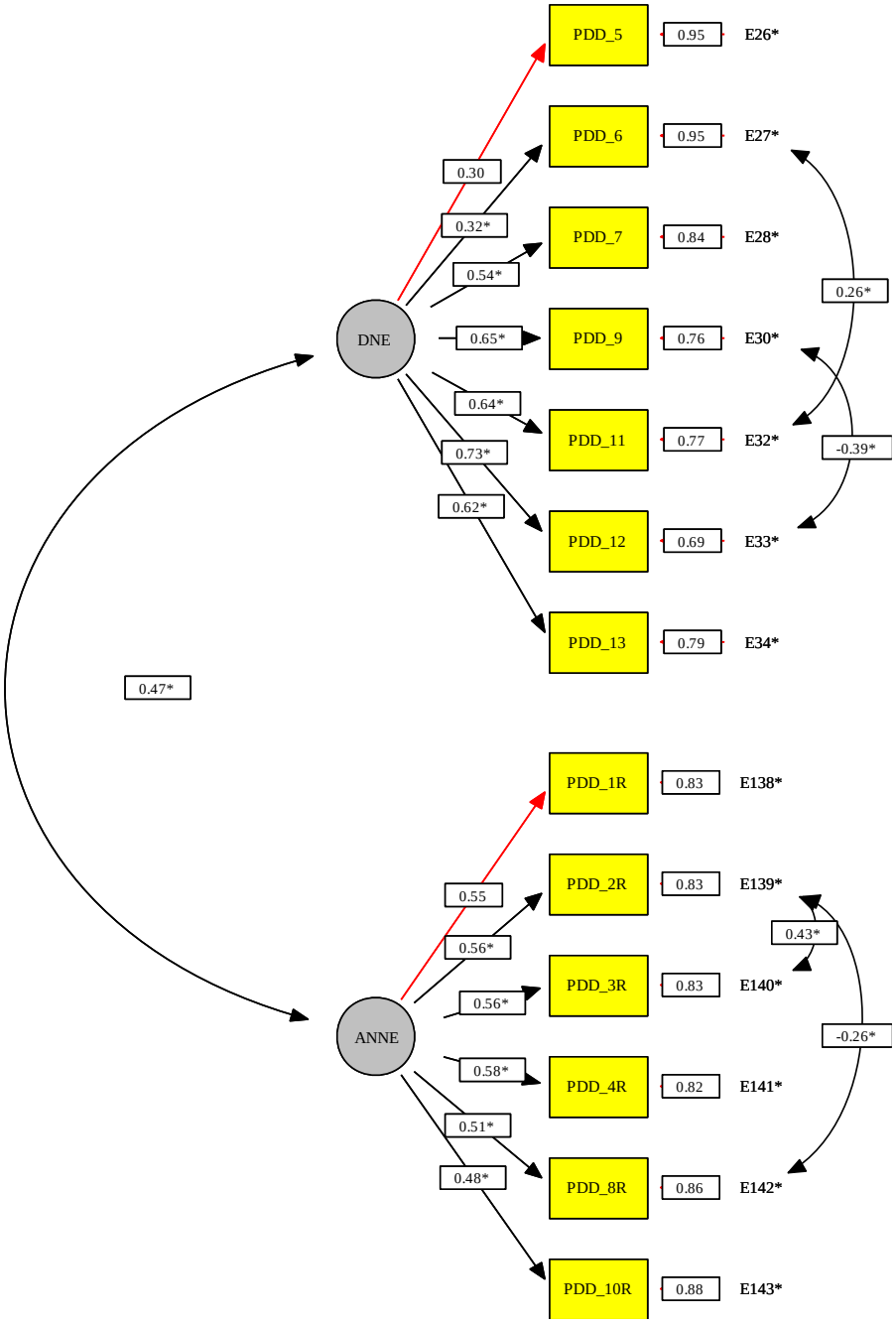

Figure 3. Path diagram of two-factor model for Turkish adaptation PDD in general community sample

Note. DNE: Perceived Discrimination and Negative Evaluation subscale, ANNE: Perceived Acceptance and Non-negative Evaluation subscale.

model. The average off-diagonal absolute standardized residual was .08. When the percentage of residuals was examined, it was seen that 71.43% of residuals fall between z scores of -0.1 and 0.1. Robust statistics produced the following results, *Satorra-Bentler* χ^2 (64) = 81.62, $p > .05$, *CFI* = .91, *RMSEA* = .06, *CI* [.00, .09]. Although the fit index in these results were below the suggested cut-off point of .95 (Hu & Bentler, 1999), it was still above the less strict and conventional cut-off point of .90 (Russell, 2002). Therefore, the model-data fit was considered to be marginally acceptable.

In order to explore for the possibilities to improve the initial model, LM test was conducted. Based on the suggestions of this test, one post-hoc modification was conducted by adding an error covariance between error terms of the indicators of items 2 and 8. This modification lead to a slight, yet significant improvement $\Delta\chi^2(1) = 5.66$, $p < .025$. The improved model had a more acceptable fit to the data, *Satorra-Bentler* χ^2 (63) = 75.96, $p > .05$, *CFI* = .93, *RMSEA* = .05, *CI* [.00, .09], supporting H_5. Figure 4 shows path diagram of the Turkish version of PDD in the clinical sample.

3.5. Convergent and Discriminant Validity

3.5.1. General community sample

Partial correlations were examined between PDD, BMI, PSOSH, RSES and BDI in order to test for convergent and discriminant validities of PDD in the community sample. Two demographic variables, which are marital status and age, were controlled in the analysis due to their associations with RSES and PDD as mentioned in the preliminary analyses.

For convergent validity, it was expected that PDD would be positively and significantly correlated with BMI (H_2) and PSOSH (H_3). The results showed that PDD and BMI were significantly and positively correlated ($r = .30$, $p < .001$). However, no significant correlation was found between PDD and PSOSH. Therefore, H_2 was accepted and H_3 was rejected.

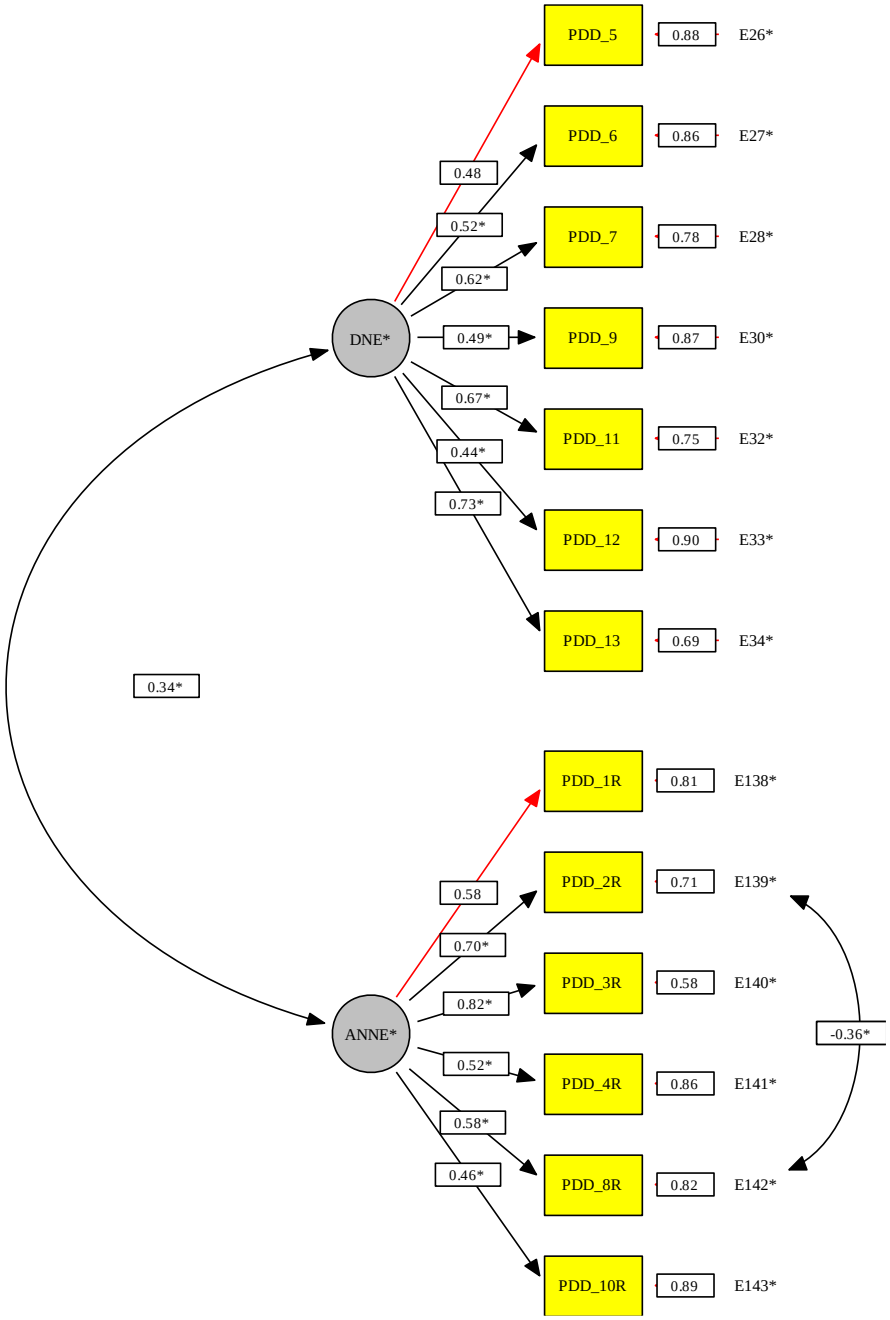

Figure 4. Path diagram of two-factor model for Turkish adaptation PDD in clinical sample

Note. DNE: Perceived Discrimination and Negative Evaluation subscale, ANNE: Perceived Acceptance and Non-negative Evaluation subscale.

In terms of discriminant validity, it was expected that PDD would be weakly correlated to RSES (H_{6b}) and BDI (H_8) below .30 level. As indicated by the results, there was no significant correlation between PDD and RSES; however, a weak but significant correlation was observed between PDD and BDI ($r = .24$, $p < .01$). Accordingly, H_{6b} was rejected and H_8 was accepted. Table 8 provides a list of correlations for the community sample.

3.5.2. Clinical sample

Convergent validity of PDD was tested in the clinical sample through partial correlations between PDD, RSES and ISMI. For the analyses in this sample, age was taken as the control variable due to its association with PDD as mentioned in the preliminary analyses. It was hypothesized that PDD would be significantly and positively correlated with both ISMI (H_1) and RSES (H_{6a}), forming the evidence for convergent validity of PDD in the clinical sample. Indeed, there was a significant positive correlation between PDD and ISMI ($r = .51$, $p < .001$) and a significant positive correlation between PDD and RSES ($r = .34$, $p < .01$). Therefore, both H_1 and H_{6a} were accepted. Table 9 summarizes correlations between PDD, RSES, ISMI and ISMI subscales.

In addition to correlations, it was hypothesized that PDD would positively and significantly predict RSES in the clinical sample after controlling for demographic variables (H_7). To test this hypothesis, first, a simple linear regression analysis was conducted to see whether PDD predicts self-esteem of the participants in the clinical sample. The results produced a significant regression equation ($F(1, 83) = 10.15$, $p < .01$, $R^2 = .11$), showing that PDD significantly predicted RSES scores in a positive direction ($\beta = .33$, $B = .91$, 95% CI [.34, 1.48], $p < .01$). In order to see whether age has a significant effect on this equation, a hierarchical multiple regression was conducted. Adding age to the model did not result in a significant increase in explained variance. However, the equation was significant ($\Delta F(2, 82) = 5.23$, $p < .01$) and PDD still predicted RSES significantly and positively ($\beta = .35$, $B = .95$, 95% CI [.37, 1.54], $p < .01$). As a result, H_7 was accepted.

Table 8

Correlations Between PDD and Other Scales in General Community Sample

Scales	PDD	PDD-DNE	PDD-ANNE	BMI	BMI-IDIR	BMI-D	BMI-S	RSES	PSOSH	BDI
PDD	-									
PDD-DNE	.83***	-								
PDD-ANNE	.76***	.28***	-							
BMI	.30***	.27***	.20*	-						
BMI-IDIR	.31***	.30***	.20*	.94***	-					
BMI-D	.25**	.22**	.18*	.86***	.65***	-				
BMI-S	.19**	.11	.21*	.55***	.42***	.44***	-			
RSES	.04	.12	-.06	.03	.05	-.04	-.05	-		
PSOSH	.12	.08	.12	.23**	.27**	.11	.14	.17	-	
BDI	.24**	.17*	.22*	.11	.12	.06	.07	.47***	.20*	-

Note 1. *$p < .05$ level (2-tailed), ** $p < .01$ level (2-tailed), *** $p < .001$ level (2-tailed).

Note 2. Age and marital status variables were controlled.

Note 3. PDD: Perceived Devaluation-Discrimination scale, PDD-DNE: PDD Perceived Discrimination and Negative Evaluation subscale, PDD-ANNE: PDD Perceived Acceptance and Non-negative Evaluation subscale BMI: Beliefs Toward Mental Illness scale, BMI-IDIR: BMI Incurability and Disturbance in Interpersonal Relationships subscale, BMI-D: BMI Dangerous subscale, BMI-S: BMI Shame subscale, RSES: Rosenberg Self-Esteem Scale, PSOSH: Perceptions of Stigmatization by Others for Seeking Help scale, BDI: Beck Depression Inventory.

