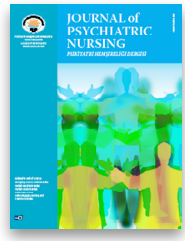
JOURNAL OF
PSYCHIATRIC NURSING

DOI: 10.14744/phd.2018.03360
J Psychiatric Nurs 2019;10(1):20-27



Original Article

The effects of psychoeducation provided to care staff working at special care centers on their beliefs about schizophrenia

Burcu Demir Gökmen,[1] Ayşe Okanlı[2]

[1]Department of Nursing, Agri İbrahim Çeçen University, School of Health Services, Ağrı, Turkey
[2]Department of Nursing, İstanbul Medeniyet University Faculty of Health Sciences, İstanbul, Turkey

Abstract

Objectives: This study analyzed the effects of psychoeducation given to the care staff working in private care centers on the beliefs about schizophrenia.

Methods: This study was carried out between November 1, 2011 and June 28, 2013 in private care centers in the city of Ağrı; 68 care staff agreed to join the research. This study had semi-experimental research design with a control group. An introductory information form and a belief scale that focused on mental illnesses were used for gathering data. Psychoeducation was provided for twelve groups (3 persons), 45 minutes of schooling time per week, 3 days per week, during 10 weeks. The session groups were composed of 12 groups of 3 people, 3 days per week, and 4 different training hours per day. Each group consists of different individuals, and 12 co-sessions were given per week. The data were evaluated by percentage distributions, t test, paired samples t test, and chi-square test.

Results: Previous to psychoeducation, the beliefs of the care staff concerning schizophrenic illness were negative; they considered patients with schizophrenia to be dangerous, that interpersonal relations would deteriorate, that feelings of helplessness were high and the belief of shame was lower. When the pre-test and post-test scores of the care staff on the RHYI scale were compared between the experimental and control group, and the experimental and control groups of the maintenance members were compared within the group, there was no statistically significant difference between the pre-test and post-test scores on the RHYI scale total score, danger and shame sub-dimensions ($p<0.05$). After psychoeducation in the care staff of experimental group, it was determined that there was a statistically significant difference between the scores on the RHYI scale helplessness and interpersonal relationship subscale scores. In the experimental group after the psychoeducation, the belief in helplessness and deterioration in interpersonal relationships decreased; the control group did not show similar changes.

Conclusion: Psychoeducation positively affects beliefs concerning schizophrenia among care staff personnel in private care centers. The results of the study should be reported to related institutions; psychoeducation in these institutions should be provided continuously in regular intervals in those institutions.

Keywords: Belief; care staff; psychoeducation; schizophrenia.

One of the institutions that have an important position in rehabilitation of disabled individuals in our country is the Special Care Units of the General Directorate of Services for Disabled People and the Elderly within the Ministry of Family and Social Policies. Mentally disabled individuals have been treated by care services provided in these centers since 2017. However, it has been determined that care personnel in these institutions are not familiar with mentally disabled individuals; that they do not have sufficient knowledge about mentally disabled patients and mental disorders; that they experience difficulties in psychiatric treatment; that they have insufficiencies in the care services area; and that they do not have sufficient education about mentally disabled individuals.[1,2] This insufficiency negatively affects the treatment and re-

Address for correspondence: Burcu Demir Gökmen, Ağrı İbrahim Çeçen Üniversitesi SYO Hemşirelik Böl. Sağlık Kamp. A-B Blok, 04100 Ağrı, Turkey
Phone: +90 472 215 40 00 **E-mail:** burcudmr04@gmail.com **ORCID:** 0000-0003-2058-8924

Submitted Date: October 20, 2016 **Accepted Date:** October 16, 2018 **Available Online Date:** February 12, 2019

What is known about this issue?

- An investigation showed that no research has been done to date on concerning beliefs and information about schizophrenia among care personnel working in specialized care centers. Further, it revealed that these personnel experience difficulties while caring for their patients and that they would benefit from psychoeducation.

What does this article add to the known facts?

- This study determined the beliefs of the caregivers working in the care center. The results showed that psychoeducation gives caregivers more confidence in their procedures and reduces their concern about deterioration in interpersonal relationships.

What is its contribution to the practice?

