A QUALITATIVE INVESTIGATION OF STIGMA EXPERIENCES OF INDIVIDUALS WITH DEPRESSIVE DISORDERS IN TURKEY

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ABSTRACT

A QUALITATIVE INVESTIGATION OF STIGMA EXPERIENCES OF INDIVIDUALS WITH DEPRESSIVE DISORDERS IN TURKEY

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The aim of the present study was to explore stigma experiences of individuals diagnosed with depressive disorders in Turkey, from their own perspective. To this end, qualitative research methodology was employed and fourteen participants who had a diagnosis of depressive disorder were interviewed for the study. The data obtained through interviews was analyzed using Interpretative Phenomenological Analysis (IPA). At the end of the analysis process, five superordinate themes were identified, which were *the experience of disorder, others' reactions, effects of disorder experiences and others' reactions on self, meaning making,* and *coping.* Quotations from the participants were provided regarding the superordinate themes and subordinate themes in the results section. Results were discussed in the light of the relevant literature. Clinical implications and future directions were also discussed.

Keywords: Mental Illness Stigma, Self-Stigma, Depressive Disorders, Qualitative, Interpretative Phenomenological Analysis

ÖZ

TÜRKİYE’DE DEPRESİF BOZUKLUK TANISINA SAHİP BİREYLERİN DAMGALANMA DENEYİMLERİNE İLİŞKİN NİTEL BİR İNCELEME

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Bu çalışma, Türkiye’de depresif bozukluk tanısına sahip bireylerin damgalanma deneyimlerini kendi perspektiflerinden anlamayı amaçlamıştır. Bu amaçla, nitel araştırma yöntemi benimsenmiş ve depresif bozukluk tanısına sahip 14 katılımcı ile görüşmeler yapılmıştır. Görüşmeler yoluyla elde edilen veri Yorumlayıcı Olgubilim Analizi yaklaşımı ile analiz edilmiştir. Analiz sürecinin sonunda beş üst-tema çıkmıştır: *bozukluğun deneyimlenmesi, çevreden alınan tepkiler, bozukluğun deneyimlenmesi ile çevreden alınan tepkilerin bireydeki etkileri, anlam verme,* ve *başa çıkma*. Sonuçlar bölümünde, üst-temalar ve alt-temalar katılımcılardan yapılan alıntılar ile birlikte sunulmuştur. Temalar ilgili alanyazın ışığında tartışılmış ve klinik çıkarımlar yapılmıştır.

Anahtar Kelimeler: Damgalama, Kendini Damgalama, Depresif Bozukluklar, Nitel Araştırma, Yorumlayıcı Olgubilim Analizi

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INTRODUCTION

"We are faced with recovering not just from mental illness, but also from the effects of being labeled mentally ill."

Patricia E. Deegan

Stigma and Self-Stigma

Stigma

The term stigma was introduced to social sciences by Goffman in 1963 in his pioneer work entitled *Stigma: Notes on the management of spoiled identity*. In his work, Goffman defined stigma as a social construction involving two components: the recognition of a difference in a person based on a distinguishing characteristic (mark) and devaluation of the person as a consequence of possessing that mark (Goffman, 1963, p. 3). The stigmatized person is viewed as *spoiled* due to the mark she or he bears; therefore, is regarded as less than normal (Goffman, 1963). The mark is essentially used for downward social designation. Link and Phelan (2001) conceptualized stigma as a progressive process involving the co-occurrence of labeling, stereotyping, separating, emotional reactions, status loss, and discrimination. First off, people label a human difference. Secondly, dominant culture associates labeled individuals with negative stereotypes. Then, labeled individuals are categorized as *them* and distanced from the rest of society. Finally, labeled individuals experience status loss and discrimination. Link and Phelan (2001) argued that stigmatization is all about power dynamics. Stigma is produced to attain power over some *others* through exclusion and discrimination (Link & Phelan, 2001). World Health Organization (2001, p. 16) officially defines stigma as “a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of areas of society.”

Scholars identified main clusters of human characteristics for which stigmatization occurs. Goffman (1963, p. 4) identified three fundamental stigmatizing attributes: tribal identities, blemishes of individual character, and abominations of the body. Tribal stigma can be understood as racism, stigmatization of a race or ethnic identity by another. Blemishes of individual character can be exemplified as the stigmatization of people with mental illness, addiction, suicidal attempts, and different sexual orientations. Stigmatizing people with disabilities and disfigurements (e.g. obesity) can be considered under the category of abominations of the body.

Stigma is a subject of interest in several fields, such as social psychology, cognitive psychology, and evolutionary psychology. Social cognitive models (Corrigan & Kleinlein, 2005, pp. 16-17) conceptualize stigma within cognitive, affective, and behavioral aspects, as in most psychological phenomena, and these aspects are strongly associated with stereotypes, prejudice, and discrimination, respectively. Stereotypes are overgeneralized cognitive representations of a group of people. Regarding people with mental illness as incompetent is a pure example of stereotypes. People may also develop adverse emotional reactions or attitudes toward the group of people exposed to stereotypes, which is called prejudice. For example, those who believe that people with mental illness are incompetent may begin to blame them for their illness after a while. Such kind of blaming would be an emotional reaction that forms the basis of prejudice. Finally, negative behavioral responses emerging from prejudice is called discrimination. For instance, excluding people with mental illness from social, educational, occupational spheres would be discrimination (Peters, Schwenk, Ahlstrom, & Mclalwain, 2017).

The just-world hypothesis, a social psychological model, explains stigma from a motivational perspective. Accordingly, people are motivated to interpret situations in a way that does not threaten their sense of justice. Therefore, they are inclined to believe that people get what they deserve. Good people will get good outcomes, whereas bad people will end up with bad outcomes (Lerner, 1980). If a person experiences an adverse life event, according to the hypothesis, she or he must have done something wrong to deserve that consequence. This interpretation results in victim-blaming and withholding help (Ottati, Bodenhausen, & Newman, 2005). People blame victims for protecting their sense of justice. Regarding the concept of stigma, people believe that some groups of people who are suffering from unfortunate circumstances must have done something to deserve it. They may have weak characters, or they may have unfavorable traits or habits, and thus, deserve stigmatization. Therefore, prejudice and discrimination towards a certain group of people become rationalized in this way. Similarly, people who suffer from mental illness are usually accused of being responsible for their situation; therefore, prejudice and discrimination towards such people become appropriate reactions (Ottati, Bodenhausen, & Newman, 2005).

The *cognitive* approach conceptualizes stigmatization in relation to categorization, a natural process of the human mind. Humans routinely categorize objects around them because making categorization is essential to generate appropriate reactions. The complexity of the outside world requires grouping stimuli into meaningful categories and forming meaningful expectations about them. In this way, the complexity is reduced to a tolerable degree. Similarly, the human mind seeks to create categories in which people are grouped to reduce the complexity of human diversity. Such a generic view is necessary to achieve a sense of predictability and control over social situations (Ottati, Bodenhausen, & Newman, 2005, p 108). Researchers also suggest that stigmatizing others helps to reduce the complexity of comprehending people as multi-faceted individuals (Allport, 1954; Tajfel, 1969). One of the consequences of stereotyped thinking is the possibility to alter the behaviors among group members, which is known as self-fulfilling prophecy (Ottati, Bodenhausen, & Newman, 2005, pp 111). When a perceiver has an expectation about a person, she or he is likely to behave in a way that elicits the expected behavior. When people expect certain behaviors from a certain group or people, they are likely to observe those behaviors. It is also the case for the members of a certain group. When they are aware of stereotypes about themselves, they are more likely to behave in ways that confirm those stereotypes. This social-cognitive process helps to explain how stigma is maintained.

The evolutionary perspective explains the motivation to stigmatize with the humans’ need to live in effective groups. Humans value and adopt group characteristics while stigmatizing those who deviate from such characteristics because group living is a key for survival. People who fail to fulfill accepted rules for adaptive social interaction are seen as unpredictable and threatening. Therefore, those with mental illness and those who are incompetent at social or other tasks or contingent to bodily abominations should be stigmatized for maintaining the group's well-being (Kurzban & Leary, 2001). Social exchange is a crucial component of group living. People with mental illness may be perceived as poor social exchange partners as well. In addition, natural selection results in the social exclusion of those with mental illness (Kurzban & Leary, 2001). Also, individuals gain an advantage of avoiding, rejecting, and eliminating others whose behaviors are disruptive to the group (Brewer, 1997).

In summary, stigma is any mark that results in the devaluation of a person who possesses the mark (Goffman, 1963, p. 3). Stigmatization occurs when public targets a person with stereotypes, prejudice, and discrimination, based on the mark that she or he possesses (Corrigan & Kleinlein, 2005, pp. 16-17). The concept of stigma was explained by several models, such as the just-world hypothesis (Lerner, 1980), the cognitive perspective (Ottati, Bodenhausen, & Newman, 2005, p 108), and the evolutionary perspective (Kurzban, & Leary, 2001). Stigma, which is a public issue, also becomes personal when it is internalized by the members of stigmatized groups, which is called self-stigma.

Self-Stigma

It is crucial to distinguish public stigma and self-stigma when studying the clinical implications of stigma. Self-stigma occurs when the three aspects of stigma - cognitive, affective, and behavioral- are applied to the self by the members of the stigmatized group. Namely, self-stigma means internalization of public stigma by the members of the stigmatized group (Corrigan & Kleinlein, 2005, pp. 16-17). Similarly, a person with mental illness who internalizes stigma endorses the public stereotypes about people with mental illness. She or he develops a negative belief about the self and concludes that one is incompetent. She or he endorses the prejudice against those with mental illness; thus, she or he develops an adverse emotional reaction towards herself or himself, which causes a decrease in self-esteem and self-efficacy. Finally, as a behavioral response to prejudice, she or he discriminates against people with mental illness, including himself or herself. Consequently, she or he fails to pursue opportunities and isolates herself or himself from people (Corrigan & Kleinlein, 2005, p. 16).

Self-stigma brings about numerous negative consequences. Although it poses different consequences in different stigmatized groups, the most prevalent ones are decreases in self-esteem and self-efficacy, and diminished confidence in one’s future (Corrigan, 1998; Holmes & River, 1998). However, research has shown that diminished self-esteem is not the inevitable consequence of stigmatization. Researchers also showed that some stigmatized individuals do not necessarily have lower levels of self-esteem (Hoelter, 1983; Verkuyten, 1994). Although they are aware of the stereotypes about their group, such people may not always self-stigmatize about themselves so that they may not lose self-esteem. Some react with righteous anger while others seem to ignore stigmatization (Corrigan, & Kleinlein, 2005, p. 26).