Table 9

Correlations Between PDD and Other Scales in Clinical Sample

Scales	PDD	PDD-DNE	PDD-ANNE	RSES	ISMI	ISMI- A	ISMI-SE	ISMI-DE	ISMI-SW	ISMI-SR
PDD	-									
PDD-DNE	.82***	-								
PDD-ANNE	.80***	.30**	-							
RSES	.34**	.20	.35***	-						
ISMI	.51***	.57***	.25*	.40***	-					
ISMI-A	.58***	.64***	.28*	.42***	.87***	-				
ISMI-SE	.23*	.34**	.03	.17	.75***	.59***	-			
ISMI-DE	.41***	.54***	.12	.24*	.83***	.64***	.59***	-		
ISMI-SW	.37***	.49***	.11	.34**	.86***	.67***	.58***	.70***	-	
ISMI-SR	.30**	.02	.47***	.28*	.36***	.24*	.01	.13	.15	-

Note 1. * $p < .05$ level (2-tailed), ** $p < .01$ level (2-tailed), *** $p < .001$ level (2-tailed).

Note 2. Age was controlled.

Note 3. PDD: Perceived Devaluation-Discrimination scale, PDD-DNE: PDD Perceived Discrimination and Negative Evaluation subscale, PDD-ANNE: PDD Perceived Acceptance and Non-negative Evaluation subscale, RSES: Rosenberg Self-Esteem Scale, ISMI: Internalized Stigma of Mental Illness scale, ISMI-A: ISMI Alienation subscale, ISMI-SE: ISMI Stereotype Endorsement subscale, ISMI-DE: ISMI Discrimination Experience subscale, ISMI-SW: ISMI Social Withdrawal subscale, ISMI-SR: ISMI Stigma Resistance subscale.

CHAPTER 4

DISCUSSION

The main goal of this study was to adapt PDD scale to Turkish language and culture by demonstrating its psychometric properties with general community and clinical samples. For this purpose, reliability and validity of PDD were examined with data from two different samples. Exploratory and confirmatory factor analyses were conducted to investigate the construct validity of the scale, Cronbach's alpha values were calculated to investigate the internal consistency reliability, correlation coefficients between PDD, ISMI, BMI, BDI, RSES and PSOSH were calculated to investigate convergent validity, and between PDD, BDI and RSES to investigate discriminant validity.

Reliability of the Turkish version of PDD was tested with internal consistency analysis. In the literature, it is generally accepted that Cronbach's alpha values above .70 are acceptable (Pallant, 2007). The results in the current study showed that PDD and its subscales had alpha values higher than this cut-off point. Therefore, it can be concluded that PDD has high internal consistency in both clinical and general community populations.

All hypotheses regarding the clinical sample were supported. That is, PDD supported a two-factor structure and it was found significantly and positively correlated to ISMI and RSES, indicating that higher PDD scores were significantly related to higher internalized stigma and lower self-esteem among psychiatric patients. Moreover, PDD predicted lower self-esteem for psychiatric patients.

For the community sample, although the majority of the hypotheses were supported, two of the hypotheses were rejected. More specifically, parallel with author's

expectations, PDD supported a two-factor structure and it was significantly and positively related to stigmatizing beliefs in general community as measured by BMI. Also, PDD was weakly related to depressive symptoms as measured by BDI among general community residents, confirming the study hypotheses. However, in contrast to the expectations, PDD was not related to stigma of seeking psychological help (PSOSH) and self-esteem (RSES) in the general community sample. Despite the two rejected hypotheses, overall, the two-factor Turkish version of PDD emerged as a reliable and valid scale to be used for stigma research in both general community and clinical populations.

In the community and clinical samples, EFA results showed that negatively-worded and positively-worded items grouped under separate factors. This finding is in line with a previous study that was conducted with a sample of Latino people with depression (Interian et al., 2010). Therefore, the factor names as in Interian et al. (2010) study were used in the present study as well. When the item-factor loadings in EFA were examined, it was seen that the loadings in the clinical sample were above the conventionally accepted cut-off point of .40 (Matsunaga, 2010). Moreover, all items in this sample loaded to their respective factors above the cut-off point of .45, which was suggested as a fair degree of factor loading by Comrey and Lee (1992). This provided a clear picture for the two-factor structure of PDD in the clinical sample. On the other hand, in the community sample, items 5 and 8 had factor loadings lower than the cut-off point of .40. Among these two items, item 5 ("Most people believe that entering a psychiatric hospital is a sign of personal failure") has previously been reported as one problematic item in an EFA conducted by Interian et al. (2010) for not loading to PDD. For the present study, although this item loaded to its respective factor, its loading was in the questionable range for the community sample. What is more, despite having a fair level of factor loading in the clinical sample, item 5 still represented one of the weakest loadings in clinical sample too. In this regard, the present study supports the previous

finding since item 5 also appears to be a relatively problematic item in the Turkish version of PDD.

The other item with questionable loading, item 8 ("Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job"), had equal loadings to both DNE and ANNE factors. However, this result was unique to the community sample and item 8 had a clear loading in the clinical sample. This difference is interesting and it might be stemming from the fact that item 8 was rated neutrally by the community sample participants (44.4% of participants rated 2, and 46.5% of participants rated 3 on a 4-point Likert scale). However, from a different perspective, this difference might also reflect the difference between opinions and experience. Undoubtedly, the participants in the clinical sample are more likely to have experienced the situation described in item 8 as a real-life situation and faced a different result than what is expressed as an opinion by community residents.

The two-factor structure of PDD as shown in EFA results was also tested with CFA. Analysis results showed that the two-factor model for PDD had a good data-model fit in the community sample and an acceptable data-model fit in the clinical sample. These findings support construct validity of PDD in general community and clinical samples. On the other hand, although the results support the two-factor structure of negatively and positively-worded subscales for PDD, it should be noted that these subscales were not proposed by Link (1987) in the original PDD scale. Therefore, the two subscales introduced in current study do not necessarily measure different aspects of perceived stigma. In fact, it is possible that the two-factor solution reflects a wording effect. It is known that making use of both positive and negative sentence structures in the same survey can lead to an artificial method factor in factor analysis (Harvey, Billings, & Nilan, 1985). Idaszak and Drasgow (1987) showed that such an "arti-factor" can disappear when the reverse-coded items are re-written in a non-reverse-coded fashion.

The literature on factor analysis of PDD also contains some evidence for a wording effect. For example, in a CFA conducted by Glass et al. (2013), reverse-coded items of a modified version of PDD were loaded on a *Latent Method Factor* in order to control for the wording-effect in PDD. The result of their study showed that CFA supports both the single factor and two-factor (perceived devaluation and perceived discrimination) structures. The present study did not test for a possible wording-effect by comparing multiple models in CFA. Therefore, separate uses of PDD subscales (DNE and ANNE) is not recommended until the wording effects are tested in the Turkish version.

In CFA, some error terms were allowed to covary in order to achieve a good data-model fit. Brown (2006) stated that correlated errors may result from social desirability and method effects, such as questionnaire structures and wording of the items. It can be argued that PDD items are more likely to generate politically correct responses in general community populations, which, by definition, consist of the perpetrators of stigmatization process as compared to the clinical populations, which consist of victims of stigmatization. Consequently, more correlated errors that arise from social desirability effect can be expected in the general community sample than the clinical sample. In fact, in order to achieve a good data-model fit, 4 error covariances were used in the general community sample CFA (between items 6 and 11, 9 and 12, 2 and 3, 2 and 8), as opposed to 1 error covariance in the clinical sample CFA (between items 2 and 8).

The correlated errors between items 2 and 8 in particular, on the other hand, can be attributed to a different reason than social desirability. Indeed, the correlated error between these two items was present in both the general community and clinical samples. When the content of these items are examined, it can be seen that item 2 (“Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person”) and item 8 (“Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job”) ask participants to rate statements based on qualities such as intelligence and job competence. Each of these

qualities can be somehow objectively measured with tools such as intelligence tests or job performance evaluation instruments. This might have resulted in a cognitive bias of belief in a just world, which is a belief that "everyone gets what they deserve and deserves what they get" (Dalbert & Donat, 2015, p.487). Such a bias might have resulted in a common error variance across both samples between items 2 and 8. Therefore, an error covariance was used between the error terms of these items.

In addition to EFA and CFA, convergent validity of PDD was tested in the clinical and community samples. In the clinical sample, this test was conducted by investigating the relationship between PDD, ISMI, and RSES. ISMI (Ritsher et al., 2003) is a survey that is used to measure internalized stigma of patients with mental disorders, and RSES (Rosenberg, 1965) is used in order to measure self-esteem. Previously, researchers reported associations between PDD and ISMI (Brohan et al., 2010; Ritsher et al., 2003), and between PDD and RSES (Link et al., 2001) in clinical sample studies. The results of the present study were in line with these findings as they demonstrated significant positive correlations between PDD and ISMI, as well as between PDD and RSES in the clinical sample. Therefore, these findings support the construct validity of PDD in the clinical sample.

In order to test for convergent validity in the community sample two stigma scales were used. One of these scales, BMI, was designed to measure cross-cultural differences in beliefs toward mental illness (Hirai & Clum, 2000). To the author's knowledge, there is no previous study that investigated the relationship between BMI and PDD. Nonetheless, BMI was included in the present study for convergent validity testing because BMI and PDD measure paralleling stigma components. In fact, as in BMI, statements on public *beliefs* about mental illness comprise a large proportion of PDD items. The results of the current study produced the expected results: BMI and PDD were significantly and positively correlated. This finding supports convergent validity of PDD in general community populations.

The second scale, PSOSH, which was used in current study to test for convergent validity of PDD in the community sample, was created by Vogel et al. (2009) to measure perception of stigma for seeking psychological help. Vogel and his colleagues (2009) reported a small but significant correlation between PSOSH and PDD to support the validity of PSOSH in a student sample. However, in contrast to the previous finding reported by Vogel et al. (2009), no significant correlation between PDD and PSOSH was observed in the present study. Sample characteristics, particularly age difference, might have accounted for this unexpected result. In fact, Vogel et al. (2009) demonstrated the correlation between PDD and PSOSH on a college student sample in the United States. However, the mean age of the community sample is 44.90 for the current study, which is much older than a typical college student sample. Therefore, the small positive correlation reported in Vogel et al. (2009) study might have lost its significance due to age difference in the current study. Cultural differences, on the other hand, are less likely to have contributed to this unexpected result. In support of this argument, a study conducted in Turkey, which applied PSOSH on an undergraduate student sample, has demonstrated that the public perception of stigma leads to self-stigmatizing attitudes and this, in turn, leads to negative attitudes toward seeking psychological help (Topkaya, Vogel, & Brenner, 2017). Hence, cultural differences do not necessarily mask the relationship between public stigma perception and help-seeking attitudes in Turkey.

Finally, discriminant validity of PDD was tested in the community sample. In order to do this, RSES and BDI were used. The main logic behind this choice comes from specific predictions of MLT. According to this theory, higher levels of perceived devaluation and discrimination should be associated with more negative psychological outcomes for people with official psychiatric diagnosis, but not for people who are not diagnosed with a psychiatric disorder (Link et al., 1989; Link et al., 2004). Previous studies showed that PDD was related to depressive symptoms (Link et al., 1997) and diminished self-esteem (Link et al., 2001) in clinical samples. It was also shown that PDD predicted demoralization among those with a psychiatric diagnosis, but not among

people without an official diagnosis (Link, 1987). As a result, for this study, it was expected that there would only be a weak, if any, relation between PDD and BDI or between PDD and RSES in the community sample, because most of the participants in this sample do not have any psychiatric diagnoses. As expected, there was a weak correlation between PDD and BDI for the community sample. Yet, no association was observed between PDD and RSES in this sample. Although the lack of a weak association between PDD and RSES resulted in rejecting the hypothesis, this finding is still an important evidence for discriminant validity of PDD in the community sample. In fact, discriminant validity is defined as a lack of relation or as a weak relation between two unrelated constructs (Mungas et al., 2014). Therefore, both the weak correlation between PDD and BDI, and the lack of relation between PDD and RSES support discriminant validity of PDD in the community sample.

Although the weak correlation between PDD and BDI is an evidence for discriminant validity of PDD in the community sample, this relation still requires an explanation, because MLT does not predict for a relation between PDD and depressive symptoms among non-labeled community members (Link et al., 2004). Moreover, Link (1987) reported a lack of association between PDD and demoralization scale, which measures some depressive symptoms among general community members. However, the demoralization scale (Dohrenwend, Shrout, Egri, & Mendelsohn, 1980) that Link (1987) used a in his study is not a direct measure of depression. Although the demoralization scale measured certain depressive symptoms such as poor appetite, sad or depressed feelings, and helplessness, it has been demonstrated that demoralization is a distinct condition from depression (Tecuta, Tomba, Grandi, & Fava, 2015). Therefore, the finding regarding the significant correlation between PDD and BDI in a general community sample does not necessarily contradict with Link's (1987) findings. Moreover, the fact that there is a small correlation between PDD and BDI might reflect negative cognitive biases associated with depressive mood. Indeed, it is established that depression might affect how people perceive different situations, recall information, and

make appraisals (Gotlib & Joorman, 2010). Therefore, participants with higher depression scores might have displayed a bias towards negative responses in PDD scale.

In conclusion, validity tests for PDD in the clinical sample provided solid evidence supporting its use as a perceived stigma measure on clinical populations. Although not as strong as the evidence in the clinical sample, the tests conducted with the general community sample also provided support for the validity of PDD's use on public populations.

4.1. Contributions and Implications

The purpose of the present study was to develop a Turkish version of PDD. Being applicable to both clinical and community populations, PDD is unique in that it allows for comparisons of patient and non-patient samples in stigma research. Such comparisons are now possible in the Turkish cultural context with the introduction of the Turkish form of PDD. Moreover, since PDD has been used in many other countries, cross-cultural comparisons including Turkish and other cultural contexts may become feasible.