- Structured psychoeducation programs have been found to enhance the treatment and rehabilitation process for individuals diagnosed with schizophrenia who are

habilitation process for persons diagnosed with schizophrenia and lowers the quality, efficiency, productivity, and continuity of care services.

The published literature shows that no research has been conducted on the beliefs of care personnel about the individuals with schizophrenia and the schizophrenia disorder. However, when worldwide and domestic studies have examined beliefs toward mental disorders in different segments of the society, it has been observed that the public, healthcare personnel, teachers, students, mukhtars, and religious officials generally exhibit discriminatory and stigma attitudes toward mentally disordered individuals and have negative opinions about mental illness.[3–10]

Schizophrenia is subjected to the highest level of negative beliefs among the mental illnesses.[11] The general view of schizophrenic individuals, signs of disease, various disease factors, disease progress and treatment, and stigma placed on the disease affect views and beliefs, primarily of patients' relatives and also wider society toward the disease.[4]

Negative beliefs and attitudes toward schizophrenia prevent these individuals to be socialized, limit their rights to marry, have children, and be employed, and therefore cause inability to effectively cope with their disease and resistance to treatment.[4,12,13] However, positive beliefs and attitudes provide relief for patients and their relatives and play a facilitating role for participation in socially integrative treatments.[9,12,14]

Other studies indicate that both patients and care providers require psychoeducation in accordance with difficulties that they meet to change negative information, beliefs, attitudes, and behaviors toward mental illnesses overall and schizophrenia in particular.[15,16]

Taking into account the care service provided by care personnel for mentally disabled individuals, healthcare personnel can experience difficulties similar to problems that families or caregivers experience and these disabled persons also require psychoeducation. From this point of view, the present research that was considered to be useful in terms of mentally disabled individuals and care personnel was carried out to determine the beliefs of care personnel toward schizophrenia and to evaluate the efficiency of psychoeducation provided in this context.

Materials and Method

The research was planned and conducted between November 1 and June 28, 2013. The preliminary preparation for the study (determining the universe and sample, receiving required permissions to conduct the research, informing participants about the study and receiving their approvals, constitution of the experimental and control groups, preparation of the scope of psychoeducation booklet and the education program) was done between the dates of November 1, 2011 and October 19, 2012. The experimental group pre-test data were collected between October 19, 2012 and December 6, 2012; the control group pre-test data were collected between December 6, 2012 and December 30, 2012. Psychoeducation was provided between December 6, 2012 and February 9, 2013. The post-test data of the experimental and control groups were collected between February 14, 2013 and March 23, 2013. The research findings were evaluated between March 23, 2013 and June 28, 2013; research outcomes were then determined.

Research Location and Design

This study used a semi-experimental research design with a control group and was carried out in special care centers in Ağrı, Turkey under the auspices of the General Directorate of Services for Disabled People and the Elderly within the Ministry of Family and Social Policies. There are two special care centers in Ağrı that provide care services for the care required for mentally, physically, and psychologically disabled individuals (in the study, these centers were coded as the care center X and the care center Y); these centers were located outside the city center and distant from each other. The X care center provides care for 72 individuals with its 32 care personnel. More than half of the individuals provided service by this care center (65%) are severely mentally disordered individuals diagnosed with schizophrenia. The Y care center provides care for 95 individuals with the 41 care personnel. More than half of the individuals that this care center provided service (85%) are severely mentally disordered individuals diagnosed with schizophrenia.

The research universe and sample: The Experimental and Control group in the study were determined through the non-probability random sampling method. Small pieces of paper on which names of the two care centers were written were put in a bag; the first care center selected constituted the experimental group of the study, and the second, the control group. Based on this method, care center Y constituted the study's experimental group and care center X constituted the control group. As 2 out of 41 care personnel working in the care center Y would quit the job soon and 3 personnel always worked in the night shift, these personnel were not included in the research. Therefore, the experimental group of the study was

constituted by 36 individuals from the care center Y and 32 individuals from the care center X.

Data Collection Tools: Introductory information form, The Beliefs towards Mental Illness Scale (BMIS) were used.

Introductory Information Form: It was designed with the questions to define descriptive characteristics of the personnel.