Corrigan, Rafacz, and Rüsch (2011) have proposed a progressive model of self-stigma, which yields four stages leading to internalization of public stigma, diminished self-esteem, and hope. The model suggests that the internalization of stigma occurs through a series of successive stages. In the awareness stage, for the example of mental illness, a person with mental illness is aware of the public stigma about mental illnesses and people with mental illness. In the agreement stage, the person agrees with the public stigma and endorses that negative stereotypes are true about people with mental illness. In the application stage, the person applies the stereotypes to herself or himself. Finally, the person suffers from significant harm because of decreases in self-esteem and self-efficacy, which constitutes the harm stage. People with mental illness may have different experiences in these stages, especially the stages of agreement and application, and avoid the final stage. The significance of this model underlies under its capacity to explain why a person from stigmatized groups does not experience loss of self-esteem, decreased self-efficacy, or personal harm (Corrigan & Rao, 2012).

As progressing through the stages, especially at the harm stage, self-stigma profoundly interferes with the achievement of life goals. Diminished self-esteem leads to feeling less worthy of catching opportunities and less capable of doing tasks; thus, failing to seek life-enhancing opportunities, which creates major problems in individuals’ lives due to undermining efforts to achieve life goals. This effect is known as *the why try effect* (Corrigan & Rao, 2012), which is a significant barrier for stigmatized individuals to achieve their life goals.

Fox, Earnshaw, Taverna, and Vogt (2018) created a framework that incorporates the relevant research on stigma. The framework illustrates the mechanisms of public stigma, self-stigma, and the interaction between the two (see Figure 1). It also differentiates the perspectives of stigmatizer and the stigmatized. While stereotyping, prejudice, and discrimination are mechanisms that are most relevant to stigmatizers, the other three mechanisms most relevant to the stigmatized are *experienced stigma, anticipated stigma, and internalized stigma*. Experienced stigma is defined as the experiences of stereotyping, prejudice, and discrimination due to one's condition in the past or present (Quinn & Earnshaw, 2011). Anticipated stigma is the extent to which a person with stigmatized identity anticipates being the target of stereotypes, prejudice, and discrimination in the future (Quinn & Earnshaw, 2011). Internalized stigma refers to the concept of self-stigma as defined before. Perceived stigma is defined as perceptions of societal beliefs (stereotypes), feelings (prejudice), and behaviors (discrimination) towards the members of a specific group (Boss, Pryor, Reeder, & Stutterheim, 2013). Intersectionality represents the characteristics that influence stigma experiences, such as gender, socioeconomic status, zeitgeist, and culture (Fox et al., 2018).

Link and colleagues (2004) pointed out that anger, irritation, anxiety, pity, and fear are likely emotions from the vantage point of the stigmatizer. On the other hand, embarrassment, shame, fear, and alienation are the possible emotions from the vantage point of the stigmatized. What the stigmatized and stigmatizers have in common during any interaction are anxiety, fear, and uncertainty about each other. Anxiety leads both parties to avoid interaction, which creates a cycle that perpetuates stigma (Hebl, Tickle, & Heatherton, 2003, p. 299).

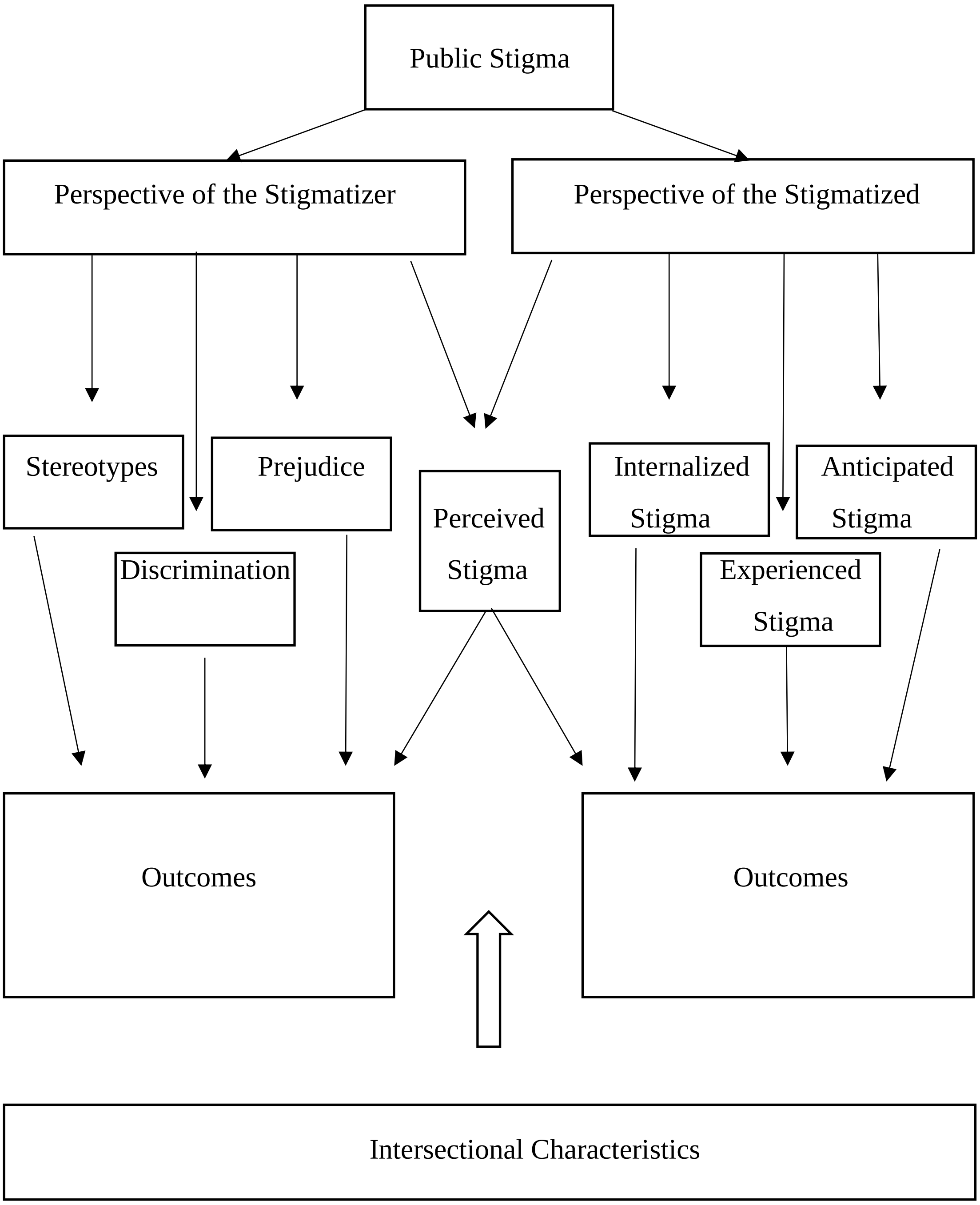

Figure 1. Stigma framework (Fox, Earnshaw, Taverna, & Vogt, 2018)

In summary, it is important to understand concepts of public stigma, self-stigma, and the way these interact to understand the clinical implications of such phenomena. Therefore, the purpose of the present study was to understand the stigma experiences of individuals with mental illness from a clinical psychology perspective and suggest ways of addressing these issues in psychotherapy. More specifically, the present study focused on stigma and self-stigma in the context of mental health by conducting qualitative interviews with individuals diagnosed with psychological disorders. Therefore, the concept of mental illness stigma is explored in more detail in the next section.

Mental Illness Stigma

Mental illnesses are universally stigmatized health conditions (Stangor & Crandal, 2003, p. 18). Goffman (1963) considered mental illness in the category of character blemishes. Both the symptoms and the label of mental illness lead the public to view it as a deviation from *normality* (Corrigan, 2000). A substantive body of research suggests that individuals who carry the label of mental illness frequently encounter negative responses (Link & Phelan, 2013). Responses and reactions to those with mental illness include dislike, devaluation, stereotyping, biased judgements and attributions, and unfavorable behaviors (Biernat & Dovidio, 2003, p. 103; Farina, 1982). Individuals with mental illness are depicted in the public with stereotypes including sickness, incompetence, character weakness, worthlessness, dangerousness, coldness, and being unpredictable and insincere (Corrigan, & Kleinlein, 2005, p. 16; Crumpton, Weinstein, Acker, & Annis, 1967). The stereotypes of individuals with mental illness tend to cluster into either the warmth domain (violent or unstable) or the competence domain (incompetent or unable to function independently) (Sadler, Meagor, & Kaye, 2012).

Although mental illness is a condition that universally bears stigma, types of mental illness differ in terms of the extent to which they are associated with stigma. Psychotic disorders were found to be carrying more stigma than non-psychotic disorders (Crisp, Gelder, Goddard, & Meltzer, 2005). Individuals with schizophrenia are more stigmatized than individuals with depression (Crisp et al., 2000; Angermeyer et al., 2015). Likewise, a study conducted with a Turkish sample revealed that, in public, the desire for social distance was higher for individuals with schizophrenia than for individuals with depression (Utz et al., 2019). Similarly, schizophrenia was found to be most associated with stigma, followed by bipolar disorder and depression (Hanafiah & Bortel, 2015). Also, characteristics of individuals with mental illness influence the degree of stigmatization. Individuals who display annoying behaviors, communicate poorly, use medications, receive electroconvulsive treatment, or have a history of hospitalization face more stigma than those who do not have such characteristics (Aydemir & Berksun, 2018).

On the other hand, public beliefs about mental illness seem to contradict with mental illness stigma. General Social Survey (GSS), which is a national survey conducted in the United States, contained modules on mental illness in its 1996 and 2006 versions. The results showed that 67% of the respondents supported biomedical causes for the explanation of major depression, and 86% supported biomedical causes when explaining schizophrenia. Based on participants’ responses, genetic factors and stressful life circumstances were more likely to cause mental disorders than weak character and God’s will. Also, 67% of the participants attributed major depression to usual ups and downs of life, and 41% to the family upbringing. Ninety one percent and 79% of the respondents endorsed talking to a professional and taking medication, respectively, as ways to overcome depression. Sixty two percent of the respondents strongly agreed that treatment can help those with mental illness (Pescosolido et al., 2010). Based on the results of the GSS, the public sees mental illness as something caused mostly by biomedical factors, life stress, and family upbringing, and believes that it is necessary to be treated. Other researchers (Schnittker, 2013) also showed that the public believes that mental illness is a result of everyday life events and can happen to anyone. Taken together, these results imply that the lay understanding of mental disorders is somewhat consistent with professionals’ views about the etiology of mental disorders.