As mentioned in the method section, a fair amount of evidence for the construct validity of PDD was reported in previous clinical population studies. With respect to this point, the current study supported previous research findings. However, only few studies investigated construct validity of PDD in general community samples. In one such study, Yin et al. (2014) investigated the construct validity of PDD with a Chinese sample using a CFA. Their results supported construct validity of PDD in Chinese general public population. Nevertheless, there is still an important gap in the literature regarding convergent and discriminant validity evidence for PDD in public populations. Hence, the present study can be another step towards filling the gap in the literature regarding the construct validity of PDD in public samples, by investigating the factor structure, and convergent and discriminant validity of PDD using a Turkish community sample.

Implications of the current study findings are limited to the general uses of PDD. First of all, PDD can be used as a perceived stigma and internalized stigma measure in

clinical populations. Secondly, it can be used in general public populations in order to assess perceived public stigma of mental illness. As mentioned previously, when used on public populations, PDD can be expected to generate less social desirability bias because it asks respondents *what most people think* rather than directly asking their personal judgment (Link & Cullen, 1983). Finally, because PDD was originally created in order to test Modified Labeling Theory predictions, it can be used to study this theory in Turkish cultural context.

4.2. Limitations of the Present Study and Future Research Directions

The current study has several limitations. First of all, due to lack of resources, EFA and CFA could not be conducted on independent samples. Therefore, the findings regarding CFA should be interpreted with caution. Future studies are needed to conduct independent CFA to test for the two-factor structure presented in the current study. Second, as mentioned previously, there are different studies reporting not only two-factor solutions for PDD but also a single-factor structure. The current study only tested for one of the two-factor solutions; however, a comparison of various models as suggested in the literature is needed, specifically after controlling for the wording effect. Third, both clinical and community samples of the present study were somewhat homogeneous. For example, the majority of the community sample consisted of university graduates and the majority of clinical sample participants were males with diagnoses from psychotic/schizophrenic spectrum. Therefore, the findings might reflect specific tendencies of these groups and may have low generalizability. Finally, as in all studies using self-report measures, social desirability bias might have affected the observed results, especially in the general community sample. For example, for BMI scale, which asks respondents' direct judgments about mental illness, the overall responses were significantly below neutral midpoint of 2.5, which indicated low stigmatizing beliefs based on composite scores in the community sample. On the other hand, for PDD, which asks participants to rate what *most people* think about individuals with mental illness, the

responses were significantly above the neutral midpoint of 2.5, which indicated high stigma perception based on composite scores in community sample. If this difference between the two stigma scales stemmed from a social desirability bias as previously exemplified by Elinson, Padilla and Perkins (1967), the true strength of some associations might be masked by this bias. The current study lacked a control measure for such a confounding effect.

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APPENDICES

A. TRY-OUT INTERVIEW QUESTIONS

1. Anketin nasıl doldurulması gerektiği yeterince net anlaşılıyor mu? Açıklayınız.
2. Ankette anlaşılması güç kelimeler, cümleler veya ifadeler bulunuyor mu? Belirtiniz.
3. Ankette genel olarak size rahatsızlık veren bir ifade var mı? Belirtiniz.
4. Anketle ilgili herhangi bir konuda (anketteki ifadeler, anketin doldurulma şekli, anketin genel görüntüsü vs.) öneriniz var mıdır? Belirtiniz.
5. Ankete eklense güzel olurdu dediğiniz bir soru var mıdır?

B. ORIGINAL PDD FORM IN ENGLISH

Please rate your level of agreement with the following statements on a scale from 1 to 4, where "1" means you strongly disagree, "2" means you disagree, "3" means you agree, and "4" means you strongly agree Note that some of the statements are inverted (meaning their scale is reversed, compared to the other questions). So please read each statement carefully, then circle the number that best expresses your feeling.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Most people would accept a person who once had a serious mental illness as a close friend.	1	2	3	4
2. Most people believe that a person who has been in a psychiatric hospital is just as intelligent as the average person.	1	2	3	4
3. Most people believe that a person who has been hospitalized for serious mental illness is just as trustworthy as the average citizen.	1	2	3	4
4. Most people would accept a person who has made a full recovery from serious mental illness as a teacher of young children in a public school.	1	2	3	4
5. Most people believe that entering a psychiatric hospital is a sign of personal failure.	1	2	3	4
6. Most people will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.	1	2	3	4

7. Most people think less of a person who has been in a psychiatric hospital.	1	2	3	4
8. Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.	1	2	3	4
9. Most employers will pass over the application of a person who has been hospitalized for mental illness in favor of another applicant.	1	2	3	4
10. Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.	1	2	3	4
11. Most young women would be reluctant to date a man who has been hospitalized for a serious mental illness.	1	2	3	4
12. Once they know a person was in a psychiatric hospital, most people will take his or her opinions less seriously.	1	2	3	4
13. Most people think that a person who has been hospitalized for serious mental illness is dangerous and unpredictable.	1	2	3	4

C. PDD FORM AFTER RECONCILIATION PROCESS

Lütfen aşağıdaki ifadelere ne derecede katıldığınızı 1'den 4'e kadar olan ölçek üzerinde belirtiniz. Ölçekteki rakamlardan "1" hiç katılmadığınız, "2" katılmadığınız, "3" katıldığınız, ve "4" tamamen katıldığınız anlamına gelmektedir. Lütfen verilen cümleleri dikkatlice okuyarak sizi en iyi ifade eden rakamı daire içine alınız. Her soru için yalnızca tek bir rakamı daire içine alınız.

	Hiç Katılmıyorum	Katılmıyorum	Katılıyorum	Tamamen Katılıyorum
1. Çoğu kişi önceden ciddi bir ruhsal hastalık geçirmiş biriyle yakın arkadaş olmayı kabul eder.	1	2	3	4
2. Çoğu kişi akıl hastanesinde tedavi görmüş birinin ortalama biri kadar zeki olduğuna inanır.	1	2	3	4
3. Çoğu kişi akıl hastanesinde yatmış birinin ortalama bir vatandaş kadar güvenilir olduğuna inanır.	1	2	3	4
4. Çoğu kişi geçirdiği ciddi ruhsal hastalıktan tamamen kurtulmuş olan birinin devlet okulunda küçük çocuklara öğretmenlik yapmasını kabul eder.	1	2	3	4
5. Çoğu kişi akıl hastanesine girmenin kişisel bir başarısızlık olduğuna inanır.	1	2	3	4
6. Çoğu kişi ciddi bir ruhsal hastalık sebebiyle hastanede yatmış olan birini, o kişi bir süredir iyi durumda olsa dahi	1	2	3	4

çocuklarına bakıcı olarak işe almaz.				
7. Çoğu kişi akıl hastanesine girmiş biriyle ilgili olumsuz düşünür.	1	2	3	4
8. Çoğu işveren ruhsal hastalık sebebiyle hastanede yatmış birini, eğer o iş için yeterli beceriye sahipse işe alır.	1	2	3	4
9. Çoğu işveren ruhsal hastalığından dolayı hastanede yatmış birini işe almak yerine başka bir adayı tercih eder.	1	2	3	4
10. Benim çevremdeki çoğu kişi herhangi birine nasıl davranıyorsa, ruhsal bir hastalık sebebiyle hastanede yatmış birine de aynı şekilde davranır.	1	2	3	4
11. Çoğu genç kadın ciddi bir ruhsal hastalıktan dolayı hastanede yatmış biri ile romantik ilişki yaşama konusunda isteksiz olur.	1	2	3	4
12. Çoğu kişi akıl hastanesinde yatmış olduğunu öğrendikleri kişinin görüşlerini daha az ciddiye alır.	1	2	3	4
13. Çoğu kişi ciddi bir ruhsal hastalık sebebiyle hastanede yatmış birinin tehlikeli ve öngörülemez olduğunu düşünür.	1	2	3	4

D. PDD FORM AFTER FINAL REVISION

Lütfen aşağıdaki ifadelere ne derecede katıldığınızı 1'den 4'e kadar olan ölçek üzerinde belirtiniz. Ölçekteki rakamlardan **"1" hiç katılmadığınız**, **"2" katılmadığınız**, **"3" katıldığınız**, ve **"4" tamamen katıldığınız** anlamına gelmektedir. Lütfen verilen cümleleri dikkatlice okuyarak sizi en iyi ifade eden rakamı daire içine alınız. Her cümle için yalnızca tek bir rakamı daire içine alınız.

	Hiç Katılmıyorum	Katılmıyorum	Katılıyorum	Tamamen Katılıyorum
1. Çoğu kişi önceden ciddi bir ruhsal hastalık geçirmiş biriyle yakın arkadaş olmayı kabul eder.	1	2	3	4
2. Çoğu kişi psikiyatri hastanesinde tedavi görmüş birinin ortalama biri kadar zeki olduğuna inanır.	1	2	3	4
3. Çoğu kişi psikiyatri hastanesinde yatmış birinin ortalama bir insan kadar güvenilir olduğuna inanır.	1	2	3	4
4. Çoğu kişi geçirdiği ciddi ruhsal hastalıktan tamamen kurtulmuş olan birinin devlet okulunda küçük çocuklara öğretmenlik yapmasını kabul eder.	1	2	3	4
5. Çoğu kişi psikiyatri hastanesine girmenin kişisel bir başarısızlık olduğuna inanır.	1	2	3	4
6. Çoğu kişi ciddi bir ruhsal hastalık sebebiyle hastanede yatmış olan birini, bir süredir iyi durumda olsa bile,	1	2	3	4

çocuklarına bakıcı olarak işe almaz.				
7. Çoğu kişi psikiyatri hastanesine girmiş biriyle ilgili olumsuz düşünür.	1	2	3	4
8. Çoğu işveren ruhsal hastalık sebebiyle hastanede yatmış birini, eğer o iş için yeterli beceriye sahipse işe alır.	1	2	3	4
9. Çoğu işveren ruhsal hastalığından dolayı hastanede yatmış birini işe almak yerine başka bir adayı tercih eder.	1	2	3	4
10. Benim çevremdeki çoğu kişi herkese nasıl davranıyorsa, ruhsal bir hastalık sebebiyle hastanede yatmış birine de aynı şekilde davranır.	1	2	3	4
11. Çoğu genç kadın ciddi bir ruhsal hastalıktan dolayı hastanede yatmış bir adamla romantik ilişki yaşama konusunda isteksiz olur.	1	2	3	4
12. Çoğu kişi psikiyatri hastanesinde yatmış olduğunu öğrendikleri kişinin görüşlerini daha az ciddiye alır.	1	2	3	4
13. Çoğu kişi ciddi bir ruhsal hastalık sebebiyle hastanede yatmış birinin tehlikeli ve öngörülemez olduğunu düşünür.	1	2	3	4

E. INFORMED CONSENT FORM

ARAŞTIRMAYA GÖNÜLLÜ KATILIM FORMU

Bu araştırma, ODTÜ Psikoloji Bölümü Yüksek Lisans öğrencisi Kutay Saçak tarafından Doç. Dr. Deniz Canel Çınarbaş danışmanlığındaki yüksek lisans tezi kapsamında yürütülmektedir. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Bu araştırmanın amacı, ruhsal hastalığı bulunan biriylere yönelik toplumdaki ayrımcılık ve değersizleştirme algısını ölçmek üzere kullanılan bir ölçüm aracının Türkçe'ye tercümesi ve uyarlamasını yapmaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz, sizden beklenen, ankette yer alan bir dizi soruyu derecelendirme ölçeği üzerinde yanıtlamanız olacaktır. Bu çalışmaya katılım ortalama olarak 20 dakika sürmektedir.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük temelinde olmalıdır. Ankette, sizden kimlik veya kurum belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak, sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayımlarda kullanılacaktır. Sağladığınız veriler gönüllü katılım formlarında toplanan kimlik bilgileri ile eşleştirilmeyecektir.

Katılımınızla ilgili bilmeniz gerekenler:

Anket, genel olarak kişisel rahatsızlık verecek sorular içermemektedir. Ancak, katılım sırasında sorulardan ya da herhangi başka bir nedenden ötürü kendinizi rahatsız hissederseniz cevaplama işini yarıda bırakmakta serbestsiniz. Böyle bir durumda anketi uygulayan kişiye, anketi tamamlamadığınızı söylemek yeterli olacaktır.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Anket sonunda, bu çalışmayla ilgili sorularınız cevaplanacaktır. Bu çalışmaya katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Psikoloji Bölümü öğretim üyelerinden Doç. Dr. Deniz Canel Çınarbaş (E-posta: dcanel@metu.edu.tr) ya da yüksek lisans öğrencisi Kutay Saçak (E-posta: kutay.sacak@metu.edu.tr) ile iletişim kurabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

İsim Soyad Tarih İmza

F. DEMOGRAPHIC FORM

Yaşınız: _____ Cinsiyetiniz: _____
Medeni durumunuz: [ ] Evli [ ] Bekar

Hanenizde yaşayan toplam kişi sayısı: _____

Aylık toplam hane geliriniz: _____

Eğitim durumunuz (*Lütfen mezun olarak bitirdiğiniz son eğitimi işaretleyiniz*):

[ ] Okuma yazma bilmiyorum ve mezuniyetim yok.
[ ] Mezuniyetim yok ancak okuma yazma biliyorum.
[ ] İlkokul mezunuyum.
[ ] Ortaokul mezunuyum.
[ ] Lise mezunuyum.
[ ] Üniversite mezunuyum.
[ ] Yüksek Lisans mezunuyum.
[ ] Doktora mezunuyum.

Lütfen son bir yıl (son 52 hafta) içerisindeki çalışma durumunuzu belirtiniz:

[ ] Son bir yılda gelir getiren bir işte toplam _____ hafta çalıştım. (*Sayısını belirtiniz*)

[ ] Son bir yıldır gelir getiren bir işte hiç çalışmadım. [ ] Şuanda emekliyim.