The Beliefs towards Mental Illness Scale (BMIS): The scale, developed by Hirai and Clum in 2000 and its Turkish validity and reliability was done by Bilge and Çam, determines positive and negative beliefs of individuals with different cultural characteristics toward mental illness. The scale is both interpreted on total score and sub-scale scores, with a high score indicating a negative belief. The scale is a 6-point Likert scale with 21 items; the total score the can be obtained from the scale is 0 to 105 points. This scale is composed of three subdimensions; which are Dangerousness (0 to 40 points), Incurability and Poor Social and Interpersonal Skills (0 to 55 points), and Embarrassment (0 to 10 points).[17] In previous study conducted by Bilge[17] on the validity and reliability of the scale, the reliability coefficient was found as α=0.82 whereas α=0.67.

Data Collection: Data were collected by the researcher between October 19, 2012 and December 30, 2012 using 20-minute face-to-face interviews with each individual from the experimental (S=36) and control (S=32) groups. Final test data were collected using the same method between February 14, 2013 and March 23, 2013, one week after the psychoeducation program ended.

Psychoeducation Program: The program was organized in 10 sessions in the 10 weeks between December 6, 2012 and February 9, 2013 because the main theme of each session was different. Each session lasted 45 minutes. As the majority of care personnel stated that they did not want to participate in an education provided outside working hours, education was provided during working hours without interrupting the work of care personnel. For this purpose, the psychoeducation program was organized in 12 groups (3 individuals in each group), 3 days per week and 4 times per day. Each group was composed of different individuals; 12 pair groups were provided per week. If care personnel were not able to attend a session due to the working process of their institution and based on a valid reason, this was compensated by their attending another pair session. The psychoeducation program was provided in the institution buildings using a computer and a projector in a wide and spacious hall that was furnished with tables and chairs that provided for education with a portable board. The education took into account the educational levels of the care personnel included in the session. Presentation followed by question-answer instruction techniques were used.

Weekly Distribution of the Content of the Psychoeducation Program

Week 1. First Session: What is schizophrenia and how is it diagnosed?

Week 2. Second Session: What are the signs and types of schizophrenia?

Week 3. Third Session: How is disease progress measured?

Week 4. Fourth Session: How is the insight into schizophrenia disease enhanced?

Week 5. Fifth Session: Treatment of schizophrenia (psychosocial treatment, electrical seizure therapy, crisis management/acute medicine therapy)

Week 6. Sixth Session: Treatment of schizophrenia (medical treatment, benefits of using medications, side effects of medications)

Week 7. Seventh Session: Recognition of intractable signs and coping with symptoms, warning signs

Week 8. Eighth Session: Schizophrenia and stress, schizophrenia and self-confidence, schizophrenia and smoking

Week 9. Ninth Session: How is schizophrenia reflected in social life?

Week 10. Tenth Session: The nursing home as a treatment environment: What should be our skills and approaches while providing care?[11,18–20]

Psychoeducation Booklet: This booklet was organized based on the content of the psychoeducation program.

Nursing Intervention Pursued in the Psychoeducation Program: The psychoeducation programs were initiated after the importance, aim, method, study plan, and targets of the study were explained to care personnel; psychoeducation booklets and participation documents were provided at the end of the program.

Research Variables: The psychoeducation program and descriptive information constitute independent variables of the study, whereas mean scores of the Beliefs towards Mental Illness Scale constitute the dependent variables of the study.

Data Analysis: Data coding and statistical analyses were performed in the computer using the SPSS 15 software program. Percentage distributions were used to analyze descriptive characteristics of care personnel; t-test independent samples and the Chi-square test were used to compare the experimental and control groups; a paired sample t-test and Chi-square test were used in in-group comparison of the experimental and control groups.

Ethics: Voluntary care personnel were informed about the study and were taken into study after they signed the "informed consent". By providing an information form that included the aim and scope of the study, required permissions were received from Ataturk University Institute of Health Sciences Ethical Committee, and from the Social Services Provincial Directorate affiliated care centers where the research conducted.

The Generalizability of the Research: The study results can be generalized for the research universe of care personnel working in the care centers.