Yet, these results failed to explain the reasons behind stigma among general public. One way of assessing stigma is through social distance, which is a person’s willingness or unwillingness to interact with stigmatized others. Measured in this fashion, 47% of the respondents in the GSS report were unwilling to work with someone with major depression, and 53% were unwilling to marry such people, although only 32% believed that someone with major depression is dangerous. Social distance was more pertinent for individuals with schizophrenia and alcohol abuse. Eighty four percent of the respondents perceived individuals with schizophrenia as dangerous, and 79% perceived individuals with alcohol abuse as dangerous. Sixty two percent were unwilling to work closely with a person with schizophrenia, 52% was unwilling to socialize with such a person (Pescosolido et al., 2010). Although the public recognizes that mental health problems can strike anyone (Schnittker, 2013), they still adopt negative views towards individuals with mental illness. They avoid interaction with those with mental health problems or totally marginalize them (Schnittker, 2013). It seems paradoxical that the public may recognize that individuals with mental illness are not responsible for their condition; however, they still degrade them (Schnittker, 2013, p 88).

One reason behind this paradox could be social desirability. Participants of various surveys may be unwilling to admit their own negative attitudes towards those with mental illness due to social desirability factor. Surveys revealed that 57% of participants believe that individuals with mental illness are treated with sympathy and care. However, fewer persons (25%) who experienced mental illnesses believed the same (Centers for Disease Control and Prevention, 2010). Indeed, people suffering from mental illnesses reported explicit discrimination (18%) and embarrassment (41%). Nevertheless, individuals with physical illnesses reported much less discrimination and embarrassment (Alonso et al., 2008). When people asked to rank a variety of stigmatized conditions based on the degree to which they were stigmatized, it was found that mental illness was stigmatized as much as homelessness (Hinshaw, 2007). Moreover, slurs are commonly used in everyday language against individuals with mental illness (e.g. crazy) (Hinshaw & Cicchetti, 2000).

Moreover, surveys monitoring public beliefs about mental illness have not revealed a decline in stigma over the years. Although general mental health literacy has improved, perceptions of dangerousness regarding mental illness have not changed much. There seems to be no obvious evidence for a decline in mental illness stigma in spite of increased knowledge and understanding (Schnittker, 2013, p 84).

The studies conducted in Turkey on public beliefs about mental illnesses yielded similar results with the international literature. The above-mentioned paradox was also evident in Turkey: people displayed negative attitudes towards individuals with mental illness although they believed that such individuals deserve more supportive attitudes (Sarıkoç & Öz, 2016; Çam & Bilge, 2011). People in Turkey perceived individuals with mental illnesses as dangerous and carried prejudice towards them (Çam & Bilge, 2011). In terms of public understanding of mental illnesses in Turkey, 69.7% of people attributed what causes mental illnesses to effects of undesired childhood events, 55.7% attributed it to genetic factors, and

20.9% attributed it to religious and spiritual phenomena (Bağ, 2003). Furthermore, most people viewed depression as a treatable disease. Viewing depression as a disease was associated with positive opinions and beliefs about its treatment while considering depression to be caused by weakness of personality was associated with negative attitudes towards it (Ozmen et al., 2005).

The paradox observed in public surveys can be explained from an evolutionary point of view. Although people admit that mental illness is a condition that originates from genetic and medical factors and requires treatment, and that individuals with mental illness are not responsible for their condition, they still avoid interacting with those who have mental illness. Surveys revealed that the public has negative views about those with mental illness, and treats them negatively. Individuals with mental illness were perceived as unpredictable and threatening by their groups because such people deviated from the fundamental group characteristics (Kurzban & Leary, 2001). From an evolutionary perspective, although people understand the conditions of the individuals with mental illness, they may still stigmatize and exclude them for the sake of the group's well-being, which is, crucial for one's survival. For instance, one may not want an individual with mental illness as an intended daughter-in-law or son-in-law for the well-being of her or his family.

In summary, findings showed that individuals with mental illness encounter negative responses frequently, such as dislike, devaluation, stereotyping, and unfavorable treatment (Biernat & Dovidio, 2003, p. 103; Farina, 1982). Such people are also faced stereotypes such as being dangerous, incompetent, and weak (Corrigan, & Kleinlein, 2005, p. 16). Interestingly, although the public indicated biomedical and genetic factors as the reasons for mental illnesses and admitted that individuals with mental illness are not responsible for their condition and should not be treated undesirably, most people still wanted to keep social distance with such people (Pescosolido et al., 2010; Schnittker, 2013). Theories of mental illness stigma shed more light onto the reasons behind and factors related to mental illness stigma.

Theories of Mental Illness Stigma

Debates in the area of mental illness stigma date back to 1960s when dissensus arose around medical model versus labeling theory. According to the medical model, which had initially been the dominant model, mental illness originates from brain’s biological dysfunctions (Engel, 1992). Neural deficits and biochemical imbalances lead to brain dysfunctions, and consequently lead to mental illnesses. Genetic defects and hormonal dysregulations also give rise to behavioral or psychological problems, which are the antecedents of mental illnesses (Bendelow, 2009; Cockerham, 1996; Kirk & Kutchins, 1992; Raabe, 2010). Mental illnesses can be treated and cured with medicine. Medical model, which conceptualized mental illness as a pure biological phenomenon, actually left no room for social, psychological, and behavioral aspects of mental illness (Engel, 1992). Scheff (1966) reacted to the total medicalization of mental illness and drew attention to social processes influencing the experience of mental illness.

Scheff proposed the labeling theory of mental illness and argued that what led mental illness was nothing but labeling (1966). The key principle in the labeling theory is that once a person is mentally ill, and therefore labeled as *deviant*; the society uniformly begins to treat the person as deviant. Actually, there are two processes co-functioning in deviance. The *primary deviance* is becoming mentally ill due to social, psychological, or biological factors. The *secondary deviance*, on the other hand, is adaptation response of the person with mental illness to societal reactions regarding primary deviance (Lemert, 1967, p.17) Common responses of society to mental illness include fear, disgust, minimizing contact, and social distance. The person is repeatedly exposed to such negative responses, prejudice and discrimination. This facilitates her or his socialization into the role of mental patient. This leads the person to display continued deviant behaviors. Scheff claimed that “the traditional stereotype of insanity becomes the guiding image for action, both for those reacting to the deviant and for the deviant herself/himself” (Scheff, 1966, p. 82). The person’s behaviors become crystallized in conformity with such expectations. Her or his behaviors becomes more and more similar to others with mental illness. The imagery finally begins to guide all of her or his behaviors, and the role becomes her or his central identity. She or he fits the label and her/his mental illness is stabilized as a result (Scheff, 1966, p. 82; Goffman, 1961). Scheff identified his theory as “an antithesis of the medical model and a sociological theory that deals only with social processes” (Scheff, 1975, pp. 75-76). Scheff emphasized how jokes, cartoons, and the media’s portraying of patients with mental illness can shape the public view about mental patients. All members of society, including both those with and without the label of mental illness, form conceptions of what it means to have a mental patient status based on those sources. Scheff relied heavily on the idea that individuals with mental illness internalize societal conceptions of what it means to be labeled as mentally ill. He also assumed that most people will devalue and discriminate against mental patients (Link et al., 1989).

Labeling theory received criticisms especially for linking development of mental illness directly to societal reactions. One of the critics of the theory, Gove, asserted that deviant labels stem from deviant behaviors. Ostracizing individuals with mental illness does not result from labeling, but it is a response to their symptomatic behaviors. Moreover, he maintained that labeling is not a prime cause of further deviant behaviors (Gove, 1975, p. 296). Gove did not see stigma as a severe problem in the lives of those with mental illness (Gove, 1982).

Professionals seesawed between these two opposite opinions for a while until Link and colleagues developed a modified labeling theory in 1980s. Their theory positioned in middle ground between the medical model and the labeling theory. The modified theory derived insights from the labeling theory, but it differentiated on certain points. The theory concurred that people develop negative conceptions of what it means to be mentally ill in the course of socialization. Such conceptions actually exist before a person becomes mentally ill. When a person is labeled as mentally ill, societal conceptions become relevant to the self for that person. She or he faces the effects of stigma because she or he and others around have already internalized the undesired view of what it means to be mentally ill. In the modified theory, however, labeling became a mediator rather than bearing a causal role. According to the modified theory, labeling a person jeopardizes the life circumstances of individuals with mental illness by harming their self-esteem, social networks, and employment opportunities. Due to remaining in a disadvantaged position in these domains, individuals with mental illness face greater risk of prolongation and relapse of mental illness. The theory stepped away from the claim of the labeling theory that labeling causes mental illness (Link, 1982, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). In addition, critics of the labeling theory asserted that rejection of individuals with mental illness is due to their aberrant behaviors, and stigma is not a significant problem in the lives of individuals with mental illness (Gove, 1975, 1982). Link and colleagues (1999), however, found that public was likely to stigmatize a person with mental illness even in the absence of any aberrant behaviors. These findings show that the modified labeling theory both positions between two opposite sides of labeling issue and addresses the extremities of both sides.

The stress-process model is a psychological model that explains how labeling and stigmatization are linked to the persistence of illness. The model predicts that stress is increased when damaged sense of self in individuals with mental illness is combined with reduced social and material resources. Increased stress poses greater risk of persistence of symptoms in individuals (Pearlin, Menaghan, Lieberman, & Mullan, 1981).

In summary, the debate was initially around the causes of mental illness. On one side, it was asserted that mental illness is caused only by medical conditions (Kirk & Kutchins, 1992); on the other side, researchers argued that social processes, such as labeling an individual as *sick,* account for the development of any mental illness (Scheff, 1966). Other researchers formed a middle ground between the two opposing sides, drew insights from both, and claimed that mental illness can be caused by both medical factors and social processes (Link et al., 1989). Whether caused by medical factors or precipitated by social processes, stigma has significant effects on the lives of individuals with mental illness.