Daha önce herhangi bir ruhsal sağlık hizmeti aldınız mı? (Örnek: Psikiyatrik ilaç tedavisi, Psikoterapi)

[ ] Hayır [ ] Evet *(Lütfen aldığınız hizmeti belirtiniz)*: _____

Şuanda herhangi bir ruhsal sağlık hizmeti alıyor musunuz? (Örnek: Psikiyatrik ilaç tedavisi, Psikoterapi)

[ ] Hayır [ ] Evet *(Lütfen aldığınız hizmeti belirtiniz)*: _____

Daha önce herhangi bir psikiyatrik tanı aldınız mı?

[ ] Hayır [ ] Evet (*Lütfen tanıyı belirtiniz*): _____

Cevabınız "Evet" ise ne kadar zaman önce bu tanıyı aldınız?: _____

Daha önce herhangi bir sebeple bir psikiyatri bölümünde <u>yatılı</u> hasta olarak sağlık hizmeti aldınız mı?

[ ] Hayır [ ] Evet (*En son ne zaman bu hizmeti aldınız?*): _____

Yakın ailenizde (anne, baba, çocuk veya kardeş) psikiyatrik tanı almış bir birey bulunuyor mu?

[ ] Hayır [ ] Evet

G. ROSENBERG SELF ESTEEM SCALE

Aşağıdaki cümleleri okuyarak sizin için uygun olan şıkkı işaretleyiniz.

1) Kendimi en az diğer insanlar kadar değerli buluyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

2) Bazı olumlu özelliklerim olduğunu düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

3) Genelde kendimi başarısız bir kişi olarak görme eğilimindeyim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

4) Ben de diğer insanların birçoğunun yapabildiği kadar bir şeyler yapabilirim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

5) Kendimde gurur duyacak fazla bir şey bulamıyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

6) Kendime karşı olumlu bir tutum içindeyim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

7) Genel olarak kendimden memnunum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

8) Kendime karşı daha fazla saygı duyabilmeyi isterdim.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

9) Bazen kesinlikle kendimin bir işe yaramadığını düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

10) Bazen kendimin hiç de yeterli bir insan olmadığını düşünüyorum.

a. Çok doğru b. Doğru c. Yanlış d. Çok yanlış

H. PERCEPTIONS OF STIGMATIZATION BY OTHERS FOR SEEKING HELP SCALE

Aşağıda çevre tarafından damgalanmaya ilişkin kişisel algıları ortaya koyan bazı ifadeler verilmiştir. Lütfen her bir ifadeyi dikkatle okuyunuz. Her bir cümleyi okuduktan sonra; **"hiç katılmıyorum"**, **"katılmıyorum"**, **"kararsızım"**, **"katılıyorum"**, **"tamamen katılıyorum"** seçeneklerinden sizin için uygun olanın altına (X) işareti koyunuz.

Eğitiminiz veya mesleğinize ilişkin kendi başınıza çözemeyeceğiniz bir sorununuz olduğunu düşünün. Bu sorunla ilgili psikolojik danışma yardımı almaya karar verirseniz, etkileşim içinde olduğunuz insanların aşağıda ifade edilen tepkileri ne düzeyde göstereceklerini düşünürsünüz?

Etkileşim içinde olduğunuz insanlar…

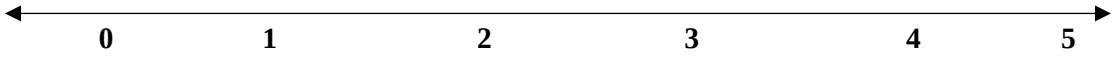
		Hiç katılmıyorum	**Katılmıyorum**	**Orta derecede katılıyorum**	**Katılıyorum**	**Tamamen katılıyorum**
1	Sizinle ilgili daha az iyi niyetli düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
2	Sizinle ilgili kötü şeyler düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
3	Size olumsuz tepki verirler.	**( )**	**( )**	**( )**	**( )**	**( )**
4	Sizi ciddi şekilde rahatsız biri olarak görürler.	**( )**	**( )**	**( )**	**( )**	**( )**
5	Başkaları için risk oluşturduğunuzu düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
6	Deli olduğunuzu düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
7	Sizden korkarlar.	**( )**	**( )**	**( )**	**( )**	**( )**
8	Sizi güçsüz görürler.	**( )**	**( )**	**( )**	**( )**	**( )**
9	Sizden daha az hoşlanırlar.	**( )**	**( )**	**( )**	**( )**	**( )**
10	Başkalarına sizinle ilgili olumsuz şeyler söylerler.	**( )**	**( )**	**( )**	**( )**	**( )**

11	Sizden utanırlar.	**( )**	**( )**	**( )**	**( )**	**( )**
12	Size çocukmuşsunuz gibi davranırlar.	**( )**	**( )**	**( )**	**( )**	**( )**
13	Sizi daha az çekici bulurlar.	**( )**	**( )**	**( )**	**( )**	**( )**
14	Sizin öngörülemez (tahmin edilemez) olduğunuza inanırlar.	**( )**	**( )**	**( )**	**( )**	**( )**
15	Bu durumun sizin hatanız olduğunu düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
16	Bir işe giremeyeceğinizi iddia ederler.	**( )**	**( )**	**( )**	**( )**	**( )**
17	Daha saldırgan ve tehlikeli olduğunuzu düşünürler.	**( )**	**( )**	**( )**	**( )**	**( )**
18	Size kızarlar.	**( )**	**( )**	**( )**	**( )**	**( )**
19	Sizin bulunduğunuz ortamlarda kendilerini rahatsız hissederler.	**( )**	**( )**	**( )**	**( )**	**( )**
20	Size diğer insanlardan farklı davranırlar.	**( )**	**( )**	**( )**	**( )**	**( )**
21	Kendi başınıza bir şeyin üstesinden gelemeyeceğinize inanırlar.	**( )**	**( )**	**( )**	**( )**	**( )**

I. BELIEFS TOWARD MENTAL ILLNESS SCALE

Aşağıdaki ifadeler, sizin ruhsal hastalığa yönelik inançlarınızı ölçmek için geliştirilmiştir. Bu ifadeleri dikkatlice inceleyerek en doğru şekilde yanıtlamanız oldukça önemlidir. Ankete vereceğiniz yanıtlar araştırmacılar dışında hiç kimse tarafından okunmayacak ve farklı bir amaçla kullanılmayacaktır. Aşağıdaki her bir maddenin yanına, ilgili madde için size göre uygun gelen sayıyı işaretleyiniz. Lütfen size uygun olan tek bir kutucuğa X işareti koyarak yanıtınızı belirtiniz.

0.Tamamen Katılmıyorum	1.Çoğunlukla Katılmıyorum	2.Kısmen Katılmıyorum	3.Kısmen Katılıyorum	4.Çoğunlukla Katılıyorum	5.Tamamen Katılıyorum



		0	1	2	3	4	5
1	Ruhsal hastalığı olan bir bireyin başkalarına zarar verme olasılığı, sağlıklı bir bireye göre daha fazladır.						
2	Ruhsal hastalıklar, fiziksel hastalıklara göre, daha uzun bir iyileşme süreci gerektirir.						
3	Davranışları tehlikeli olması nedeniyle, ruhsal hastalığı olan bireylerden uzak durmak iyi bir fikirdir.						
4	"Ruhsal hastalık" ifadesi beni rahatsız eder.						
5	Ruhsal hastalığı olan bir bireyin, sorumluluğu az olan bir işte çalışması gerekir.						
6	Ruhsal hastalığı olan bireylerin suç işleme olasılığı daha fazladır.						

7	Ruhsal hastalıklar tekrarlayıcıdır.						
8	Ruhsal hastalık teşhisi alırsam; patronumun, arkadaşlarımın ve başkalarının, hakkımda düşünecekleri şeyler beni endişelendirir.						
9	Ruhsal hastalık teşhisi konmuş bireyler, hastalıklarının olumsuzluklarını ömür boyu yaşayacaklardır.						
10	Bir kez ruhsal hastalık tedavisi alan bireyler, gelecekte tekrar tedaviye gereksinim duyma eğilimindedirler.						
11	Ruhsal hastalığı olan bireylerin dakik olma veya sözünde durma gibi toplumsal kurallara uyması zordur.						
12	İnsanlar daha önce ruhsal hastalık tedavisi alan bir birey ile yakın arkadaşlık kurduğumu bilseydi, utanırdım.						
13	Bana zarar verebileceği nedeniyle, ruhsal hastalığı olan bireyden korkarım.						
14	Ruhsal hastalığı olan bir bireyin iyi anne- baba olma olasılığı daha düşüktür.						
15	Ailemden bir bireyin ruhsal hastalığı olsa, utanırım.						
16	Ruhsal hastalığın tamamen iyileşebileceğine inanmıyorum.						
17	Sorumluluk alamadıkları için ruhsal hastalığı olan bireylerin kendi başlarına yaşayabilmeleri çok uygun değildir.						
18	Çoğu birey ruhsal hastalığı olan bir bireyle, bile bile arkadaşlık kurmaz.						

19	Ruhsal hastalığı olan bireylerin davranışları önceden tahmin edilemez.						
20	Ne kadar tedavi edilirse edilsin, ruhsal hastalığın iyileşmesi mümkün değildir.						
21	Çalışma ekibimdeki ruhsal hastalığı olan bir bireyin yaptığı işe güvenemem.						

J. BECK DEPRESSION INVENTORY

Aşağıda, kişilerin ruh durumlarını ifade ederken kullandıkları bazı cümleler verilmiştir. Her madde, bir çeşit ruh durumunu anlatmaktadır. Her maddede o duygu durumunun derecesini belirleyen 4 seçenek vardır. Lütfen bu seçenekleri dikkatlice okuyunuz. **Son bir hafta içindeki (şu an dahil)** kendi duygu durumunuzu göz önünde bulundurarak, size uygun olan ifadeyi bulunuz. Daha sonra, o madde numarasının karşısında, size uygun ifadeye karşılık gelen seçeneği bulup işaretleyiniz.

1. a) Kendimi üzgün hissetmiyorum.
   b) Kendimi üzgün hissediyorum.
   c) Her zaman için üzgünüm ve kendimi bu duygudan kurtaramıyorum.
   d) Öylesine üzgün ve mutsuzum ki dayanamıyorum.

2. a) Gelecekten umutsuz değilim.
   b) Geleceğe biraz umutsuz bakıyorum.
   c) Gelecekten beklediğim hiçbir şey yok.
   d) Benim için bir gelecek yok ve bu durum düzelmeyecek.

3. a) Kendimi başarısız görmüyorum.
   b) Çevremdeki birçok kişiden daha fazla başarısızlıklarım oldu sayılır.
   c) Geriye dönüp baktığımda, çok fazla başarısızlığımın olduğunu görüyorum.
   d) Kendimi tümüyle başarısız bir insan olarak görüyorum.

4. a) Her şeyden eskisi kadar zevk alabiliyorum.
   b) Her şeyden eskisi kadar zevk alamıyorum.
   c) Artık hiçbir şeyden gerçek bir zevk alamıyorum.
   d) Bana zevk veren hiçbir şey yok. Her şey çok sıkıcı.

5. a) Kendimi suçlu hissetmiyorum.
   b) Arada bir kendimi suçlu hissettiğim oluyor.
   c) Kendimi çoğunlukla suçlu hissediyorum.
   d) Kendimi her an için suçlu hissediyorum.

6. a) Cezalandırıldığımı düşünmüyorum.
   b) Bazı şeyler için cezalandırılabileceğimi hissediyorum.
   c) Cezalandırılmayı bekliyorum.
   d) Cezalandırıldığımı hissediyorum.

7. a) Kendimden hoşnutum.
   b) Kendimden pek hoşnut değilim.
   c) Kendimden hiç hoşlanmıyorum.
   d) Kendimden nefret ediyorum.

8. a) Kendimi diğer insanlardan daha kötü görmüyorum.
   b) Kendimi zayıflıklarım ve hatalarım için eleştiriyorum.
   c) Kendimi hatalarım için her zaman suçluyorum.
   d) Her kötü olayda kendimi suçluyorum.

9. a) Kendimi öldürmek gibi düşüncelerim yok.
   b) Bazen kendimi öldürmeyi düşünüyorum fakat bunu yapamam.
   c) Kendimi öldürebilmeyi isterdim.
   d) Bir fırsatını bulursam kendimi öldürürdüm.

10. a) Her zamankinden daha fazla ağladığımı sanmıyorum.
    b) Eskisine göre şu sıralar daha fazla ağlıyorum.
    c) Şu sıralar her an ağlıyorum.
    d) Eskiden ağlayabilirdim, ama şu sıralar istesem de ağlayamıyorum.

11. a) Her zamankinden daha sinirli değilim.
    b) Her zamankinden daha kolayca sinirleniyor ve kızıyorum.
    c) Çoğu zaman sinirliyim.
    d) Eskiden sinirlendiğim şeylere bile artık sinirlenemiyorum.

12. a) Diğer insanlara karşı ilgimi kaybetmedim.
    b) Eskisine göre insanlarla daha az ilgiliyim.
    c) Diğer insanlara karşı ilgimin çoğunu kaybettim.
    d) Diğer insanlara karşı hiç ilgim kalmadı.

13. a) Kararlarımı eskisi kadar kolay ve rahat verebiliyorum.
    b) Şu sıralarda kararlarımı vermeyi erteliyorum.
    c) Kararlarımı vermekte oldukça güçlük çekiyorum.
    d) Artık hiç karar veremiyorum.