Table 1. Comparison of descriptive characteristics of the care personnel between the experimental and control groups

Descriptive characteristics	Experimental Group (n=36)		Control Group (n=32)		Total (n=68)		Significance Level
	n	%	n	%	n	%	
Age							x^2=0.186
Less than or equal to 27	15	41.7	15	46.9	30	44.1	SD:1
More than or equal to 28	21	58.3	17	53.1	38	55.9	p=0.426
Sex							x^2=1.004
Male	19	52.8	13	40.6	32	47.1	SD=1
Female	17	47.1	19	59.4	36	52.9	p=0.224
Marital status							x^2=3.064
Married	20	55.6	11	34.4	31	45.6	SD:1
Single	16	44.4	21	65.6	37	54.4	p=0.066
Living in residence							x^2=2.841
Village /town	2	5.6	6	18.8	8	11.8	SD=1
City	34	94.4	26	81.3	60	88.2	p=0.095
Education status							x^2=0.442
Primary school	14	38.9	15	46.9	29	42.6	SD=1
Secondary school or higher education	22	61.1	17	53.1	39	57.4	p=0.338
Family income status							x^2=0.810
Low	23	63.9	17	53.1	40	58.8	SD=1
Medium	13	36.1	15	46.9	28	41.2	p=0.257

Table 2. BMIS pre-test and post-test mean scores of the care personnel in the experimental and control groups (n=68)

BMIS	Possible	Selected		Mean±Standard deviation	
	Min-Max values	Min-Max values			
		Pre-test	Post-test	Pre-test	Post-test
Dangerousness	0–40	12–36	9–36	24.69±5.97	24.77±5.36
Incurability and poor social and interpersonal skills	0–55	23–53	16–52	42.61±6.21	40.67±10.1
Embarrassment	0–10	0–10	0–10	1.16± 2.58	1.17±2.41
Total	0–105	46–93	35–92	68.47±10.7	65.89±11.4

BMIS: Beliefs towards Mental Illness Scale

Results

The comparison of descriptive characteristics of care personnel in the experimental and control group is provided in Table 1. In the experimental group, 41.7% of the individuals 27 years of age or younger; this ratio was 46.9% in the control group. In the experimental group, 58.3% of the individuals were 28 years of age or older; this ratio was 53.1% in the control group. In the experimental group and control group, respectively, 52.5% and 40.6% of the individuals were male; in the control group. In the experimental group and control group, respectively, 47.1% and 59.2% of the individuals were female. In the experimental group and control group, respectively, 55.6% and 34.4% of the individuals were married. In the experimental group and the control group, respectively, 44.4% and 65.6% of the individuals were single. In the experimental group and the control group, respectively, 5.6% and 18.8% lived in a village/town. In the experimental group and the control group, respectively, 94.4% and 81.3% of the individuals lived in the city. In the experimental group and control group, respectively, 38.9% and 46.9% were primary school graduates. The ratio of the secondary school/higher education graduates and control group, respectively, was 61.1% and 53.1%. The ratio of participants with low income level and control group, respectively, was 63.9% and 53.1%. The ratio of participants with medium income level and con-

Table 3. BMIS pre-test and post-test mean scores of the care personnel in the experimental and control groups

BMIS		Experimental Group (n=36)	Control Group (n=32)	Test value and significance value	
				t	p
Pre-Test, Mean±SD	Dangerousness	24.94±6.15	24.40±5.84	-.369	.714
	Helplessness, Deterioration in IPR	43.41±5.20	41.71±7.16	-1.127	.264
	Embarrassment	1.02±2.59	1.31±2.60	.451	.654
	Total	69.38±10.54	67.43±11.14	.742	.461
Post-Test, Mean±SD	Dangerousness	25.36±5.70	24.12±4.95	-.948	.346
	Helplessness and Deterioration in IPR	38.69±8.73	41.34±6.42	1.409	.164
	Embarrassment	1.00±2.01	1.37±2.82	.635	.527
	Total	65.05±13.00	66.84±9.58	.639	.525

BMIS: Beliefs towards Mental Illness Scale; IPR: Interpersonal relationships; SD: Standard deviation.