Effects of Mental Illness Stigma

Mental illness stigma is a significant concern for both individuals with mental illness and their families. An accumulated body of research elaborates on the effects of mental illness stigma. According to research findings, individuals with a history of mental illness have been degraded and rejected and have experienced prejudice similar to those of ethnic minorities (Hayward & Bright, 1997). Researchers have also reported that social interactions of individuals with mental illness are disrupted due to acting less confidently and more defensively, or avoiding social contact altogether (Link & Phelan, 2013, p. 25). Individuals with mental illness tend to have more constricted social networks (Link et al., 1989), decreased quality of life (Markowitz, Angell, & Greenberg, 2011), low self-esteem (Link, Castille, & Stuber, 2008), high depressive symptoms (Perlick et al., 2007), unemployment and income loss (Link, 1987), poor treatment adherence (Sirey et al., 2001), treatment discontinuation (Sirey et al., 2001), and difficulty in obtaining satisfying housing opportunities (Wahl, 1999). Psychiatric patients are also less likely to receive adequate health care (Druss & Rosenheck, 1998). Mental illness stigma leads to a progressive process of marginalization and discrimination for people with mental illness (Evans-Lacko et al., 2012).

Internalization of stigma of mental illness seems to be a bigger threat to the well-being of individuals with mental illness than mental illness stigma itself. Studies conducted with individuals with mental illness showed that decreased self-esteem is a significant problem for such people (Wahl, 1999). Individuals with mental illness believe to be less valued because of their mental disorder (Link & Phelan, 2001). It has been found that self-stigma of mental illness correlates negatively with hopefulness, self-efficacy, sense of purpose, quality of life, social support, occupational participation, and healthcare service use. Yet, self-stigma correlates positively with self-isolation, psychiatric symptom severity, and treatment non-adherence (Livingston & Boyd, 2010; Corrigan & Rao, 2012). Self-stigma is a more powerful predictor of failing to seek help than public stigma. It has been found out that high levels of self-stigma hinders help seeking behavior (Barney, Griffiths, Jorm, & Christensen, 2006). In a study, it was found that individuals who internalized mental illness stigma had lower functionality levels, shorter remission periods, and longer depressive periods. The study had correlational design; therefore, the direction of the relationships was not specified (Üstündağ & Kesebir, 2013).

Mental illness stigma is encountered by family members as well. This phenomenon is called *courtesy stigma* (Goffman, 1963, pp. 30-31) and reflects that family, healthcare providers, and others associated with the person with mental illness experience prejudice and discrimination too. Studies have documented that family members report diminished self-esteem, shame, and an inclination to hide the mental illness of their family members (Wahl & Harman, 1989; Phelan, Bromet, & Link, 1998; Külüğ & Coşkun, 2012). On the other hand, it was documented that family members display stigmatizing attitudes towards the person with mental illness as well (Arkar & Eker, 1992).

In brief, mental illness stigma affects self-esteem, quality of life, social life, occupational life, and health negatively (Link et al., 1989; Link, Castille, & Stuber, 2008; Markowitz, Angell, & Greenberg, 2011; Perlick et al., 2007; Sirey et al., 2001). Yet, diminished self-esteem is not an inevitable result for individuals with mental illness. Some individuals expressed righteous anger and others seemed to ignore stigma altogether (Corrigan, & Kleinlein, 2005, p. 26). Thus, it is possible to cope with mental illness stigma. Individuals with mental illness develop ways to cope with mental illness stigma and it is quite important to understand their ways of coping.

Stigma and Coping

Stigma is a daily source of stress for the members of stigmatized groups. However, individuals who are exposed to stigma do not necessarily suffer from reduced well-being; instead, they develop adaptive responses as coping mechanisms. Coping is defined as “a person’s constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person’s resources” (Lazarus & Folkman, 1984, p. 141). Coping occurs when a situation is perceived as stressful (Miller & Major, 2003, p. 247). Stigma, if stressful, brings about coping responses. Individual, as well as situational factors, determine such coping strategies. Two types of coping have been researched extensively: problem-focused and emotion-focused coping responses. In problem-focused strategies, the target can be the self, the other, or the situation in which the interaction between the self and the other occurs. In problem-focused coping, seeking therapy to overcome mental illness is an example of targeting the self. Avoiding situations in which individuals may be stigmatized is an example of targeting the situation. Finally, education campaigns can be regarded as targeting others to overcome stigma.

Emotion-focused coping responses, on the other hand, are used to regulate emotions associated with stigma by minimizing negative affect and protecting self-esteem. There are three ways of emotion-focused coping: downward social comparison, attributions, and denial. Downward social comparison with others who are in worse situation provides a relief from disequilibrium and regulate negative emotions. Attributions can also help while coping with stigma. Attributing negative outcomes to external factors is less likely to elicit negative emotions (Weiner, 1985). Attributing negative outcomes to prejudice and discrimination rather than one’s lack of competence helps to protect one’s self-esteem. Denial of discrimination is another way of coping with stigma-associated emotions. Denying or minimizing the extent to which one is the target of prejudice or discrimination is sometimes an adaptive strategy because it perpetuates the sense of control over one’s outcomes. Selectively devaluing or reducing the significance of situations in which individuals are stigmatized is also a way of protecting self-esteem (Miller & Major, 2003, pp. 252-260).

Link and colleagues also studied coping responses to mental illness stigma (Link et al., 1989, 2002; Link, Mirotznik, & Cullen, 1991). They documented a number of coping orientations, such as secrecy, education, withdrawal, challenging, and distancing. Secrecy means hiding one's mental illness. Education refers to providing information to people to reciprocate stigmatizing stereotypes. Withdrawal refers to avoiding potentially stigmatizing situations. Challenging is direct and active confrontation with stigmatizing behaviors by pointing out that one disagrees with the content of stigmatizing attitudes. Distancing means cognitively separating self from the stigmatized group, and saying that I am not like them (Link et al., 2002). These coping responses have importance since they were reported to be used by individuals with mental illness when facing mental illness stigma.

Similar to the coping responses to mental illness stigma explained above, Thoits (2011) presented a concept called *stigma resistance*. She argued that some people with mental illness may resist stigma and protect their self-esteem. This happens through "deflecting, impeding, or refusing to yield to the penetration of a harmful force or influence and challenging, confronting, or fighting a harmful force or influence" (Thoits, 2011). In deflecting, a person responds to stereotypes by separating herself or himself from such stereotypes, saying that it is not me. In challenging, a person tries to change others' beliefs and behaviors through confronting and enlightening others, and/or engaging in advocacy and activism. Thoits suggested that standing up for oneself or one's group improves self-esteem regardless of the outcome (Thoits, 2011).

No coping orientation is likely to be effective across all stigmatizing situations. Rather, certain coping responses work best in certain situations (Miller & Major, 2003). For instance, educating others regarding mental illness stigma would work in a social environment where one is likely to be respected. In a highly stigmatizing and discriminating environment, however, secrecy would work better. The person's goals and the characteristics of the situation are critical in determining which strategy to use. Also, all coping strategies have a cost (Miller & Major, 2003). An individual who hides her or his mental illness may be avoiding possible shame feelings, but may unknowingly sacrifice the integrity of her or his identity. Another individual may be protecting her or his self-esteem by withdrawing from potentially stigmatizing situations, but may be missing opportunities of socializing, networking, and growth. Similarly, an individual may raise her or his voice to address a possible stigmatizing comment in a job interview, however, she or he may be discriminated against and lose the job. In addition, individual coping orientations are unlikely to be effective in dealing with the fundamental problem of societal stigma, which is deeply embedded in the culture (Link & Phelan, 2013 p. 537). Link and colleagues (1991) found no evidence that individual coping orientations buffered individuals with mental illness from undesirable consequences of stigma. According to them, the best solutions are changing societal conceptions regarding mental illness by taking collective action with individuals with mental illness (Link et al., 1991).

In summary, there are two main types of coping strategies: emotion-focused and problem-focused. Problem-focused strategies target the self, others, or the situation where the self and others interact. Emotion-focused strategies, on the other hand, are used to regulate negative emotions caused by stigma. Downward social comparison, attributions, and denial help to regulate stigma-associated emotions. Individuals with mental illness also use strategies, such as secrecy, withdrawal, education, challenging, and distancing, to cope with mental illness stigma. Coping is especially important when studying mental illness stigma in the field of clinical psychology. Clients have their own ways of coping and if necessary, the clients' ways of coping should be addressed in psychotherapy when stigma issues arise. Therefore, the present study explored individuals' coping experiences related to mental illness stigma along with their overall experiences related to mental illness stigma. Experiences of coping, stigma, and mental illness in general are highly subjective and culture-bound. Although researchers aim to explore patterns that apply to various populations, there are contexts in which generalizability of findings are problematic. Thus, the cultural context should also be taken into account when investigating mental illness stigma.

Mental Illness as a Social Construct

Although various symptoms of mental illness, such as hallucinations, delusions, and painful emotions may be the same across cultures, manifestations of these symptoms, understandings of them, and the meanings attached to them vary dramatically from culture to culture (Aneshensel, Phelan, & Bierman, 2013, p. 3). Stated differently, expressions, definitions, and meanings of symptoms and the mental illness they are related to can be culture specific. A state that is considered as a mental illness in a culture may not be regarded so in the other. For instance, states such as paranoia, seizures, and trances are considered as abnormal in Western societies while they are within the normal spectrum of behaviors in other cultures namely Indian Americans or natives in Siberia (Horwitz, 2013, p. 104). A state called *susto*, which is described as somatic suffering due to an emotional trauma, is conceptualized as a *soul loss* resulting from spiritual attacks rather than an illness among Latin Americans (Aneshensel, Phelan, & Bierman, 2013, p. 9). Thus, interpretations and meaning of symptoms vary in considerable degree across cultures.

Cultures also differ in attributing causes to mental illnesses. Western cultures, which have embraced the medical model of disorders long before other cultures, usually attribute mental illnesses to physiological causes. Medical model is not only a scientific model in the Western world but also a dominant folk model about disorders (Engel, 1992). On the other hand, some cultures may attribute mental disorders to spiritual, metapsychological, religious, interpersonal, or societal causes (Engel, 1992; Hopper, 1991).

Culture shapes the subjective experience of a disease as well as the meaning of it. The behavioral options available to individuals to express their distress may vary across cultural contexts. Thus, culture shapes expectations about illness behavior. Similarly, the interpretative options available to individuals related to the symptoms they experience are partly determined by the specific cultural context. Culture creates explanations about illnesses. Therefore, the subjective experience of an illness is culture-bound (Angel & Thoits, 1987; Kleinman, 2011; Roe, Mashiach-Eizenberg, & Lysaker, 2011). Coping is another culturally specific behavior in response to mental illnesses (Kleinman, 2011). Social support, specifically, plays a major role in coping with mental illness, and is affected by cultural characteristics (Thoits, 2011).