14. a) Dış görünüşümün eskisinden daha kötü olduğunu sanmıyorum.
    b) Yaşlandığımı ve çekiciliğimi kaybettiğimi düşünüyor ve üzülüyorum.
    c) Dış görünüşümde artık değiştirilmesi mümkün olmayan olumsuz değişiklikler olduğunu hissediyorum.
    d) Çok çirkin olduğumu düşünüyorum.

15. a) Eskisi kadar iyi çalışabiliyorum.
    b) Bir işe başlayabilmek için eskisine göre kendimi daha fazla zorlamam gerekiyor.
    c) Hangi iş olursa olsun, yapabilmek için kendimi çok zorluyorum.
    d) Hiçbir iş yapamıyorum.

16. a) Eskisi kadar rahat uyuyabiliyorum.
    b) Şu sıralar eskisi kadar rahat uyuyamıyorum.
    c) Eskisine göre 1 veya 2 saat erken uyanıyor ve tekrar uyumakta zorluk çekiyorum.
    d) Eskisine göre çok erken uyanıyor ve tekrar uyuyamıyorum.

17. a) Eskisine kıyasla daha çabuk yorulduğumu sanmıyorum.
    b) Eskisinden daha çabuk yoruluyorum.
    c) Şu sıralar neredeyse her şey beni yoruyor.
    d) Öyle yorgunum ki hiçbir şey yapamıyorum.

18. a) İştahım eskisinden pek farklı değil.
    b) İştahım eskisi kadar iyi değil.
    c) Şu sıralar iştahım epey kötü.
    d) Artık hiç iştahım yok.

19. a) Son zamanlarda pek fazla kilo kaybettiğimi sanmıyorum.
    b) Son zamanlarda istemediğim halde üç kilodan fazla kaybettim.
    c) Son zamanlarda beş kilodan fazla kaybettim.
    d) Son zamanlarda yedi kilodan fazla kaybettim.

20. a) Sağlığım beni pek endişelendirmiyor.
    b) Son zamanlarda ağrı, sızı, mide bozukluğu, kabızlık gibi sorunlarım var.
    c) Ağrı, sızı gibi bu sıkıntılarım beni epey endişelendirdiği için başka şeyleri düşünmek zor geliyor.
    d) Bu tür sıkıntılar beni öylesine endişelendiriyor ki, artık başka bir şey düşünemiyorum.

21. a) Son zamanlarda cinsel yaşantımda dikkatimi çeken bir şey yok.
    b) Eskisine göre cinsel konularla daha az ilgileniyorum.
    c) Şu sıralarda cinsellikle pek ilgili değilim.
    d) Artık cinsellikle hiçbir ilgim kalmadı.

K. INTERNALIZED STIGMA OF MENTAL ILLNESS SCALE

Bu testte sık sık geçen "ruhsal hastalık" terimi, en geniş anlamda kullanılmıştır. Her bir cümleyi dikkatle okuduktan sonra eğer

"Kesinlikle aynı fikirde değilim" diyorsanız (1) rakamını ;

"Aynı fikirde değilim" diyorsanız (2) rakamını ;

"Aynı fikirdeyim" diyorsanız (3) rakamını ;

"Kesinlikle aynı fikirdeyim" diyorsanız (4) rakamını daire içine alarak

Okuduğunuz cümleye ne ölçüde katıldığınızı ya da katılmadığınızı belirtiniz. Her cümle için rakamlardan sadece bir tanesini işaretleyiniz.

	Kesinlikle aynı fikirde değilim	Aynı fikirde değilim	Aynı fikirdeyim	Kesinlikle aynı fikirdeyim
1. Ruhsal bir hastalığım olduğu için kendimi bu dünyada bir yabancı gibi hissediyorum.	1	2	3	4
2. Ruhsal hastalığı olan kişiler saldırgan olmaya eğilimlidirler.	1	2	3	4
3. Ruhsal bir hastalığım olduğu için insanlar bana farklı davranıyorlar.	1	2	3	4
4. Reddedilmemek için, ruhsal hastalığı olmayan kişilere yaklaşmaktan kaçınıyorum.	1	2	3	4
5. Ruhsal bir hastalığım olduğundan dolayı utanıyorum.	1	2	3	4
6. Ruhsal hastalığı olan kişiler evlenmemelidir.	1	2	3	4

7. Ruhsal hastalığı olan kişiler topluma önemli katkılarda bulunurlar.	1	2	3	4
8. Kendimi ruhsal hastalığı olmayan kişilerden daha aşağı hissediyorum.	1	2	3	4
9. Ruhsal hastalığım benim "garip" görünmeme ya da davranmama neden olabileceğinden dolayı eskisi kadar sosyal değilim.	1	2	3	4
10. Ruhsal hastalığı olan kişiler iyi ve doyum verici bir hayat yaşayamazlar.	1	2	3	4
11. İnsanları ruhsal hastalığımla sıkmak istemediğimden dolayı, kendi hakkımda fazla konuşmam.	1	2	3	4
12. Halk arasındaki ruhsal hastalıklarla ilgili olumsuz düşünceler, benim "normal" yaşamın dışında kalmama neden oluyor.	1	2	3	4
13. Ruhsal hastalığı olmayan kişilerle birlikteyken, kendimi sanki o ortama ait değilmiş ve yetersizmişim gibi hissediyorum.	1	2	3	4
14. Ruhsal hastalığı açıkça anlaşılan biriyle toplum içinde birlikte görülmek beni rahatsız etmez.	1	2	3	4
15. Sırf ruhsal hastalığımdan dolayı insanlar bana sık sık ne yapmam gerektiğini söyleyip, sanki çocukmuşum gibi davranırlar.	1	2	3	4
16. Ruhsal hastalığım olduğu için kendimden memnun değilim.	1	2	3	4
17. Ruhsal hastalığımın olması hayatımı berbat etti.	1	2	3	4

18.İnsanlar görünüşümden ruhsal bir hastalığımın olduğunu anlayabilirler.	1	2	3	4
19.Ruhsal hastalığımdan dolayı benimle ilgili çoğu kararı başkalarının vermesine ihtiyaç duyarım.	1	2	3	4
20.Ailemi ve arkadaşlarımı utandırmamak için sosyal ortamlardan uzak dururum.	1	2	3	4
21.Ruhsal hastalığı olmayanların beni anlamaları mümkün değildir.	1	2	3	4
22.Sırf ruhsal hastalığım olduğu için insanlar beni göz ardı eder ya da pek ciddiye almazlar.	1	2	3	4
23.Ruhsal hastalığım olduğu için topluma hiçbir katkım olamaz.	1	2	3	4
24.Ruhsal bir hastalıkla yaşamak beni mücadeleci bir insan yaptı.	1	2	3	4
25.Ruhsal bir hastalığım olduğu için kimse bana yakınlaşmak istemez.	1	2	3	4
26.Genel olarak, hayatı istediğim şekilde yaşayabiliyorum.	1	2	3	4
27.Ruhsal hastalığıma rağmen, iyi ve dolu dolu yaşadığım bir hayatım var.	1	2	3	4
28.İnsanlar ruhsal bir hastalığım olduğu için hayatta fazla başarılı olamayacağımı düşünüyorlar.	1	2	3	4
29.Akıl hastalarıyla ilgili olumsuz yaygın inanışlar benim durumum dikkate alındığında hiç de yanlış sayılmaz.	1	2	3	4

L. ETHICAL APPROVAL OF METU HUMAN SUBJECT ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
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08 ŞUBAT 2018

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Doç.Dr. Deniz Canel ÇINARBAŞ ;

Danışmanlığını yaptığınız yüksek lisans öğrencisi Kutay SAÇAK' ın ***"Turkish version of Perceived Devaluation-Discrimination scale: An Adaptation study /Algılanan Değersizleştirme-Ayrımcılık ölçeğinin Türkçeye uyarlama çalışması"*** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2017-SOS-220** protokol numarası ile **08.02.2018 - 30.12.2018** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Yrd. Doç. Dr. Pınar KAYGAN
Üye

Yrd. Doç. Dr. Emre SELÇUK
Üye

M. ETHICAL APPROVAL OF HOSPITALS

T.C.
ANKARA VALİLİĞİ
İL SAĞLIK MÜDÜRLÜĞÜ
Ankara Sincan Dr. Nafiz Körez Devlet Hastanesi

Sayı : 22568850/929
Konu : Kutay SAÇAK (Araştırma İzni)

ANKARA İL SAĞLIK MÜDÜRLÜĞÜNE

İlgi : 03/05/2018 tarihli ve 90169164-799-1163 sayılı yazınız.

Ortadoğu Teknik Üniversitesi'nde yüksek lisans yapmakta olan Kutay SAÇAK'ın "Turkish Version Of Perceived Devoluation- Discriminiotion Scale: An Adaptation Study /Algılanan Değersizleştirme – Ayrımcılık Ölçeğinin Türkçeye Uyarlama Çalışması" başlıklı araştırmasını hastanemizde yapma isteği hakkındaki ilgi sayılı yazınıza istinaden; adı geçenin söz konusu talebi, hasta mahremiyetine dikkat edilmesi halinde Başhekimliğimizce uygun görülmüştür.

Bilgilerinize arz ederim.

e-imzalıdır
Dr. Gül KURTULUŞ
Başhekim a.
Başhekim Yardımcısı

T.C.
SAĞLIK BAKANLIĞI
Sağlık Bilimleri Üniversitesi Ankara Dr. Abdurrahman Yurtaslan Onkoloji Sağlık Uygulama ve Araştırma Merkezi

TIPTA UZMANLIK ve EĞİTİM KURULU TOPLANTI KARAR TUTANAĞI

Toplantı Sayısı : 43

Toplantı Tarihi : 26.06.2018 Salı

Saat : 14:00

Sayın Kutay SAÇAK

Ortadoğu Teknik Üniversitesi'nde yüksek lisans yapmakta olan Kutay SAÇAK tarafından Doç. Dr. Deniz Canel ÇINARBAŞ danışmanlığında yürütülecek olan " Turkish Version Of Perceived Devoluation- Discriminiotion Scale: An Adaptation Study /Algılanan Değersizleştirme – Ayrımcılık Ölçeğinin Türkçeye Uyarlama Çalışması" başlıklı tez çalışmasının hastanemizde yapılabilmesi hususunun uygun olduğu oy birliği ile kabul edilmiştir.

Prof. Dr. Halil BAŞAR
Eğitim Koordinatörü

AYDIN İL SAĞLIK MÜDÜRLÜĞÜ - AYDIN SAĞLIĞIN GELİŞTİRİLMESİ BİRİMİ
01/08/2018 11:05 - 69836136 - 605.01 - E.721
00074070225

T.C.
AYDIN VALİLİĞİ
İl Sağlık Müdürlüğü

Sayı : 69836136-605.01
Konu : Kutay SACAK'ın Araştırma İzni

MÜDÜRLÜK MAKAMINA

Orta Doğu Teknik Üniversitesi Klinik Psikoloji Bölümü Yüksek Lisans Öğrencisi Kutay SACAK'ın "Turkish Version Of Perceived Devaluation –Discrimination Scale:An Adaptation Study / Algılanan Değersizleştirme - Ayrımcılık Ölçeğinin Türkçeye Uyarlama Çalışması" konulu araştırma izni talebi ile Kamu Hastaneleri Hizmetleri Başkanlığı'nın 31/07/2018 tarihli 73997804 barkod nolu uygun görüş yazısına istinaden çalışma yapılması planlanmaktadır.

Söz konusu çalışmanın 01 Ağustos - 15 Eylül 2018 tarihleri arasında Nazilli Devlet Hastanesi'ne bağlı Toplum ve Ruh Sağlığı Merkezi'nde yapılabilmesi hususunu;

Olurlarınıza arz ederim.

e-imzalıdır.
Dr.Mete ERKİ
Sağlık Hizmetleri Başkanı

O L U R
.../.../2018
e-imzalıdır.
Dr. Fevzi YAVUZYILMAZ
İl Sağlık Müdürü

N. TURKISH SUMMARY / TÜRKÇE ÖZET

ALGILANAN DEĞERSİZLEŞTİRME-AYRIMCILIK ÖLÇEĞİNİN TÜRKÇEYE UYARLAMA ÇALIŞMASI

1. Giriş

1.1. Toplumsal Damgalamanın Tanımı

Sosyal bilimlerde 50 yılı aşkın bir süredir toplumsal damgalama konusu çalışılmaktadır. 1963 yılında Goffman, yayımladığı ünlü çalışmasında damgalamayı tanımlarken "Bireyi zihinimizde bir bütünden ve olağan bir insandan, kusurlu ve değersiz birine indirgeyen olumsuz bir atıf" ifadelerini kullanmıştır (s.3). Crocker ve arkadaşları (1998) ise damgalamayı "damgalanan kişinin sahip olduğuna inanılan özellikler ve atıflarca taşınan, belirli sosyal ortamlarda değersizleştirilen toplumsal bir kimlik" olarak tanımlamışlardır (s.505). Geçen bu süre içerisinde toplumsal damgalama konusu pek çok farklı disiplin tarafından ele alınmış, psikolojik, sosyolojik, antropolojik ve evrimsel açıdan pek çok toplumsal damgalama modelleri önerilmiştir.

Damgalama kavramının tanımı üzerine yapılan incelemelerde damgalamanın olumsuz kalıp yargılarla ve önyargıyla benzer tanımları olduğu görülmüş, ve bu alanda yapılan araştırmalarda hastalık ve engellilik konularına odaklanarak daha çok damgalanan bireylerin bakış açısı üzerinde durulduğu ifade edilmiştir (Phelan ve ark., 2008; Corrigan ve Penn, 1999). Bu tezde de yine bir hastalık konusu çalışılmış ve ruhsal hastalıkların damgalanması konusu üzerinde durulmuştur.