Table 4. In-group comparison of the BMIS pre-test and post-test mean scores of care personnel in the experimental and control groups

Sub-scales of the Scale		BMIS		Test value and significance value	
		Pre-Test (Mean±SD)	Post-Test (Mean±SD)	t	p
Experimental Group (n=36)	Dangerousness	24.94±6.15	25.36±5.70	-.429	.670
	Helplessness, Deterioration in IPR	43.41±5.20	38.69±8.73	3.186	.003
	Embarrassment	1.02±2.59	1.00±2.01	.081	.936
	Total	69.38±10.54	65.05±13.00	2.053	.048
Control Group (n=32)	Dangerousness	24.40±5.84	24.12±4.95	.713	.481
	Helplessness, Deterioration in IPR	41.71±7.16	41.34±6.42	.742	.464
	Embarrassment	1.31±2.60	1.37±2.82	-.223	.825
	Total	67.43±11.14	66.84±9.58	1.304	.202

BMIS: Beliefs towards Mental Illness Scale; IPR: Interpersonal relationships; SD: Standard deviation.

trol group, respectively, was 36% and 46.9%. Comparing the descriptive characteristics of the experimental and control groups, it was determined that these two groups were regarding age, gender, marital status, living in residence, education status, and family income level (p>0.05).

The caregivers' mean scores of dangerousness subscale of the BMIS scale were 24.69±5.97 in the pre-test and 24.77±5.36 in the post-test; mean scores of helplessness and deterioration in interpersonal relationships were 42.61±6.21 in the pre-test and 40.67±10.17 in the post-test; the mean scores of Embarrassment were 1.16±2.58 in the pre-test and 1.17±2.41 in the post-test; and total mean scores were 68.47±10.79 in the pre-test and 65.89±11.47 in the post-test (Table 2). The values and scores obtained from the BMIS scale confirmed that caregivers had negative beliefs about mental disorders.

No statistical difference was found between the experimental and control groups in pre-test mean scores of caregivers or BMIS post-test scores of caregivers. After the psychoeducation, the post-test mean scores of the helplessness and deterioration in interpersonal relationships subscales of the BMIS scale of the caregivers in the experimental group (38.69±8.73) decreased compared to the those of the comparison group (41.34±6.42), but no statistically significant difference was found between the groups (p>0.05, Table 3).

The in-group comparison of the pre-test and post-test BMIS mean scores of the care personnel in the experimental group revealed that after psychoeducation was provided, the BMIS mean scores of helplessness and deterioration in interpersonal relationships subscales (38.69±8.73) decreased compared with the mean scores prior the psychoeducation (43.41±5.20),

and the difference between the groups was statistically significant ($p<0.05$, Table 4).

Further, the in-group comparison of the pre-test and post-test BMIS mean scores of the care personnel in the experimental and control groups showed no statistically significant difference in terms of the dangerousness and embarrassment subscales mean scores and the total mean scores ($p>0.05$, Table 4).

Discussion

In the published literature, no psychoeducational research in experimental type has been conducted on the beliefs of care personnel toward mental disorders. The data obtained from the present study took into consideration previous studies in that area. Previous psychoeducational studies toward schizophrenia disease were mostly implemented on patients and their relatives,[14,21,22,23] mukhtars,[16] nurses,[24] midwifery students,[25] nursery students,[26] medicine students,[13,27] and university students.[10,28]

The findings of the BMIS for care personnel revealed that they had negative beliefs toward schizophrenia disease and considered individuals diagnosed with schizophrenia to be dangerous; furthermore, they deeply believed that their interpersonal relationships would deteriorate and that they would experience helplessness. However, their belief about Embarrassment was low (Table 2).

Büyüksandıç's study[22] on the relatives of schizophrenia patients found their beliefs to be negative and that they believed that these patients are dangerous; they stated that they experienced helplessness, Güngörmüş and Durmaz[29] found that care personnel had negative beliefs toward mental disorders; in their research, Bilge and Çam[30] found that the participants considered that mentally disordered individuals have a higher possibility to commit a crime and perceived these individuals as dangerous. the participants thought that these diseases cause people to experience helplessness and interpersonal relationships would deteriorate. Ünal et al.[6] conducted a study with university students and found that there is a strong relationship between an increase in beliefs that mentally disordered individuals are dangerous and the belief of deterioration in interpersonal communication and experience in helplessness. Karakaş[31] found that nurses who did not receive education on psychiatry after graduation think that mental disorders and mentally disordered patients are more dangerous; in addition, nurses who do not feel safe in the psychiatric clinics believe that they experience more helplessness and deterioration in interpersonal relationships. All of these prior studies show similarities with the present study, but although it shows there is more helplessness and deterioration in interpersonal relationships in care personnel, these care personnel have lower embarrassment levels and higher levels of negative beliefs. It is proposed that high beliefs of care personnel on helplessness and deterioration in communication result from low income status, lack of information, insufficient coping mechanisms, and providing care for severe mentally disordered individuals, and their low level of embarrassment is due to the religious and cultural factors that emphasize "It should not be embarrassed as it is given by God."