To sum up, there are considerable variances across cultures in perception and experience of, and coping with mental illness. Therefore, mental illness is both an independent reality and a social product. A full understanding of mental illness requires considering both the cultural chemistry and the brain chemistry (Karp &

Birk, 2013). All the variation in perception and interpretation of mental illnesses across cultures lead to variations in stigma associated with them (Carpenter-Song et al., 2010). Therefore, stigma is also a social construct and responses to individuals with mental illness depend on the cultural context as well. Societal conceptualization of mental illnesses, public values and beliefs, and other components of culture play an important role in the extent to which certain mental illnesses are associated with stigma. Not only do the states considered as mental illness vary across cultures, but also various aspects of mental illnesses stigma vary across cultures. Therefore, stigma experiences of individuals with mental illness change from culture to culture. To this end, the aim of the present study was to explore stigma experiences of individuals who were diagnosed with depression within Turkish cultural context. Since such experiences are subjective and idiosyncratic even within the same cultural context, they can only be understood in the words of those who experience them, namely, in first person accounts.

First Person Accounts and Making Stigma Meaningful

Mental health experts from various fields, such as psychologists, psychiatrists, nurses, and social workers, talk and write about experiences of those who suffer from mental illness. However, voices of those who experience mental illness are often heard vaguely or indirectly mostly in quantitative research. Mental illness is a perplexing situation. Hearing one’s diagnosis for the first time, disclosing it to the others, learning to cope with the illness are major experiences that challenge sufferers. Individuals with mental illness actively evaluate and make meaning out of their experiences regarding these challenges. Meaning making is at the heart of mental illness experience (Karp & Birk, 2013, p. 28). Narratives, in this sense, powerfully reflect the experience of individuals with mental illness while affirming the experience for them and informing others about the phenomenon (Angell, Cooke, & Kovac, 2005, p. 69). Recently, narratives by first persons have been recognized more as a valuable source of understanding the perspectives of individuals with mental illness. Understanding the perspectives of individuals with mental illness makes way for raising consciousness, developing appropriate forms of treatment, and transforming both those with mental illness and the public opinion. Karp and Birk (2013, p. 25) pointed out that studying feeling disorders without getting in touch with the feelings of sufferers is at least incomplete. Kleinman (1988, p. xiii) also underlined the importance of narratives by the first persons:

> Nothing so concentrates experience and clarifies the central conditions of living as serious illness…. Illness narratives edify us about how life problems are created controlled, made meaningful. They also tell us about the way cultural values and social relations shape how we perceive and monitor our bodies, label and categorize bodily symptoms [and] interpret complaints in the particular context of our life situation….

First person accounts are a valuable way of understanding illness experiences as well as stigma experiences. The Schizophrenia Bulletin published a series of articles titled First Person Accounts, in 1994. The aim of the series was to share the experiences of individuals with mental illness with their own words and to make their issues and difficulties more visible to the world. Kathleen M. Gallo, a forty-year-old librarian and writer who had been diagnosed with schizophrenia and hospitalized once, shared her experiences of self-stigma in the First Person Accounts series (Gallo, 1994, pp. 407-408):

> I perceived myself, quite accurately, unfortunately, as having a serious mental illness and therefore as having been relegated to what I called ‘the social garbage heap’. I tortured myself with the persistent and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist. Thus, I would do things such as standing away from others at bus stops and hiding and cringing in the far corners of subway cars. Thinking of myself as garbage, I would even leave the sidewalk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings.

Similarly, Esso Leete who lived with schizophrenia for more than 25 years wrote about her stigma experiences in her article published in Schizophrenia Bulletin in 1989:

> I can talk, but I may not be heard. I can make suggestions, but they may not be taken seriously. I can voice my thoughts, but they may be seen as delusions. I can recite experiences, but they may be interpreted as fantasies. To be a patient or even an ex-client is to be discounted. Our label is a reality that never leaves us; it gradually shapes an identity that is hard to shed. … too many times our efforts to cope go unnoticed or are seen as symptoms themselves.

Patricia E. Deegan, who is a psychologist and researcher, had been diagnosed with schizophrenia as a teenager. She shared how the diagnosis affected her teenage world (Deegan, 1997, p. 370):

> I was told that I had a disease that was like diabetes, and if I continued to take neuroleptic medications for the rest of my life and avoided stress, I might be able to cope. … it felt as if my whole teenage world – in which I aspired to dreams of being a valued person in valued roles … began to crumble and shatter. It felt as if these parts of my identity were being stripped from me. I was beginning to undergo that radically dehumanizing and devaluing transformation from being a person to being an illness.

These excerpts showed how painful stigma can be and how stigma and internalization of stigma can be dehumanizing and devaluing. Stigma was such a significant concern in these participants' lives that it led them to withdraw from interactions and opportunities and to lose self-esteem. It can be observed how stigma experiences shaped the overall experience of mental illness and challenged the self, self-esteem, and identity. In addition, it was evident from these excerpts that first person narratives are a valuable source of information when studying psychological phenomena, such as mental illness and mental illness stigma from a clinical perspective. Qualitative studies that focus on narratives help researchers understand what beneficiaries of mental health services experience personally, as well as inform them about the yet to be explored aspects of the phenomena. To this end, the present study adopted a qualitative methodology in order to explore the experiences of individuals with depressive disorders.

Depressive Disorders and Stigma

In the fifth edition of Diagnostic Statistical Manual (DSM-5), eight disorders are defined under the category of depressive disorders: disruptive mood dysregulation, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder, substance or medication induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (American Psychiatric Association, 2013, p. 155). Major depressive disorder, which includes major depressive episodes, is defined with the symptoms of depressed mood, loss of interest or pleasure, significant weight loss or gain, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness, excessive guilt, diminished ability to concentrate, indecisiveness, psychomotor agitation or retardation, and recurrent thoughts of death (American Psychiatric Association, 2013, pp. 160-161). The symptoms must persist at least two weeks and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning for the individual to be diagnosed with major depressive disorder. In persistent depressive disorder, depressed mood persists for at least two years. (American Psychiatric Association, 2013, p. 168). These two types of depressive disorders are of concern in the present study.

Depressive disorders are one of the most prevalent mental disorders all around the world. One-year prevalence for major depressive disorder in the United States is 7% while it is 0.5 for persistent depressive disorder (American Psychiatric Association, 2013, pp. 160-170). The lifetime prevalence of depression varies between 10-25% for females and 5-12% for males. Males are more likely to be under-diagnosed with depression (Sadock et al., 2007). The lifetime incidence of depression is 10 to 20% in Turkey (Bilican, 2013). World Health Organization predicted that depression would be the second most prevalent disorder by the 2020 (Chapman & Perry, 2008).

There are fundamental differences between chronic and time-limited depression (McCullough, 2000). Chronic depression is a complex process in which persistent feelings of emptiness and engulfment, and chronic life problems affect the individual (Rhodes, Hackney, & Smith, 2019). Low self-esteem, helplessness, and hopelessness accompany chronic depression (Moore & Garland, 2003). Daily life problems are persistent and extreme for individuals with chronic depression whereas time-limited depression is often precipitated by one or more dramatically adverse changes in the person’s life (Rhodes, Hackney, & Smith, 2019). Self-criticism is less extreme in individuals with time-limited depression than in those with chronic depression (Smith & Rhodes, 2015). Both of them require different treatments as well (McCullough, 2000). The central experience shared by both is disconnection from others (Rhodes, Hackney, & Smith, 2019).

Recently, researchers conducting qualitative studies on depression have pointed out that the DSM is missing some core features of the depression experience. For instance, Granek (2006) argued that relational issues are at the heart of the depression and suggested that depression is characterized by social isolation and an alteration in relationships with others. Karp and Birk (2013, p. 33) suggested that depression is an illness of isolation and disconnection. Granek (2006) also described the role of anger in relation to interpersonal problems in depression and added that anger should also be listed among the diagnostic criteria of depression in the DSM.

Rhodes and Smith (2010) drew attention to alteration of self in depression experience. They argued that all systems of self, including motivation, emotions, thought, action capacities, and the experience of being the same person over time change with depression. Ridge (2009), similarly emphasized how depression creates a fundamental change in the experience of self and how severe cases go through a process called self-annihilation. Self-annihilation is more than just being shaken-up of the self; it is the loss of self. Loss of self involves loss of former abilities, identities, and relationships (Ridge, 2009, p. 64). The effect of depression on self was touched much earlier as well. Freud (1917 as cited in Rhodes & Smith, 2010) famously suggested that depression is a sort of "wounding, reduction and mortification of one's normal self." Normal life functions are jeopardized and may even stop in severe cases. From this perspective, depression can be seen as a kind of death, a form of dying of the normal self rather than just an emotion (Jago, 2002, p. 742; Rhodes & Smith, 2010). Loss of self is a theme that is frequently reported in the qualitative literature on depression (Ridge, 2009, p. 64). The alteration of self in the experience of depression is not mentioned in conventional diagnostic lists, such as the DSM, except for the symptom of feelings of worthlessness.

In qualitative studies, moderate to severe depression was described as an existential misery rather than just having a low mood (Ridge, 2009, p. 13). Depression raises the fundamental question "Who actually am I?" Van Manen (1990) described four existential dimensions of life: sociality, corporeality, temporality, and spatiality. These dimensions represented one's relations with others, embodied presence, background, and unfolding life ahead, which are taken for granted for everyone. Smith and Rhodes (2015) showed that these domains become depleted in depression experience. For example, the feeling of being in relation was depleted during depression. Rather, the participants described disconnection and isolation. Also, they questioned the extent to which they have a life behind them and a future ahead of them. They even questioned their taken for granted spatial place in the world. The depletion in spatial dimension was observed in such expressions of the participants as: "Reversing out of my drive, knowing that I wasn't coming back to the house" (Joseph) "Perhaps half my heart has gone away" (Sally). Depression was a powerful phenomenon that made the very existential features of life questionable

(Smith & Rhodes, 2015). In severe cases, the person questioned her or his aim in life and reason of existence on Earth. This process may end with suicide, which is the most significant aspect of depression. The existential features of depression, however, except for suicidal inclination, are not noted in the DSM.

The causal role of life events in depression, which was also not mentioned in the DSM, was documented by several studies. Mazure (1998) suggested that 80% of depressive episodes were preceded by major life events. Kessler (1997) reported precipitating events, such as disasters and widowhood. Paykel (2003) pointed out that depression is often triggered by *exit* events, such as separations and bereavements. Women were vulnerable to depression after loss, humiliation, and entrapment (Brown, Harris, & Hepworth, 1995). Ziebland (2006) also reported that people experience difficult life events and losses before the onset of depression.