1.2. Ruhsal Hastalıkların Damgalanmasının Kavramsallaştırılması

Yukarıda da bahsedildiği üzere toplumsal damgalama daha önce pek çok disiplin ve bakış açısından incelenmiştir. Bu bölümde ise daha kısıtlı bir alan olmak üzere ruhsal hastalıkların damgalanmasına ilişkin modeller ve yaklaşımlardan bahsedilmiştir.

1.2.1. Toplumsal Damgalamada Psikolojik Yaklaşım

Psikoloji literatüründe damgalamaya ilişkin özellikle üç konu öne çıkmıştır. Bunlar damgalamanın boyutları (Jones ve ark., 1984), damgalamanın sosyal bilişsel süreçleri (Corrigan, 2000) ve kimlik-tehdit modeli olarak sıralanabilir (Major ve O'Brien 2005).

Jones ve arkadaşları (1984) yaptıkları çalışmada damgalamanın altı boyutuna değinmişlerdir. Bunlardan ilki, tehlike (peril), damgalanan özelliğin ne derecede tehlikelilik ile ilişkilendirildiği ile ilgilidir. Bu boyutta bir özellik ne kadar tehlikeli olarak algılanıyorsa o denli damgalanabilir olmaktadır. İkinci boyut olan gizlenebilirlik (concealability) yine damgalanan durumun ne derece gizlenebilir olduğuna ilişkindir. Bu noktada, daha görünür olan durumlar daha çok damgalanmaya yatkındır. Üçüncü boyut olan köken (origin) ise damgalanan özelliğin edinilmesinde kişinin sorumluluğuna işaret eder. Bu boyutta damgalama genetik aktarıma, kişisel sorumluluk, tercihler v.b. atıflara göre farklılık gösterebilir. Yıkıcılık (disruptiveness), damgalamada dördüncü boyut olup damgalanan özelliğin kişilerarası ilişkileri, kişisel başarıları ve sosyal etkileşimleri ne derecede etkilediğine göre farklılık gösterir. Beşinci boyut olan seyir (course) ise damgalanan durumun gidişatıyla ilgilidir. Damgalanan durumun kalıcı veya iyileştirilebilir olması bu boyutta damgalamanın olumsuzluğunu etkileyen faktörlerdendir. Altıncı ve son boyut olan estetik (aesthetics) ise damgalanan özelliğin bireyin çekiciliğini ne derecede etkilediği ile ilişkilidir.

Damgalamanın sosyal bilişsel süreçleri incelendiğinde bilişsel, afektif ve davranışsal bir takım faktörlerin ele alındığı görülür. Örneğin, Corrigan (2000) bu faktörleri kalıp yargılar, önyargı ve ayrımcılık konuları altında incelemiştir. Corrigan'a

(2000) göre ruhsal hastalığı bulunan bireylerle ilişkilendirilen psikiyatrik semptomlar ve çeşitli beceri eksiklikleri çevredeki insanlarda ayırt edici uyaran (discriminative stimuli) olarak işlev görür. Bu uyaranlar kalıp yargılar ve önyargı gibi bilişsel mekanizmaları harekete geçirir. Sonuç olarak ise ayrımcılık halini alan davranışlar ortaya çıkar.

Bu bakış açısı damgalanan bireylerden çok damgalayan bireyleri tarif etse de Corrigan ve Watson (2002) bu modelde damgalanan bireyleri de tarif etmenin mümkün olduğunu göstermiştir. Damgalayan insanlar kalıp yargıları dışarıdaki bir insanve gruba yöneltirken damgalanan insanlar yine benzeri kalıp yargıları kendilerine yönelterek içselleştirilmiş damgalamayı ortaya çıkarırlar. Önyargılar ve olumsuz inanışları kabul eden damgalayıcı bireyler korku ve öfke gibi duygular sergileyebilirken yine bu olumsuz inanış ve önyargıları kabul eden damgalanmış birey ise düşük benlik saygısı ve düşük öz yeterlilik tepkileri verebilirler.

Damgalamaya bir diğer psikolojik açıdan bakıldığında Major ve O'Brian (2005) tarafından derlenen kimlik-tehdit modelinden bahsedilebilir. Bu modele göre damgalanan bireyler damgalanmakta olan kimliklerinin toplumda ne şekilde tasvir edildiğinin farkında olup olmamaları önemlidir. Zira damgalanan kimliklere yönelik kalıp yargıların farkında olan damgalanmış bireyler, günlük yaşantılarındaki bağlamsal bir takım damgalanma ipuçlarını algılamada daha hassas hale gelebilir. Bu noktada damgalanmaya karşı hassasiyet, grup aidiyet hissi, kişisel hedefler gibi bir takım değişkenler kişinin damgalanmaya ilişkin stresörleri nasıl değerlendirdiğini belirler. Eğer bir damgalanma vakası damgalanan bireyin baş etme kapasitesinin üzerinde ise, bu bireyde fizyolojik, duygusal ve davranışsal bir takım stres reaksiyonları ortaya çıkması beklenir. Yine Major ve O'Brien'ın modeline göre bu reaksiyonlar sağlık ve akademik başarı gibi çeşitli değişkenler üzerinde sonuçlar doğurabilir.

Ruhsal hastalıkların damgalanmasına psikolojik açıdan bakıldığında damgalamanın boyutları ile damgalamanın doğasının açıklandığını, sosyal bilişsel süreçlerle günlük yaşantıda damgalamanın nasıl oluştuğunu ve yine kimlik-tehdit modeliyle damgalanmaya nasıl tepkiler verildiğini, bu tepkilerin nelere yol açabildiğini

görülebilmektedir. Ancak psikolojik yaklaşımlar içerisinde damgalamaya yönelik kimi sosyal değişkenlerin etkisi yeterince işlenmemiştir. Bu sebeple sosyolojik yaklaşımları da dikkate almak faydalı olacaktır.

1.2.2. Toplumsal Damgalamada Sosyolojik Yaklaşım

Erving Goffman'ın ardından damgalamayla ilgili sosyolojik çalışmalar sembolik etkileşimci gelenekte, özellikle de sapkınlık literatüründeki etiketleme yaklaşımı ile devam etmiştir. Etiketleme teorisine göre sapkın kimlikler doğrudan sapkın davranışlardan çok bir etiketleme sürecinin sonucunda ortaya çıkar (Becker, 1963). Lemert (1972) bu durumu birincil ve ikincil sapkınlık süreçleri ile açıklamıştır. Buna göre bireyin genelde çevre tarafından normalleştirilen sapkın davranışları sapkın bir kimliğin oluşmasına sebep olmaz. Ancak bu sapkın davranışlar çevre tarafından normalleştirilmeyip etiketlenirse o zaman sapkın öz kimlikler etiketlemenin içeriğiyle bağlantılı olarak ortaya çıkar, bu durum da ikincil sapkınlığa örnek teşkil eder (Giddens, 2009).

Bu düşünce paralelinde Scheff (1966) etiketleme teorisinin kapsamını genişleterek teoriyi ruhsal hastalıkların damgalanması ile ilişkilendirmiştir. Ona göre ortaya çıkan ilk psikiyatrik semptomların çevredeki insanlarca etiketlenmesi, kronik psikiyatrik hastalığın en önemli sebebidir. Ancak bu etiyolojik iddia çok fazla eleştiriyi de beraberinde getirmiştir. Eleştiriler kronik psikiyatrik rahatsızlığın etiketlenmeden kaynaklandığını reddetmiş, sapkın öz kimlikleri sapkın davranışların kendisine bağlamıştır (Gove, 1975; Gove, 1982).

Scheff'e yönelik eleştiriler devam ederken bir yandan Bruce Link (1982) tartışmayı genişletmiş, etiketlemenin psikiyatri hastaları üzerinde etiyolojik sonuçlarının dışındaki sonuçlarına odaklanmıştır. Link (1987) Scheff'in formülasyonundan yola çıkarak Değiştirilmiş Etiketleme Teorisini (DET) ortaya atmıştır. Bu teoriye göre insanlar sosyalizasyon süreçleri ile toplumda ruhsal hastalıklı bireylerin nasıl algılandığını içselleştirir ve toplumda ruhsal hastalıklı bireyin nasıl değersizleştirildiğini

ve onlara karşı ayrımcılık yapıldığını öğrenir. Bir birey daha sonra ruhsal hastalığa yakalandığında, önceden öğrendiği bu bilgilerin tamamının artık bizzat kendisi ile ilgili hale geldiğini fark eder. Bu noktada birey algıladığı değersizleştirme ve ayrımcılık derecesine göre düşük öz-saygı, işsizlik, azalmış sosyal çevre gibi çeşitli olumsuz sosyolojik ve psikolojik sonuçlarla karşılaşabilir (Link ve ark., 1989). Link bu hipotezlerini test etmek üzere Algılanan Değersizleştirme-Ayrımcılık (ADA) ölçeğini geliştirmiştir (Link, 1987). Yapılan çalışmalar etiketlemenin gerçekten de işsizliğe (Link, 1987), azalmış sosyal çevreye (Link ve ark., 1989), azalmış öz-saygıya (Wright, Gronfein, & Owens, 2000), depresyon semptomlarına (Link ve ark., 1997) ve düşük yaşam kalitesine (Rosenfield, 1997) sebep olduğunu göstermiştir.

Özetle damgalamada sosyolojik yaklaşımlar sosyolojideki sapkınlık literatüründen ortaya çıkmış, ilk olarak sapkın davranışlar ve sapkın öz kimlikler arasındaki bağlantıyı incelemiştir. Daha sonra etiketleme teorisinin ruhsal hastalıklara uyarlanması ile etiketlemenin gerek etiyolojik gerekse çeşitli psikolojik-sosyolojik değişkenler üzerindeki etkisi üzerine yeni tartışma alanları açılmıştır. Gelinen noktada psikolojik ve sosyolojik literatürler birbirini tamamlar hale gelmiştir. Ancak damgalamaya yönelik yaklaşımlar psikolojik ve sosyolojik yaklaşımlara indirgenmemelidir. Daha yeni yaklaşımlar olan evrimci ve antropolojik yaklaşımların da dikkate alınması önemlidir.

1.2.3. Toplumsal Damgalamada Evrimsel Yaklaşım

Evrimsel açıdan bakıldığında Kurzban ve Leary (2001) insan ve insan olmayan hayvanlar üzerinde yaptıkları incelemeler sonucunda toplumsal damgalamayı açıklayan üç farklı süreç tanımlamışlardır. Bunları ikili dayanışma (dyadic cooperation), koalisyonel sömürme (coalitional exploitation) ve parazit kaçınımı (parasite avoidance) olarak adlandırmışlardır.

Bu yaklaşıma göre ikili dayanışma, insanların karşılıklı fedakarlıkla fazla kaynaklarını çevresindeki sosyal etkileşim partnerleri ile paylaşarak gelecekte bir kazanç

beklentisi içerisine girmesini ifade eder. Eğer ki paylaşım yapılan partner öngörülemez davranışlar gösteriyorsa, bu durumda paylaşımların dönütü de öngörülemez hale gelir. Bu sebeple paylaşım yapacak birey öngörülemez ve tehlikeli bulduğu bireye karşı damgalayıcı tutumlar sergileyerek paylaşımı reddedebilir. İkinci bir süreç olan koalisyonel sömürüye göre ise insanlar grup seviyesindeki davranışları ile çeşitli kaynakların edinimini kolaylaştıracak bireyleri grubuna kabul ederken, kaynak edinimine katkısı olmayacak bireyleri ise damgalayıcı tutumlarla grup dışına iterek onları sömürmeye başlar. Son olarak parazit kaçınımı ise çeşitli bakteri, virüs ve böceklerin sebep olduğu davranış ve fiziksel anomalilerine sahip bireylerin damgalayıcı tutumla dışlanmasını ifade eder. Bu nokta özellikle Jones ve arkadaşlarının (1984) belirttiği estetik boyutuna denk gelir. Ancak bu üçüncü süreç ruhsal hastalıklara uyarlanmada yeterli bilimsel kanıt olmadığı gerekçesi ile eleştirilmiştir (Phelan ve ark., 2008).

1.2.4. Toplumsal Damgalamada Antropolojik Yaklaşım

Tüm bu yaklaşımlara ek olarak Yang ve arkadaşları (2007) toplumsal damgalamaya antropolojik ve etnografik yaklaşımın gerekliliğini belirtmiştir. Bu yaklaşımda özellikle törel (moral) boyutun önemi vurgulanmıştır. Burada törel kavramı insanların günlük yaşamında kendileri için en önemli olan değeri ifade etmek üzere kullanılmıştır. Buna göre Yang ve arkadaşları (2007) damgalamanın en olumsuz etkilediği şeyin insanların kültürel değerlerinde kendileri için en önemli olan şeye denk geldiğini ifade etmiştir. Buna örnek olarak Yang ve Kleinman (2008) damgalamanın etkisinin en çok da Çin toplumunda en önemli değerlerden olan evlenmek ve aileyi devam ettirmenin üzerinde olumsuz etkisiyle kendini gösterdiğini ortaya koymuşlardır.

1.3. Ruhsal Hastalıkların Damgalanmasında Araştırma Bulguları

Tarihsel olarak incelendiğinde ruhsal hastalıkların damgalanmasına ilişkin araştırmaları iki kategoride incelemek mümkündür. Bunlardan ilki daha çok halkın

ruhsal hastalıklara yönelik genel tutumlarına odaklanmış ve damgalamayı azaltmayı denemiştir (örn: Cumming ve Cumming, 1957). Diğer grup çalışmalar ise ruhsal hastalık damgalanmasının içselleştirilmesine odaklanmış ve bu içselleştirmenin hastalar üzerindeki olumsuz etki ve sonuçlarını incelemiştir (örn: Drapalski ve ark., 2013). Bu bulguların kısa bir incelemesi bu bölümde verilmiştir.