In the present study, the BMIS pre-test and post-test mean scores of the care personnel in the experimental and control group were close to each other. The scores revealed that psychoeducation does not affect the BMIS sub-scales of dangerousness and embarrassment beliefs, but it decreases the belief on deterioration in interpersonal relationships but not on a significant level (Table 3). In general, as people gain their beliefs through perception, intuition, emotion, and experiences, when these beliefs once have settled into human memory they tend to be permanent and resistant to change. However, when the old information existed in the memory regarding the belief contradicts with new information, the beliefs begin to be questioned; thus, when learning concepts are presented through effective communication techniques, beliefs can be changed.[32] In sum, because it is difficult to change beliefs, taking into consideration life experiences and information levels of care personnel, providing psychoeducation for care personnel may begin to affect their beliefs.

Comparing the pre-test and post-test BMIS mean scores of the care personnel in the experimental group with those of the control group showed no change in the control group before and after the psychoeducation was provided; however, in the experimental group there was an increase in the beliefs of helplessness and deterioration in interpersonal relationships, and the beliefs of dangerousness and embarrassments were not affected (Table 4). It is possible that the psychoeducation increases the beliefs that care providers who able to understand schizophrenia diagnosed individuals more effectively, were able to solve their communication problems, and did not feel helplessness. In some studies that have investigated beliefs in nurses and nursing students about mental disorders, positive beliefs were associated with the health education that the participants received.[9,24,26,33]

Some published studies have stated that psychoeducation has positive effects on beliefs and attitudes toward mental illnesses.[10,21,26,28] These include a significant increase in care personnel's information level;[10,14,26] positive changes in feelings of embarrassment and attitudes toward mental illnesses;[16,22] decreased negative beliefs toward mental illnesses and reduced social distance.[27,34,35] Further, psychoeducation increases the tendency of care personnel to seek solutions to problems;[13,22] develops coping methods;[13,14] increases patient adaptation to treatment;[36] and decreases the rate of relapse by half.[36–38] Another study found psychoeducation useful for increasing care personnel information about mental health, and made positive changes in caregiver evaluation of patients, perception of burden, and emotional support.[23] Evaluating those study findings with a similar study results, the present study supports the literature.

The study limitations of this study involved applying psychoeducation to changing beliefs of care personnel toward schizophrenia, providing the education only through the researcher conducted who the study, and generalizing the results to the care personnel who were working in the care centers where the study was carried out. but were not participants in the study.

In conclusion, the psychoeducation provided to the care personnel is effective for positive changes on the beliefs of helplessness and deterioration in interpersonal relations. In accordance with these results, considering the role of care personnel on the lives of mentally disabled individuals, it is recommended that structured psychoeducation programs be introduced in other institutions where mentally disabled individuals are rehabilitated to change exiting negative beliefs toward mental disorders, to provide continuous education, and to conduct more detailed studies to evaluate differing results from psychoeducation on care personnel.

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

Peer-review: Externally peer-reviewed.