Depression is also associated with stigma even though it is less so than other mental illnesses such as psychotic disorders (Ozmen et al., 2004; Utz et al., 2019). Since depression is a highly prevalent disorder, public familiarity with depression might be higher compared to less prevalent disorders (Bostancı, 2005; Bilican, 2013). Therefore, more people are likely to have family members, friends, or colleagues experiencing depression. This may lead to establishment of more sympathetic relations with individuals with depression, less social distance, and less stigma as a result (Bag et al., 2006). Contrary to the expectations, however, in a cross-national study conducted by ASPEN/INDIGO Study Group in 35 countries worldwide, the participants reported disadvantages of having major depressive disorder in family (40%), in marriage (23%), in dating or intimate relationships (21%), in public (34%), among friends (33%), in the workplace about keeping the position (34%), and in personal safety and security (21%) (Lasalvia et al., 2013). A similar cross-national study was conducted on workplace discrimination by the same study group in 35 countries. The findings indicated that 62% of the participants anticipated or experienced discrimination in the workplace, and 60% of the respondents reported avoiding work, education, or training environments, because they anticipated to be discriminated against (Brouwers et al., 2016). Although depression was found to be less stigmatized than other mental disorders, it can even be more stigmatized if the symptoms are perceived as willful (Hinshaw & Stire, 2008). In a study, the participants blamed the person with depression if her or his depression could not be explained by a sufficiently severe source of distress (Barney, Griffiths, Christensen, & Jorm, 2009). Researchers in Turkey obtained similar results regarding the stigmatization of individuals with depressive disorders. In a study conducted in a rural area in Turkey, 75% of the respondents reported that they would not marry with someone with depression; 50% reported that they would not like it if they had a neighbor with depression; 57% stated that they would not rent their house to someone with depression; and 50.5% indicated that individuals with depression would be dangerous (Taşkın et al., 2006).

Fundamental characteristics of depression experience, such as the alteration in the experience of self, alteration in identity, change in self-esteem, stigma experiences, and the inherent human activity of making meaning of depression experience were exemplified in the excerpts below. Martha Manning (1994), a woman who suffered from severe depression, reflected on her experience about shame regarding depression, losing pre-illness sense of self, struggling to find post-illness sense of self, and being in between two selves in her memoir:

> One year ago today I … was released from the hospital. I have struggled greatly over this year with the shame of the depression, the hospital, the ECT. I've seen them as concrete signs of giving up, falling apart, getting an 'F' in life. Being hospitalized on a psychiatric unit was… like crossing over into a different state. I've lost citizenship in the old place, but I haven't totally settled into the new one either ….
> My criterion for healing has been to be able to pick up right where I left off, like mid-page in a novel…. I'm still not back to that page. Kay and Lew [daughter and husband] try to tell me, in their own gentle ways, to stop waiting. I think they're trying to tell me that I'm never going to get back to that page. That I'm in an entirely new book now, most of it unwritten. (Manning, 1994, p. 185–186).

Similarly, William Styron (1990, pp. 64-65) who suffered from chronic depression wrote about the duality of self in his memoir:

> A phenomenon that a number of people have noted while in deep depression is the sense of being accompanied by a second self –a wraithlike observer who, not sharing the dementia of his double, is able to watch with dispassionate curiosity as his companion struggles against the oncoming disaster, or decides to embrace it.

One of the participants of a qualitative study conducted on illness and identities illustrated how depression initiated new and unfamiliar identities (Karp and Birk, 2013, p. 34):

> You know, I was a mental patient. That was my identity…. Depression is very private. Then all of a sudden it becomes public and I was a mental patient…. It's no longer just my own pain. I am a

> mental patient. I am a depressive. *I am a depressive* (said slowly and with intensity). This is my identity. I can't separate myself from that. When people know me they'll have to know about my psychiatric history, because that's who I am.

Although depression experiences were examined extensively in qualitative studies from various perspectives such as symptoms, self, and identity, studies examining stigma experiences of individuals with depression are scarce in the relevant literature. In a qualitative study, how individuals with depression communicated with their families and friends from stigma perspective was investigated (Y-Garcia et al., 2012). The results revealed that the participants were feeling labeled, judged, lectured, and rejected by their families and friends when discussing depression. One of the participants explained feeling of being labeled by saying that "As far as discussing (depression) with family members… I wouldn't feel comfortable doing that… they might put a label on me, you know, I'm crazy or something like that." The participants reported feeling judged when they were told they had so much to be glad for. One participant talked about this issue by saying "Other people are, like, 'You should be so happy. You have two kids. You have a nice husband. You have this, you have that.' (My mother) is like 'Why are you so miserable all the time?' I'm like, I just am." Also, the participants felt being lectured when they were told that depression was all in their head. One of the participants said that:

> One thing that I really didn't want to be told, and I was told multiple times, uh, was that it's all in my head. Uh, it's all in my head, and, uh, you know, it's all in my head and get over it. … it's like belittling, you know? It, it made me feel like I'm the one that's trying to draw attention to myself, you know, or I'm blowing it out of proportion.

One of the participants expressed feelings of being rejected by family members as follows:

> They're tired. They've been tired. They've been living with it. They're tired. They're fed up. They don't have the strength anymore… when we go to them one more time and say, "blah, blah, blah, bah, blah." You know, they don't want to hear it. They, they don't want to hear it.

The results of another qualitative study revealed that individuals with depression received stigmatizing responses from their families and friends when they sought help for their depression (Griffiths, Crisp, Barney, & Reid, 2011). For instance, some family members did not accept the validity of the person's depression. A participant stated that “Some denied it or questioned the validity of my experience and explanations for it. It was very disappointing and upsetting to ask for help and not receive it.” Others reported that they were scorned, ridiculed, and criticized. Another participant stated that “Everyone wants to know what’s going on and then when you tell them they treat you as if you are a whiner.” Some participants indicated that they were concerned about what others would think and they feared others would judge them, pity them, and reject them. Participants also mentioned their concern of being a burden, and their feeling of shame when disclosing about their depression (Griffiths et al., 2011).

The available findings in the literature on stigma experiences of individuals with depression are consistent with each other. Individuals with depressive disorders encounter stigmatization, including criticisms, humiliation, rejection, and labeling, anticipate being stigmatized, and internalize stigma; they feel shame about their disorder. Depressive disorders were chosen as the focus of the present study because they are the most prevalent type among mental illnesses (American Psychiatric Association, 2013, pp. 160-170). Stigma negatively affects the prognosis and outcome of depression. Also, individuals with depressive disorders frequently become the target of stigma and have to cope with it. Thus, the current study aimed to capture stigma experiences of those who were diagnosed with depressive disorders in Turkish context. Achieving an understanding of such experiences can help clinicians working with sufferers of depressive disorders. The clinical implications of the present study, thus, also have practical importance.

Aim of the Study

In summary, stigma is a significant concern and source of distress in the lives of individuals with mental illness. It is essential to understand this construct within different cultural contexts to produce culturally valid scientific information and to find effective solutions to the problems of individuals with mental illness. Focusing on what individuals with depression experience within a specific cultural context based on their own perspectives is necessary to develop social and clinical interventions accordingly. In Turkey, available studies focusing on mental illness stigma are mostly quantitative ones (Çam & Bilge, 2007, 2013; Sarıkoç & Öz, 2016). Qualitative studies that attempt to discover the construct from individuals’ own words are lacking. Moreover, the relevant research focused mostly on exploring the stigma experiences of individuals with psychotic disorders (Karanci et al., 2019). There is no known qualitative study that explored stigma experiences of individuals with depressive disorders in Turkey. To this end, the aim of the present study was to understand stigma experiences of individuals with depressive disorders in Turkey and their ways of coping.

Accordingly, the research questions of the present study were

1) How do the individuals diagnosed with depressive disorders experience stigma in Turkey?
2) How do individuals diagnosed with depressive disorders cope with stigma in Turkey?

CHAPTER 2

METHODOLOGY

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis methodology has guided this research study throughout the way. IPA represents an epistemological position based on phenomenological philosophy (Smith & Osborn, 2015 pp. 25-26). Phenomenology goes back to Husserl's declaration of "back to things themselves" (Husserl, 1900 as cited in Smith & Osborn, 2015, pp. 25-26). It is an attempt "to see things as they present themselves in their own terms" (Smith & Osborn, 2015, pp. 25-26). Therefore, IPA aims to explore individuals' personal lived experiences and their making meaning of those experiences in detail (Smith & Osborn, 2015, pp. 25-26). IPA is also connected to hermeneutics and theories of interpretation. The researcher tries to get an insider's perspective, but actually cannot achieve this purely and completely. The researcher's own conceptions accompany the research process and these conceptions are indeed required in order to interpret other's meaning making activity. Therefore, the researcher indeed interprets the participant's meaning making of experience. This comes from Heidegger's hermeneutic phenomenology (Heidegger, 1927 as cited in Smith & Osborn, 2015, pp. 25-26). A double-hermeneutic process is involved in which participants are trying to make sense of their world while the researcher is trying to make sense of participants' meaning making (Smith, 2004; Smith & Osborn, 2015, pp. 25-26).

Three features characterize IPA. IPA is *idiographic*, *inductive* and *interrogative* in nature (Smith, 2004). IPA is idiographic in examination of data. One case is examined in detail until some degree of closure is achieved. In-depth analysis is repeated for each case. The researcher, then, looks for convergence and divergence in the data. Detailed analysis can only be conducted with small samples. Therefore, most IPA studies consist of small samples (Smith, 2004; Smith & Osborn, 2015, p. 27).

IPA's inductive feature refers to absence of pre-determined expectations about the data. IPA does not begin with hypothesis and therefore does not attempt to verify or negate them. It rather constructs broad research questions and collects expansive data. This allows themes to emerge from the data. IPA is open to what comes from the data (Smith, 2004).

Interrogative feature of IPA refers to IPA's aim of contributing to psychology field through interrogating and illuminating existing research. The results of IPA studies are discussed in relation to the psychology literature and they eventually contribute to the understanding the phenomenon under investigation (Smith, 2004).