1950 ve 1960'lı yıllarda genel toplum popülasyonlarında yapılan çalışmalar göstermiştir ki toplum ruhsal hastalığı olan bireyleri tehlikeli, öngörülemez ve kirli insanlar olarak değerlendirmiştir (Nunnally, 1961; Cumming ve Cumming, 1957). Daha sonra Philips (1966) damgalanan bireylerin toplum tarafından reddedilip dışlandığını ortaya koymuştur. Toplum tarafından yapılan damgalamayı azaltmak üzere çeşitli çalışmalar bu bulguları izlemiştir (Stuart, 2016, Hinshaw ve Cicchetti, 2000). Toplumsal damgalamadaki değişimler onlarca yıl boyunca takip edilmiştir (örn: Angermeyer ve ark., 2014). Ancak 2012 yılında yayımlanan bir meta-analize göre ruhsal hastalıklardaki biyolojik etkiler üzerine toplumdaki bilgi birikiminin artmasına rağmen damgalamada bir azalma meydana gelmemiş, ruhsal hastalıklı bireyler toplumda daha kabul görür hale ulaşmamıştır (Schomerus ve ark., 2012; Pescosolido, 2013).

İkinci grup ruhsal hastalık damgalanması çalışmalarına odaklandığımızda daha çok hastaların bakış açıları ile içselleştirilmiş damgalamaya odaklanıldığını görülür. İçselleştirilmiş damgalama hastalar arasında oldukça yaygındır, nitekim 14 Avrupa ülkesinde 1229 psikiyatrik hasta katılımcı ile yapılan bir araştırma göstermiştir ki hastaların %41.7'si orta veya üst düzey içselleştirilmiş damgalamaya sahiptir (Brohan ve ark., 2010). İçselleştirilmiş damgalamanın hastalar üzerindeki olumsuz sonuç ve etkileri de yine pek çok araştırmada ortaya konmuştur. Bunlar öz-saygı, öz-yeterlilik, hayat kalitesi, sosyal entegrasyon, umut gibi değişkenlerde azalma ve psikiyatrik semptomların seviyesinde ise bir artma olarak listelenebilir (Livingston ve Boyd, 2010; Drapalski ve ark., 2013). Dahası, içselleştirilmiş damgalama tedavi devamlılığını sekteye uğratmakta ve tedavi programına bağlılığı azaltarak (Sirey ve ark., 2001; Fung ve ark., 2010) tedavinin önünde önemli bir bariyer oluşturmaktadır (Yanos ve ark., 2010).

1.4. Ruhsal Hastalıkların Damgalanmasında Ölçüm Araçları

Bilimsel literatürde toplumsal damgalamaya pek çok farklı yaklaşımın oluşu, damgalama ölçüm araçlarının da zengin ve çeşitli olmasına yol açmıştır. Yang ve Link (2016) literatürdeki damgalama ölçüm araçlarını damgalamanın hangi alanını ölçtüklerine göre iki farklı kategoride sınıflandırmıştır. Bunlar (1) genel toplum tutumları ve (2) ruhsal sağlık hizmeti tüketicileri ile onların ailelerinin sahip oldukları damgalamalar olmak üzere ayrılmıştır.

Genel toplum tutumları ölçüm araçlarına bakıldığında bu kategoride sosyal uzaklık (Bogardus, 1925), kalıp yargılar (Osgood ve ark., 1957), ruhsal hastalığa yönelik tutumlar (Taylor ve Dear, 1981), ruhsal hastalık damgalama algısı (örn: ADA ölçeği), sorumluluk atfı (örn: Corrigan ve ark., 2003) ve ruhsal hastalıklı bireylere karşı duygusal tepkiler (Angermeyer ve Matschinger, 1996) gibi ölçüm alanları öne çıkmaktadır. Ruhsal sağlık hizmeti alan bireyler ve ailelerine ilişkin ölçekler ise daha çok içselleştirilmiş damgalama, yabancılaşma, damgalanmaya karşı direnç (örn: Ritsher et al., 2003), kalıp yargıların farkında olma (örn: Corrigan et al., 2006), değersizleştirme ve ayrımcılık algısı (örn: ADA), ayrımcılık deneyimleri (örn: Brohan ve ark. 2013) ve damgalamayla baş etme stratejileri (örn: Link ve ark. 2002) gibi damgalama alanları ölçülmektedir.

1.5. Türkiye'de Ruhsal Hastalıkların Damgalanması

1.5.1. Türkiye'deki Araştırma Bulguları

Türkiye'de ruhsal hastalıkların damgalanmasına yönelik ilk çalışmalar 1970'li yıllarda yapılmış olup daha çok genel toplumun ruhsal hastalıklı bireylere yönelik tutumları incelenmiştir. Bu çalışmalarda genel olarak toplumun ruhsal hastalıklı bireylere karşı sosyal anlamda kısıtlayıcı, kaçıngan ve cezalandırıcı tutumlar ortaya koyduğu gösterilmiştir (Taşkın, 2007). Ruhsal hastalıkların etiyolojisine dair toplumun bilgisi 1970'lerden bu yana artmış olsa da (Taşkın, 2007) olumsuz inanış ve tutumların

2000'li yıllar itibarıyla hala varlığını koruduğu üniversite öğrencileri örneklemi (Ünal ve ark., 2010) ve kırsal alan örneklemlerinde (Taşkın ve ark.) gösterilmiştir. Bunlara ek olarak, sağlık çalışanlarının ruhsal hastalıklı bireylerin tehlikeli olduğunu düşünmesi (Bağ ve Ekinci, 2005) ve acil servis çalışanlarının psikiyatri hastalarının fiziksel semptomlarını tedavi ederken ihmalkar davranması (Saillard, 2010) gibi çeşitli damgalayıcı inanış ve davranışlar da rapor edilmiştir.

Tıpkı Kuzey Amerika ve Avrupa'da yapılan çalışmalar gibi, Türkiye'de de genel toplum popülasyonlarında yapılan ilk damgalama çalışmalarını ikinci bir grup izlemiş, bu çalışmalarda ise damgalanan bireylerin bakış açıları incelenmiştir. Psikiyatri hastalarının, aileleri, sağlık çalışanları ve toplum tarafından damgalandıklarını düşündükleri ve bu damgalamanın günlük yaşantılarını zorlaştırıp tedavi devamlılıklarını azalttığı belirtilmiştir (Yüksel ve ark., 2013). Ayrıca, içselleştirilmiş damgalamanın sosyal işlevsellik, umut, gelir gibi bir takım değişkenleri olumsuz etkilediği görülmüştür (Doğanavşargil-Baysal ve ark., 2013). Sonuç olarak, Türkiye'de ruhsal hastalıkların damgalanması ile mücadele etmek önemli bir hedef olarak gösterilmiş, bu hedef için faydalı olabilecek çeşitli yöntemler (toplumu eğitmek, sağlık çalışanlarının eğitim müfredatını genişletmek vb.) tartışılmıştır (Çam ve Bilge, 2013).

1.5.2. Türkçe Literatürde Ölçüm Araçları

Ruhsal hastalıkların damgalanması ölçüm araçlarının geliştirilmesinde Türkiye'de iki farklı yaklaşım vardır. Bunlardan ilki çeviri/uyarlama çalışmalarından oluşmaktadır. Bu yöntemle geliştirilen Türkçe ölçeklere Ruhsal Hastalıkların İçselleştirilmiş Damgalanma Ölçeği (Ritsher ve ark., 2003; Ersoy ve Varan, 2007), Ruhsal Hastalıklara Yönelik İnançlar Ölçeği (Hirai ve Clum, 2000; Bilge ve Çam, 2008), Ruhsal Sorunlu Bireylere Yönelik Toplum Tutumları Ölçeği (Taylor ve Dear, 1981; Bağ ve Ekinci, 2006), Psikolojik Yardım Aramada Yakın Çevre Damgalaması Ölçeği (Vogel ve ark., 2009; Sezer ve Kezer, 2013) ve Psikolojik Yardım Alma Nedeniyle Sosyal

Damgalanma Ölçeği (Komiya ve ark., 2000; Topkaya, 2011) gibi ölçüm araçları örnek gösterilebilir.

İkinci yaklaşım ise kültürel bir takım özellikleri de yakalamak amacıyla Türkiye kültürel bağlamı içerisinde geliştirilmiş ölçekleri oluşturmaktadır. Bunlara örnek olarak Şizofreni hastaları ve aileleri için geliştirilen Kendini Damgalama Ölçeği-Hasta (Yıldız ve ark., 2018) ve Kendini Damgala Ölçeği-Aile (Yıldız ve ark., 2018) ölçüm araçları verilebilir. Bu tip çalışmalar Türkçe literatürde oldukça nadir olup sayısınım artması önem arz etmektedir. Zira damgalama her ne kadar evrensel olsa da damgalamanın şekli ve içeriği kültürler arasında ciddi farklılıklar gösterebilmektedir (Yang ve ark., 2007; Koschorke ve ark., 2016).

1.6. Algılanan Değersizleştirme-Ayrımcılık

1.6.1. Algılanan Değersizleştirme-Ayrımcılık Ölçeği Kullanım Alanları

ADA ölçeği Link (1987) tarafından DET hipotezlerini ölçmek amacıyla oluşturulmuştur. ADA hem ruhsal hastalığı olan bireylere hem de hasta olmayan bireylere uygulanabilmektedir. Bu noktada ADA, farklı psikiyatrik durumdaki gruplar arası karşılaştırma yapma amacıyla kullanılabilmektedir. ADA hastalarda damgalanma algısına ek olarak içselleştirilmiş damgalamayı ölçmek için de kullanılabilmektedir. Gerçekten de bir meta-analizde ADA en sık kullanılan içselleştirilmiş damgalama ölçeklerinden biri olarak rapor edilmiştir (Livingston ve Boyd, 2010). Genel toplum popülasyonlarında ise ADA toplumdaki genel damgalama algısını ölçmek için kullanmakta ve toplumdaki değişimleri yere ve zamana göre kıyaslamakta kullanılmaktadır (örn: Zieger ve ark., 2016; Schomerus ve ark., 2006; Angermeyer ve ark. 2014).

1.6.2. Algılanan Değersizleştirme-Ayrımcılık Neden Türkçeye Çevrilmeli?

ADA ölçeğinin Türkçeye çevrilme sebeplerinin tartışılması gerekirse ilk olarak Türkçe literatürde hasta ve hasta olmayan grupları karşılaştırabilecek bir damgalama ölçeği bulunmamasından bahsedilebilir. ADA ölçeği Türkçe literatürde bu eksiği dolduran bir ölçüm aracı olacaktır. İkinci sebep olarak damgalama ölçüm araçlarında çeşitliliğin önemi dikkate alınmalıdır. Daha önce bahsedildiği üzere damgalamaya pek çok yaklaşım ve bu yaklaşımların da getirdiği modeller, kavramsallaştırmalar mevcuttur. ADA ölçeği ise DET ile yapılan değersizleştirme ve ayrımcılık algılarının ölçülebilmesi için özel olarak geliştirilmiştir. Bu noktada DET ile ilgili çalışmaları Türkiye'de yürütmek açısından ADA ölçeğinin Türkçe versiyonunun bulunması önem arz etmektedir. Ayrıca ADA ölçeği yanıtlarda sosyal beğenilme etkisinden (social desirability bias) daha az etkilenmek amacıyla katılımcılara doğrudan kendilerinin ne düşündüğünü sormak yerine toplumdaki *çoğu insanın* ne düşündüğünü soracak şekilde geliştirilmiştir (Link ve Cullen, 1983). Bu yüzden üçüncü bir sebep olarak sosyal beğenilme etkisinden daha az etkilenebilecek bir damgalama ölçeğini Türkçeye kazandırmak gösterilebilir. Dördüncü ve son sebep olarak, ADA ölçeği daha önce pek çok dile çevirilmiş bir ölçek olarak kültürler arası damgalama kıyaslamaları açısından byük bir avantaj sunmaktadır. ADA daha önce İsveççe, İspanyolca, Almanca, Çince gibi dillere çevirilmiştir (Björkman, ve ark., 2007; Martinez-Zambrano ve ark., 2016; Matschinger ve ark., 1991; Yin ve ark., 2014). ADA ölçeğini Türkçeye kazandırmak Türkiye kültürünü damgalama konusunda bu ülkelerle kıyaslama fırsatı sunacaktır.

1.7. Amaç ve Hipotezler

Bu çalışmanın amacı ADA ölçeğini Türkçeye uyarlamak ve geçerlilik ve güvenirlik özelliklerini genel toplum ve klinik örneklemlerinde test etmektir. Bunun için aşağıdaki hipotezler oluşturulmuştur:

H1: ADA ölçeği klinik örneklemde Ruhsal Hastalıkların İçselleştirilmiş Damgalanma Ölçeği (RHİDÖ) ile pozitif ve anlamlı biçimde korelasyon oluşturacaktır.

H2: ADA ölçeği genel toplum örnekleminde Ruhsal Hastalıklara Yönelik İnançlar Ölçeği (RHYİÖ) ile pozitif ve anlamlı biçimde korelasyon oluşturacaktır.

H3: ADA ölçeği genel toplum örnekleminde Psikolojik Yardım Aramada Yakın Çevre Damgalaması Ölçeği (PYAYÇDÖ) ile pozitif ve anlamlı biçimde korelasyon oluşturacaktır.

H4: ADA ölçeği genel toplum örnekleminde iki faktörlü bir yapı destekleyecektir.

H5: ADA ölçeği klinik örneklemde iki faktörlü bir yapı destekleyecektir.