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

References

1. Kurt E, Alataş G, Çöpür M, Yerlikaya K, et al. Özürlüler Alanındaki Kanun ve Yönetmeliklerin Değerlendirilmesi. Türkiye ruh sağlığı sistemi üzerine değerlendirme ve öneriler. RCHP 2007; Özel sayı:59–69.
2. Çiftçi A. Özel Bakım Merkezleri Çalıştayı. Jan 23, 2012. Available at: http://www.ozurluveyasli.gov.tr/tr/haberler. Accessed Feb 15, 2012.
3. Bilge A, Çam O. The fight against stigma toward mental illness. TAF Preventive Medicine Bulletin 2010;9:71–8.
4. Taşkın EO. Stigma Ruhsal Hastalıklara Yönelik Tutumlar Ve Damgalama. İzmir: Turkuaz Bilişim-Bilgisayar ve Yayıncılık-Meta Basım; 2007. p. 117–37, 255–79.
5. Eker F, Öner Ö, Şahin S. Knowledge and attitudes of religious officials towards schizophrenia (example of Düzce, Turkey). Journal of Psychiatric Nursing 2010;1:63–70.
6. Ünal S, Hisar F, Çelik B, Özgüven Z. Üniversite öğrencilerinin ruhsal hastalığa yönelik inançları. Düşünen Adam Psikiyatri ve Nörolojik Bilimler Dergisi 2010;3:145–50.
7. Kütük MÖ, Durmuş E, Gökçen C, Toros F, et al. Rehber Öğretmenlerin Ruhsal Hastalıklara Yönelik İnançlarının, Tutumlarının ve Öğrencilerini Çocuk ve Ergen Psikiyatri Uzmanına Yönlendirme Gerekçelerinin Belirlenmesi. Dusunen Adam The Journal of Psychiatry and Neurological Sciences 2016;29:227–36.
8. Aslantaş H, Gültekin BK, Söylemez A, Dereboy F. Bir üniversite hastanesi psikiyatri polikliniğine ilk kez başvuran hastaların damgalamayla ilgili inanç, tutum ve davranışları. Adnan Menderes Üniversitesi Tıp Fakültesi Dergisi 2010;1:11–7.
9. Arkan B, Bademli K, Çetinkaya Duman Z. Sağlık çalışanlarının ruhsal hastalıklara yönelik tutumları: son 10 yılda Türkiye'de yapılan çalışmalar. Psikiyatride Güncel Yaklaşımlar 2011;3:214–31.
10. Kara N. Sosyal Hizmet Bölümü Öğrencilerinin Ruhsal Hastalıklara Yönelik İnançları ve Ruhsal Hastalıklara Yönelik Verilen Teorik Eğitimin Etkileri. Bilişsel Davranışçı Psikoterapi ve Araştırmalar Dergisi 2015;2:69–77.
11. Çoban A. Şizofreni-Bin Parça Akıl. İstanbul: Timaş Yayınları; 2009.
12. Liberman RP. Yeti Yitiminden İyileşmeye: Psikiyatrik İyileştirim El Kitabı. In: Yıldız M, editor. Ankara: Türkiye Sosyal Psikiyatri Derneği: 2011.
13. Yenilmez Ç, Güleç G, Ernur D, Aydın A, et al. Eskişehir'de tıp fakültesi öğrencilerinin şizofreniye yönelik bilgi ve tutumları. Klinik Psikiyatri 2010;13:185–95.
14. Tel H, Terakye G. Şizofrenik hasta ailelerine yönelik bir psikoeğitimsel yaklaşım uygulaması denemesi. Anadolu Psikiyatri Dergisi 2000;1:133–42.
15. Babacan Gümüş A. Şizofrenide hasta ve ailelerin yaşadığı güçlükler psikoeğitim ve hemşirelik. Hemarge Dergisi 2006;1:23–34.
16. Çam MO, Bilge A, Engin E, Baykal Akmeşe Z, et al. Investigating the Effectiveness of Education of the Fight Against Stigma on Mental Illness to Headmen. Journal of Psychiatric Nursing 2014;5:129–36.
17. Bilge A, Çam O. Ruhsal Hastalığa Yönelik İnançlar Ölçeği'nin geçerliliği ve güvenilirliği. Anadolu Psikiyatri Dergisi 2008;9:91–6.
18. Arieti S. Bir Şizofreni Anlamak-Aile ve Arkadaşlar İçin Rehber. In: Eti A, editor. İstanbul: Doruk Yayımcılık; 2008.
19. Öztürk O, Uluşahin A. Ruh Sağlığı ve Bozuklukları I. 11th ed. Ankara: Nobel Tıp Kitapevleri; 2008. p. 242–322.
20. Kültür S, Mete L, Erol A. Şizofreni. In: Köroğlu E, Güleç C, editors. Psikiyatri Temel Kitabı. 2nd ed. Ankara: HYB Basım Yayım; 2007.
21. Chan JY, Mak WW, Law LS. Combining education and video-based contact to reduce stigma of mental illness: "The Same or Not the Same" anti-stigma program for secondary schools in Hong Kong. Soc Sci Med 2009;68:1521–6.
22. Büyüksandıç Özşen P. Şizofren Hastaların Yakınlarının Şizofreniye yönelik Bilgileri, İnançları ve Yardım Arama Davranışları. [Yüksek Lisans Tezi] Gaziantep: Gaziantep Üniversitesi Sağlık Bilimleri Enstitüsü; 2013.
23. Sin J, Gillard S, Spain D, Cornelius V, et al. Effectiveness of psychoeducational interventions for family carers of people with psychosis: A systematic review and meta-analysis. Clinical Psychology Review 2017;56:13–24.
24. Elçi T. Hemşirelerin Ruhsal Hastalıklara ve Hastalara Yönelik İnanç ve Tutumları. [Yüksek Lisans Tezi] İstanbul: Haliç Üniversitesi Sağlık Bilimleri Enstitüsü; 2013.
25. Bilge A, Baykal Akmeşe Z, Çakır Koçak Y, Sarıcan ES. A group of midwifery students' beliefs toward mental ilnesses in Turkey. Balıkesir Sağlık Bilimi Dergisi 2013;2:9–14.