Interpretative phenomenological analysis was chosen as the qualitative methodology of the present study, because it enables in-depth investigation of personally lived experiences and facilitates self-disclosure. Suffering from depression, facing stigma, coping with depression and stigma, and making meaning out of these experiences are very significant personal experiences that need to be better understood from an idiosyncratic point of view. The idiosyncratic lens of IPA is attuned with the aim of the present study, which was to understand stigma experiences of individuals with depressive disorders and their making meaning of such experiences. This commitment to understand individuals at the idiosyncratic level is crucial when working with clients in psychotherapy. Also, IPA emphasizes the person-in-context perspective (Larkin, Watts, & Clifton, 2006). IPA was also chosen to understand stigma experiences of those who are depressed in the Turkish context, because stigma experiences are dependent on the context. Moreover, IPA is in line with the epistemological standing of the researcher. The researcher adopted a *constructionist* position, which refers to the rejection of a single reality that can be obtained through correct methodology. Rather, it suggests existence of multiple and socially constructed realities (Madill, Jordan, & Shirley, 2000).

Trustworthiness of the Study

Qualitative research embraces standards of quality known as *validity* or *trustworthiness*, which allow researchers to have credible findings. The four standards in qualitative research area are subjectivity, reflexivity, adequacy of data, and adequacy of interpretation (Morrow, 2005). Those standards were followed in the present study.

It was assumed in the qualitative research tradition that data gathered via interviews and the process of analyzing them are subjective in their very nature (Morrow, 2005). Instead of trying to limit or control subjectivity, qualitative methodology embraces and uses it as a tool. Interpretative and constructivist paradigms acknowledge the position of the researcher as a co-constructor of meaning and as an integral part of the interpretation of data. Therefore, the work is grounded on subjectivity in qualitative research (Morrow, 2005). The subjectivity of the researcher was also recognized in the present research study. It was acknowledged that the researcher's perspective has inevitably affected the whole research process. Making that perspective overt to self and others was the second standard, which is reflexivity.

The second standard of quality in qualitative research is reflexivity. It refers to attending to the way the researcher has participated in constructing research findings (Fischer, 2009). This can be achieved via bracketing. Bracketing means identification of interests, sociocultural background, personal experiences, and assumptions that could influence how a researcher views the data (Fischer, 2009). These possible influences are made overt to the self and others. Via bracketing, the researcher acknowledges her or his engagement in the development of the understanding of research phenomenon and process (Fischer, 2009). The purpose of bracketing is to enable readers to take the perspective of the researcher so that it opens them to new understandings. Readers may also find alternative understandings by taking different perspectives (Fischer, 2009). For the sake of reflexivity, the researcher's background, interests, and experiences were delineated in the reflexivity part of the present research. Among a number of strategies suggested (Finlay, 2002), two strategies were used in the present study. First, several direct quotations from the participants were provided in the results section in order to support emerging themes.

Second, the thesis supervisor was consulted several times for her feedback about the emerging themes.

The third standard which is adequacy of data refers to adequacy in both amounts of and variety in kinds of evidence (Morrow, 2005). For the current study, the researcher recruited an adequate number of participants, conducted interviews with them in adequate length of time in order to collect adequate amount and variety of data. The final standard which is adequacy of interpretation refers basically to getting immersed in the data (Morrow, 2005). For adequacy of interpretation, the researcher personally conducted interviews, transcribed them, read and re-read them several times, took notes, and reviewed them in order to reach a deep understanding of the data.

Reflexivity

The subjective influence of the researcher on the entire research process, including the construction of the results was acknowledged and welcomed in the present study. For the sake of reflexivity, the perspective, interests, and background of the researcher were delineated.

I have always been prone to take the side of the oppressed. This tendency must have been rooted in my personal story, and my education at Middle East Technical University Psychology department has reinforced this tendency. The idea of studying stigma and giving voice to the stigmatized might have come from such sources. Similar to stigma, the idea of working with individuals with depressive disorders was not coincidental. I remember feeling on the edge of depression several times, going back and forth between depressed and non-depressed states. Yet, depression remained as a self-diagnosed condition for me most of the time. I suppose, I wanted to advocate for those with depressive disorders facing stigma by giving voice to them in my research study. Therefore, I approached this research study as an activity of advocacy of individuals with depressive disorders facing stigma, in academia.

I had some presuppositions when I was designing this research study, and they lasted throughout the process. For example, I assumed that being diagnosed with depressive disorder is something negative, individuals diagnosed with depressive disorders necessarily face stigma, and they are necessarily affected negatively by stigma in Turkish context. I did not expect that the public may have positive attitudes towards individuals with depressive disorders, or that individuals with depressive disorders may not be significantly affected by stigma. I expected stigma to emerge significantly in the interviews. This strong presupposition may come from my contact with the relevant literature. It is also possible that, the literature that supported my assumptions called my attention. As a result, I may have looked for discrimination in my sample, so that I can advocate for individuals with mental illness.

Therefore, during the interviews, I may have asked questions to *find* (already existing –according to me) stigma experiences, I may have probed extensively if they disclosed a stigma experience, and I may have overlooked possible neutral or positive aspects of their experiences. Also, I may have expected the participants to be interested in stigma as well, because stigma was my area of interest and I viewed it as a problem that needed to be solved. Nonetheless, stigma may not have been the most salient concern or problem in the lives of the participants. Alternatively, they may not have been psychologically ready to admit that they faced stigma and discrimination. Expecting the participants to acknowledge discrimination and stigma might have affected the interviews as well as the results.

In summary, my personal story and educational background have motivated me to take the side of the oppressed, have affected my choice of research topic, sample, and design in this research study. I wanted to advocate for those with depressive disorders who encounter stigma in Turkey by giving voice to them. This motivation, which energized me throughout the process, might have also affected the construction of meaning in this study.

Participants

Idiographic emphasis and inductive purpose of IPA require relatively small sample sizes in research studies (Smith & Osborn, 2015). Sample size should be small to enable an in-depth examination of each case; and should be large enough to distinguish similarities and differences among cases. Fourteen participants were recruited for the present study. Participants were selected using purposive sampling technique, which means including individuals with certain characteristics relevant to the objective of the study (Howitt, 2010). A homogenous sample was formed based on inclusion criteria, consistent with IPA principles. The commitment to homogenous samples in IPA is based on the understanding that the research question will be more significant in well-defined groups (Smith & Osborn, 2015). Stated differently, through purposefully forming a well-defined and homogenous sample, the researcher employing IPA, acquires a sample which she or he can probe her or his research question. Therefore, the sample in the present study consisted of individuals who have major depressive disorder diagnosis with at least two years of history and at least one hospitalization; and individuals who have persistent depressive disorder with at least one hospitalization history. The sample consisted of adult participants. Namely, a diagnosis of depressive disorder, a history of hospitalization, and being an adult were determined as inclusion criteria in the present study. Those with hospitalization history were selected because it was assumed that stigma would be more salient among individuals with psychiatric hospitalization history. Exclusion criteria were having no history of hospitalization, and having another primary condition and having depressive disorder as the secondary condition. Some participants with comorbid disorders were included, however, as long as a depressive disorder was the primary diagnosis. Two of the participants had comorbid obsessive-compulsive disorder and anxiety disorder, one had comorbid social phobia and anxiety disorder, and one had comorbid anxiety disorder.

The participants in this study consisted of a retired worker, a retired government official, an emergency medical technician, a student, a religious official, two accountants, two teachers and five housewives. Nine of them were females and 5 of them were males. Their ages ranged between 33 and 68 with a mean of 46,21. The majority of the participants (12) reported being married and living with family members. One participant was widowed and living with children, and one participant was single, living with parents. In addition, the majority of the participants (11) stated they lived in city and the majority of the participants (10) answered the question “Which socioeconomic status do you think you belong to?” as middle socioeconomic status (see Table 1)

All of the participants had at least one hospitalization history since they were first diagnosed with a depressive disorder. Some participants had a more persistent disorder; they had several hospitalizations, longer duration of stay at the hospital, and longer use of medication; whereas others were affected with the disorder for a shorter period in their lives. Nevertheless, the majority of the participants were receiving pharmacological treatment at the time of interviews. The average depression level of the participants was 20,85 measured by the Beck Depression Inventory-I at the time of interviews (see Table 2).

Table 1

Demographic Information of the Participants

	Gender	Age	Education	Occupation	With Whom They Live	Place of Residence	Perceived Socioeconomic Status
Participant 1	M	59	High School	Retired Government Official	Spouse	Country Side	Middle
Participant 2	M	68	High School	Retired Worker	Children	City	Middle
Participant 3	F	43	Elementary School	Housewife	Family	City	Middle
Participant 4	F	33	High School	Emergency Medical Technician	Family	City	Low
Participant 5	F	58	Illiterate	Housewife	Family	City	High
Participant 6	F	36	High School	Student	Parents	City	High
Participant 7	M	42	High School	Accountant	Family	City	Middle
Participant 8	F	43	Elementary School	Housewife	Spouse	City	Middle
Participant 9	F	51	University	Teacher	Family	City	Middle
Participant 10	M	50	University	Teacher	Single	City	Low
Participant 11	F	50	Elementary School	Housewife	Family	Country Side	Middle
Participant 12	M	36	University	Religious Official	Family	District	Middle
Participant 13	F	41	Vocational School	Nurse	Family	City	Middle
Participant 14	F	37	High School	Accountant	Family	City	Middle

Table 2

Physical and Psychological Health Status of the Participants

	Psychological Diagnosis	Time of the Diagnosis	Number of Hospitalizations	Medications	BDI-I Score	Physical Disorders
Participant 1	Major Depressive Disorder	15 years ago	1	Citoles	12	-
Participant 2	Depressive Disorder	48 years ago	2	-	5	-
Participant 3	Depressive Disorder	3 years ago	1	Sulinex	37	High Blood Pressure, Cervical Disc Hernia, Spinal Disc Hernia
Participant 4	Depressive Disorder, Anxiety Disorder, Social Phobia	11 years ago	2	Xanax, Efexor, Dideral	48	Difficulty in Hearing
Participant 5	Depressive Disorder	4 years ago	3	Cipralex	4	Parasthaesia
Participant 6	Depressive Disorder	3 years ago	1	Prozac	10	-
Participant 7	Depressive Disorder	4 years ago	1	-	4	-
Participant 8	Depressive Disorder	10 years ago	More than 5	Lustral	35	-
Participant 9	Depressive Disorder	5 years ago	2	Paxera, Dideral, Desyrel	18	-
Participant 10	Depressive Disorder	17 years ago	3	Seroquel, Buspon, Misol	23	Cervical Disc Hernia, Spinal Disc Hernia, Arrhythmia
Participant 11	Depressive Disorder, Anxiety Disorder	12 years ago	2	Desyrel, Paxera	3	Visual Disturbances

Table 2 Cont'd

Participant 12	Major Depressive Disorder	10 years ago	2	Abizol, Duloxx	31	-
Participant 13	Depressive Disorder, Anxiety Disorder, Obsessive-Compulsive Disorder	13 years ago	2	Akineton, Lustral, Prozac, Efexor	13	Migraine
Participant 14	Depressive Disorder, Anxiety Disorder, Obsessive-Compulsive Disorder	10 years ago	4	Efexor, Lustral, Prozac, Zedprex, Wellbutrin	49	-

Materials

The materials of this study were a demographic form, Beck Depression Inventory-I and interview questions. Demographic form was prepared by the researcher and edited by her supervisor. The form included questions about participants' gender, age, occupation status, marital status, education, socio-economic status, place (district or city) of residence, with whom they live, if they have physical disorders or psychological disorders, if they have been hospitalized before, and medications used (see Appendix A).