H6: ADA ölçeği ve Rosenberg Benlik Saygısı Ölçeği (RBSÖ) klinik ve genel toplum örneklemlerinde farklı ilişkiler gösterecektir. Daha net bir ifadeyle, demografik değişkenler kontrol edildikten sonra ADA ölçeği klinik örneklemde RBSÖ ile anlamlı ve pozitif bir korelasyon ortaya koyacaktır (H_{6a}). Ancak genel toplum örnekleminde ADA ve RBSÖ arasında .30 seviyesinin altında zayıf bir korelasyon olacaktır (H_{6b}).

H7: Demografik değişkenler kontrol edildikten sonra ADA ölçeği klinik örneklemde RBSÖ'yü anlamlı ve pozitif bir biçimde yordayacaktır.

H8: Genel toplum örnekleminde ADA ölçeği ve Beck Depresyon Envanteri (BDE) arasında .30 seviyesinin altında zayıf bir korelasyon olacaktır.

2. Yöntem

2.1. Örneklem

Bu çalışmada iki farklı örneklem grubundan veri toplanmıştır. İlk örneklemde genel toplum popülasyonundan 18 yaş ve üzeri 150 kişi kartopu örneklem yöntemi ile çalışmaya davet edilmiştir. Bunlardan 1 kişi anket paketini teslim etmemiş, 4 kişi ise eksik teslim ettiği için çalışmadan düşürülmüş, dolayısıyla 145 kişi çalışmaya dahil edilmiştir. Bu örneklemde katılımcıların yaş ortalaması 44.90 (*SS* = 14.74) olup çoğunluğu (%64.83) üniversite mezunudur. Klinik örneklemde toplum ruh sağlığı merkezleri ve Şizofreni derneklerinde 18 yaşından büyük olmak, kronik psikiyatrik

bozukluğu bulunmak, hastalığının alevlenme döneminde olmamak ve anket doldurmaya mani olacak herhangi bir bilişsel bozukluğa sahip olmamak şartları ile 85 kişi çalışmaya dahil edilmiştir. Klinik örneklemdeki katılımcıların çoğu erkek (%78.82) ve şizofreni tanısı almış (%69.42) bireylerden oluşmaktadır. Klinik örneklemdeki katılımcılara şu kurum ve derneklerden ulaşılmıştır: Dr. Abdurrahman Yurtaslan Ankara Onkoloji Eğitim ve Araştırma Hastanesi Toplum Ruh Sağlığı Merkezi (TRSM), Ankara Dr. Nafiz Körez Sincan Devlet Hastanesi TRSM, Aydın Nazilli Devlet Hastanesi TRSM, Ankara Şizofreni ile Yaşamayı Öğrenme ve Destekleme Derneği (AŞDER), ve Ankara Şizofreni Hastaları ve Yakınları Dayanışma Derneği (Mavi At).

2.2. Veri Toplama Araçları

Bu çalışmada veri toplama araçları olarak Demografik Bilgi Formu, yine bu çalışmada geliştirilen ADA ölçeği Türkçe versiyonu, Rosenberg Benlik Saygısı Ölçeği (Rosenberg, 1965; Çuhadaroğlu, 1986), Psikolojik Yardım Aramada Yakın Çevre Damgalaması Ölçeği (Vogel ve ark., 2009; Sezer ve Kezer, 2013), Ruhsal Hastalıklara Yönelik İnançlar Ölçeği (Hirai ve Clum, 2000; Bilge ve Çam, 2008), Beck Depresyon Envanteri (Beck ve ark., 1961; Hisli, 1988) ve Ruhsal Hastalıkların İçselleştirilmiş Damgalanma Ölçeği (Ritsher ve ark., 2003; Ersoy ve Varan, 2007) kullanılmıştır.

2.3. İşlem

2.3.1. Ölçek Çevirisi

ADA ölçeği iki ayrı psikolog çevirmen tarafından bağımsız şekilde Türkçeye çevirilmiş, ardından üçüncü bir bağımsız psikolog çevirmen tarafından bu iki çeviri arasında uzlaşmaya gidilmiştir. Ortaya çıkan form psikiyatrik tanısı olan 3 bireye ve tanısı olmayan 6 bireye uygulanmış, gelen geribildirimler dikkate alınarak ölçeğe son hali verilmiştir.

2.3.2. Veri Toplama

Gerekli etik izinler ve katılımcıların bilgilendirilmiş onamları alındıktan sonra genel toplum örneklemindeki katılımcılara Demografik Bilgi Formu, ADA, RBSÖ, PYAYÇDÖ, RHYİÖ, ve BDE'den oluşan anket paketi verilmiş, klinik örneklemdeki katılımcılara da ADA, RBSÖ ve RHİDÖ'den oluşan anket paketi verilerek anketleri doldurmaları istenmiştir.

2.4. İstatistiksel Analiz

Veri analizi için SPSS 20.0 ve EQS 6.1 programları kullanılarak ANOVA, iç tutarlılık katsayısı, korelasyon hesaplamarı, regresyon analizi, keşfedici ve doğrulayıcı faktör analizleri yapılmıştır.

3. Sonuçlar

Yapılan veri analizleri sonucunda keşfedici faktör analizi ADA için her iki örneklemde de iki faktörlü bir yapı ortaya koymuştur. Bu yapıya göre ADA'nın pozitif (madde 1,2,3,4,8 ve 10) ve negatif (madde 5,6,7,9,11,12 ve 13) ifadeli maddeleri ayrı faktörlerde gruplanmıştır. Benzeri bir sonucu daha önce Interian ve arkadaşları (2010) depresyon hastaları üzerinde yaptıkları bir çalışmada rapor etmişlerdir. Bu sebeple alt faktörlere Interian ve arkadaşlarının çalışmasında ifade edilen isimler konmuştur. Bu bağlamda pozitif ifadelerden oluşan faktöre *Algılanan Kabul ve Olumsuz Olmayan Değerlendirme* (KOOD) ve negatif ifadelerden oluşan faktöre de *Algılanan Ayrımcılık ve Olumsuz Değerlendirme* (AOD) isimleri verilmiştir. ADA'nın iç tutarlılık katsayıları Cronbach alfa değerleri genel toplum ve klinik örneklemlerde sırasıyla .76 ve .79 olarak bulunmuş, alt ölçeklerinin de .72 ve .77 arasında değiştiği gözlenmiştir. Yapılan doğrulayıcı faktör analizi çeşitli modifikasyonlardan sonra her iki örneklemde de iki faktörlü yapıyı doğrulamıştır. Genel toplum örnekleminde veri-model uyuşması iyi bulunmuş (*Satorra-Bentler* $\chi^2(60) = 70.80$, $p > .05$, CFI = .96, RMSEA = .04, *CI* [.00,

.07]), klinik örneklemde de kabul edilebilir bulunmuştur (*Satorra-Bentler* χ^2 (63) = 75.96, $p > .05$, *CFI* = .93, *RMSEA* = .05, *CI* [.00, .09]).

Klinik örneklemde yapılan yakınsak geçerlilik analizleri sonucunda ADA ve RHİDÖ arasında pozitif ve anlamlı bir korelasyon ($r = .51$, $p < .001$), ayrıca ADA ve RBSÖ arasında da pozitif ve anlamlı bir korelasyon bulunmuştur ($r = .34$, $p < .01$). Buna göre yüksek ADA skorları yüksek içselleştirilmiş damgalama ve düşük benlik saygısı ile ilişkili bulunmuş, ayrıca ADA'nın klinik örneklemde benlik saygısını anlamlı ve pozitif olarak yordadığı görülmüştür. Sonuç olarak klinik örneklem çalışmasındaki hipotezlerin tümü desteklenmiştir. Öte yandan genel toplum örnekleminde yapılan yakınsak ve ayırd edici geçerliliği analizlerinde bir takım hipotezler desteklenirken, diğer hipotezler ise desteklenmemiştir. İlk olarak beklenildiği gibi genel toplum örnekleminde ADA ve RHYİÖ arasında anlamlı ve pozitif bir ilişki bulunmuş ($r = .30$, $p < .001$), yine beklendiği gibi ADA ve BDE arasında zayıf bir korelasyon ($r = .24$, $p < .01$) bulunmuştur. Bunlar ADA için yakınsak ve ayırd edici geçerliliği kanıtları olarak hipotezleri desteklemiştir. Ancak beklenilenin aksine ADA ile PYAYÇDÖ arasında ve ADA ile RBSÖ arasında bir ilişki çıkmamıştır. Sonuç olarak ADA ölçeğinin genel toplum örnekleminde yakınsak ve ayırd edici geçerliliği kısmi destek bulmuştur.

4. Tartışma

Bu araştırmanın amacı ADA ölçeğinin Türkçe uyarlamasını yaparak psikometrik özelliklerini klinik ve genel toplum örneklerinde test etmektir. Yapılan analizler sonucunda ADA ölçeğinin literatürde kabul gören iç tutarlılık katsayısı olan .70'in (Pallant, 2007) üzerinde olduğu, dolayısıyla klinik ve genel toplum örneklemlerinde güvenilir bir ölçüm aracı olduğu ortaya konmuştur. Yapılan keşfedici ve doğrulayıcı faktör analizleri sonucunda ADA'nın literatürde kabul gören istatistiksel değerlerde iki faktörlü yapıyı desteklediği bulunmuştur (Matsunaga, 2010; Comrey ve Lee, 1992; Hu ve Bentler, 1999; Russell, 2002). Bu durum ADA'nın her iki örneklemde de yapı geçerliliğini destekleyici bir kanıt olarak değerlendirilmiştir.

Yakınsak ve ayırd edici geçerliliği incelendiğinde ise ADA'nın klinik örneklemde yakınsak geçerliliği için güçlü kanıtlar bulunmuştur. Genel toplum örnekleminde ise kısmi yakınsak geçerliliği kanıtı ve ayırd edici geçerliliği kanıtları bulunmuştur. Her ne kadar genel toplum örnekleminde ADA ile RBSÖ arasında beklenen zayıf ilişki bulunamayıp hipotez reddedilmiş olsa da, ayırd edici geçerliliğin tanımı gereği bu iki ölçeğin arasında ilişki bulunmamış olması genel toplum örnekleminde ADA için ayırd edici geçerlilik kanıtı olarak kabul edilmiştir. ADA ile BDE arasında genel toplum örneklemindeki küçük korelasyon ise hipotezle uyumlu olsa da açıklamaya ihtiyaç duymaktadır. Çünkü DET genel toplumdaki etiketlenmemiş bireylerde ADA ile olumsuz psikolojik sonuçlar arasında bir ilişkinin olmayacağını ifade etmektedir. Dahası, geçmişte Link (1987) ADA ile içerisinde bir takım depresyon semptomlarının da ölçüldüğü demoralizasyon ölçeği (Dohrenwend ve ark., 1980) arasında, genel toplum örnekleminde bir ilişki bulunmadığını rapor etmiştir. Ancak daha sonra yapılan bir incelemede demoralizasyonun depresyondan daha farklı bir klinik durum olduğunu ortaya koymuştur (Tecuta ve ark., 2015). Bu nedenle ADA ile BDE arasındaki genel toplum örnekleminde bulunan küçük korelasyon, Link (1987) tarafından rapor edilen bulgu ile tümüyle çelişmemektedir. ADA ile BDE arasındaki küçük korelasyon, depresyonla ilişkilendirilen olumsuz bilişsel süreçlere yatkın olma sonucu ADA sorularının yanıtlanmasındaki bir yanlılık haliyle açıklanabilir (Gotlib ve Joorman, 2010).

Bu çalışmada şaşırtıcı bir sonuç olan ADA ile PYAYÇDÖ arasında genel toplum örnekleminde bir ilişki bulunmayışı ise örneklem özellikleri ile bağlantılı olabilir. Özellikle Vogel ve arkadaşlarının (2009) ADA ile PYAYÇDÖ arasında anlamlı bir pozitif korelasyon rapor ettiği çalışmadaki örneklem incelendiğinde, katılımcıların üniversite öğrencilerinden oluştuğu görülür. Şimdiki çalışmadaki genel toplum örnemleminin ise yaş ortalaması 44.90 olup, Vogel ve arkadaşlarının yaptığı çalışmadaki örneklemden çok farklı bir yaş grubunu temsil etmektedir.

Sonuç olarak, geçerlilik ve güvenirlik testlerinde ADA ölçeği için klinik örneklemde güçlü kanıtlar ortaya konmuş, genel toplum örnekleminde ise güçlü güvenirlik kanıtları ve kısmi geçerlilik kanıtları bulunmuştur. Öte yandan bu çalışmanın bir takım eksiklikleri mevcuttur. Özellikle ADA için keşfedici ve doğrulayıcı faktör analizleri için bağımsız örneklemlerin kullanılamamış olması sebebiyle gelecek çalışmalarda bağımsız örneklemlerde doğrulayıcı faktör analizi tekrarlanarak literatürde önerilen çeşitli tek faktörlü ve çift faktörlü yapılar test edilmelidir. Ayrıca bu testler yapılana dek şuanki çalışmada ortaya çıkan alt faktörlerin (KOOD ve AOD) ayrı ayrı kullanılması uygun olmayacaktır. Genel toplum örnekleminde çok sayıda üniversite mezunu olması, klinik örneklemde de çok sayıda Şizofreni/Psikotik spektrumda tanı almış erkek katılımcıların olması örneklemlerde kısmen homojen özellikler oluşturmaktadır. Bu durum ve muhtemel bir sosyal beğenilme etkisi analizlerde ortaya konan ilişkilerin gerçek büyüklüğünü maskelemiş olabilir. Araştırmacı tarafından gelecek çalışmalarda sosyal beğenilme etkisinin kontrol edilmesi önerilmektedir.

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