26. Kayahan M. Hemşirelik öğrencilerinin şizofreniye karşı tutumları ve psikiyatri eğitiminin etkisi. Harran Üniversitesi Tıp Fakültesi Dergisi 2009; 1:27-34.
27. Yadav T, Arya K, Kataria D, Balhara YP. Impact of psychiatric education and training on attitude of medical students towards mentally ill: A comparative analysis. Ind Psychiatry J 2012;21:22–31.
28. Markström U, Gyllensten AL, Bejerholm U, Björkman T, et al. Attitudes towards mental illness among health care students at Swedish universities – A follow-up study after completed clinical placement. Nurse Educ Today 2009;29:660–5.
29. Güngörmüş K, Durmaz H. Bir bakım evinde görev yapan bireylerin maruz kaldıkları şiddetin ruhsal hastalık inancına etkisi. III. Uluslararası VII. Ulusal Psikiyatri Hemşireliği Kongresi, Kongre kitabı. Eylül 1–3, 2014. Ankara: 2014.
30. Çam O, Bilge A. Türkiye'nin batısında yaşayan halkın ruhsal hastalığa ve hastalara yönelik inanç ve tutumlarının belirlenmesi. New Symposium Journal 2011;49:131–40.
31. Karakaş M. Psikiyatri ve psikiyatri dışı kliniklerde çalışan hemşirelerin ruhsal hastalığa yönelik inançlarının belirlenmesi. [Yüksek Lisans Tezi] Ankara: Gazi Üniversitesi Sağlık Bilimleri Enstitüsü; 2016.
32. İnceoğlu M. Tutum Algı İletişim. 6. Baskı. Ankara: Siyasal Kitabevi; 2011.
33. Akgün Çıtak E, Budak E, Kaya Ö, Öz Ş, et al. Başkent Üniversitesi'nde öğrenim gören hemşirelik öğrencilerinin ruhsal hastalıklara karşı inançlarının belirlenmesi. Sağlık Bilimleri Fakültesi Hemşirelik Dergisi 2010;17:68–73.
34. Altindag A, Yanik M, Ucok A, Alptekin K, et al. Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. Psychiatry Clin Neurosci 2006;60:283–8.
35. Karadağ Ş, Çalık H, Arslantaş H, Adana F. Hemşirelik bölümünde öğrenim gören 1. ve 4. sınıf öğrencilerinin ruhsal hastalıklara bakış açılarının belirlenmesi III. Uluslararası VII. Ulusal Psikiyatri Hemşireliği Kongresi, Kongre Kitabı. Eylül 1–3, 2014. Ankara: 2014.
36. Asi Karakaş S, Okanlı A. Şizofreni hastalarına verilen 'bağımsız ve sosyal beceriler topluma yeniden katılım programı' uygulamasının sosyal işlevsellikler ve ilaç uyumuna etkisi. II. Uluslararası VI. Ulusal Psikiyatri Hemşireliği Kongresi, Kongre Kitabı. Ekim 4–7, 2012. Erzurum: 2012.
37. Maldonado JG, Urızar AC. Effectiveness of a psycho-educational intervention for reducing burden in Latin American families of patients with schizophrenia. Qual Life Res 2007;16:739–47.
38. Cheng LY, Chan S. Psychoeducation program for Chinese family carers of members with schizophrenia. West J Nurs Res 2005;27:583–99.