Beck Depression Inventory-I was used in order to assess current depression levels of the participants (see Appendix B). Beck Depression Inventory-I is a self-report inventory consisting of 21 items, and measures the presence as well as the severity of depression (Beck, Steer, & Garbin, 1988). The items of the scale are based on the symptoms of depression reported in the DSM. The items measure symptoms of depression such as depressed mood, feelings of guilt, worthlessness, failure and punishment, self-dislike and criticalness, social withdrawal, suicidal thoughts or wishes, crying, loss of interest and energy, tiredness, and changes in sleep and appetite. The total score that can be obtained from the inventory ranges between 0 and 63. Cut off scores differ according to sample. Harrell (1983) suggested a cut off score of 9 for differentiating the non-depressed and a cut off score of 17 to differentiate clinical depression in psychiatric patients. In out-patients, Nielsen (1980) suggested a cut off score of 10 to catch depressive symptoms and a cut off score of 17 and above to indicate moderate to severe depression. The inventory was adapted to Turkish by Hisli (1988). The Turkish version of the inventory was found to have acceptable reliability and validity scores. Cronbach's alpha coefficient was .74 and split-half reliability was .80 in the Turkish version of the inventory. Its concurrent validity was established with the correlation between BDI and the Turkish version of the Minnesota Multiphasic Personality Inventory – Depression scale. The correlation between the two instruments was .63 in student sample and .50 in psychiatric sample. Hisli suggested a cut off score of 17 to indicate clinical depression (Hisli, 1988). In the present study, Beck Depression Inventory-I was used to screen the current depression levels of the participants so that they can be referred to appropriate psychological or psychiatric treatment units if needed.

The interview questions were prepared by the researcher based on IPA methodology and reviewed by the thesis supervisor. There were five categories of questions including diagnosis, meaning of the diagnosis for the participant, effects of the diagnosis on self-concept, stigma associated with depressive disorders, and internalized stigma of depressive disorders (see Appendix C). The questions were in open-ended format and included probes in accordance with IPA guidelines.

Interviews

Semi-structured interviews, with a mean duration of 46 minutes were conducted with the participants. Semi-structured interviews are preferred in IPA studies due to several reasons. Semi-structured interviews facilitate establishing rapport with the participant, which is important in an in-depth examination of personal experience, and allow the researcher to probe unforeseen areas that may be relevant to research question (Smith & Osborn, 2015, p. 31). Accordingly, when the participants' responses implied an area that was not included in the original interview questions but was relevant to the research question, the researcher stopped her questions for a while and probed the new area. Interviews were conducted with the participants individually, in isolated settings. The researcher observed that some of the participants were anxious and hesitant to disclose themselves in the beginning of the interviews. They gave socially desirable responses. However, as the interview proceeded and the rapport between the researcher and the participant was formed, the participants disclosed themselves more openly.

Procedure

After obtaining ethical approval for the study from Middle East Technical University Human Subjects Ethical Committee, the participants were recruited in two ways. Initially, potential participants were contacted via acquaintances and they were asked whether they would volunteer to participate in the study. These interviews were conducted at either the participants' homes or at the researcher's home. Then, the researcher obtained necessary permissions and collaborated with the mental health unit of the local hospital in Bolu. Former patients who were hospitalized and received treatment with depressive disorder diagnosis were contacted. Those who volunteered to participate in the study were invited to the hospital. They were interviewed by the researcher in a private room. Initially, 23 participants were recruited for the study. They were reviewed by the researcher and her supervisor. 9 of the participants were excluded based on the exclusion criteria, and 14 of them were included in the study.

Before beginning the interviews, all participants were informed about the aims of the study, that the interviews would be audio recorded, that their responses would be reported anonymously and their identities would be kept confidential. They signed an informed consent form (see Appendix D). They were also given a debriefing form following their participation in the study (see Appendix E).

Analysis

IPA offers a set of guidelines for conducting research and analyzing data. The data of the present study was analyzed in line with the IPA guidelines. Initially, the 14 interviews were transcribed verbatim by the researcher. Then, the researcher read and re-read the transcripts several times in order to familiarize herself with the data. Afterwards, the researcher split the first transcript into meaning units. A meaning unit is the smallest piece of meaning that can consist of phrases or sentences (Sugawara & Mori, 2018). At this point, themes began to for the first transcript. Meaning units that were related to similar experiences were grouped together as subordinate themes. Subordinate themes were clustered together and superordinate themes were formed. Finally, each meaning unit was assigned to a subordinate and a superordinate theme. Initial themes were obtained through this way for the first transcript. Then, the thesis supervisor was consulted for her feedback about the themes for the first transcript. Based on her feedback, the themes were simplified, reduced in number, and some of the theme names were replaced with more representative names. The same process of theme abstraction was repeated for each transcript. The meaning units were assigned either to the themes from previous transcripts or to new themes. New themes continued to emerge until the last transcript. After the last transcript, the whole data was reviewed again for the integrity of themes. The entire data was revised several times before the themes were finalized. Five superordinate themes and 18 subordinate themes emerged at the end of the analysis process.

CHAPTER 3

RESULTS

At the end of the analysis of fourteen interviews, five superordinate themes and eighteen subordinate themes emerged. An overview of the themes was presented in Table 3. Each superordinate theme and subordinate theme was explained in detail with quotations from the participants in this part.

Table 3

List of Superordinate and Subordinate Themes with Quotations

Superordinate Themes	**Subordinate Themes**	**Quotations**
The Experience of Disorder	Affective Experiences of Disorder	You realize you're sick. You feel psychologically devastated and you feel empty. (Participant 2)
	Cognitive Experiences of Disorder	Thoughts, negative thoughts in my head all the time. It's as if something bad will happen. They're all negative, like fear of death. (Participant 13)
	Somatic Experiences of Disorder	There was pain in my chest. I couldn't sleep. (Participant 11)
	Effects of Disorder on Other Domains	I had to quit work due to my psychological disorder. (Participant 3)

Table 3 Cont'd

Others' Reactions	Intentional Attacks	Everybody excludes you instead of protecting you. (Participant 11)
	Unintentional Insult	The other day, my mother in law said to me 'when will you get better.' Maybe she didn't say it with ill will, but it made me feel bad. (Participant 14)
	Minimization and Disbelief	(They say) 'there's nothing to be distressed about" Do I want to suffer? Do I have to suffer? Do I crave suffering? No! But… (they don't understand) (Participant 14)
Effects of Disorder Experiences and Others' Reactions on Self	Challenge to Self-Esteem	I felt half human. (Participant 1)
	Secrecy	I haven't shared, except with you. (Participant 11)
	Disconnection	I was social, I was at peace with my social environment. When I experienced such things (stigma) from my loved ones, I withdrew from all people. (Participant 10)
	Anticipation of Stigma	The society wasn't aware and affirming. I was thinking, what if they find out about my visits to the doctor. (Participant 9)
	Resentment	I got reactions at first. I was vexed, extremely vexed. (Participant 12)
Meaning Making	Perceived Causes	I got married before and then got divorced. I was exposed to violence by my ex-husband. I lived through very hard times for three years. … I suppose

Table 3 Cont’d

		these were the foundations of my depression, because I did not have any problems before then. (Participant 9)
	Normalizing	It’s one of the diseases after all. It can happen to anyone. (Participant 10)
Coping	Social Support	My family had a very big role (in my recovery). They took me out walking. … My sister took me out shopping. … They helped me a lot in getting well. I was not alone. If they were not there for me, perhaps I would have gotten over it in a very long time. (Participant 9)
	Seeking Treatment	I am still using medication. I am monitored constantly. My doctor prescribes my medication when they run short. (Participant 8)
	Stigma Resistance	It doesn’t affect me; I say ‘yes I am crazy. I am pleased to be hospitalized.’ (Participant 3)
	Cognitive Reframing	We are not crazy. We are here just to receive our treatment. This is our process. We aren’t crazy, we have a disorder and we are receiving the treatment for our disorder. (Participant 8)

The Experience of Disorder

The first superordinate theme was *the experience of disorder.* This theme included the participants’ descriptions of the experience of depression: What it is like to be in a depressive episode or in depression in general and what they observe in themselves in regards to different levels such as emotional, cognitive, and physiological levels, in relation to depression. Stated differently, this theme encapsulated how the participants experience depression personally. Experiences of depression clustered into three categories, which are affective experiences, cognitive experiences, and somatic experiences. The effects of depression that were not affective, cognitive, or somatic were categorized under effects of the disorder on other domains. Therefore, this superordinate theme had four subordinate themes, which were *affective experiences of disorder, cognitive experiences of disorder, somatic experiences of disorder,* and *effects of the disorder on other domains*.

Affective Experiences of Disorder

This subordinate theme represented the participants' affective experiences of depression such as loss of interest and pleasure, anhedonia, anger at self as well as others, irritability, tearfulness, feelings of emptiness and meaninglessness, alienation and numbness. Emotions of unhappiness, frustration, shame and guilt about the disorder and guilt about suicidal thoughts, anxiety regarding the disorder were also frequently expressed by the participants. The intensity of the emotions were noteworthy in the participants' expressions.

The turmoil of emotions and anger can be exemplified in the words of Participant 10: "It was very severe in the first one. Whenever I was walking on the road, I was suddenly having episodes of crying for no reason. I was anxious that somebody would say hi to me. Actually, I would fight if one said hi to me." Similarly, Participant 13 expressed intense emotions in the experience of depression:

> I was feeling kind of weird. It's like there is something deadly inside of you. I was feeling terribly bad. I remember myself in those times, nothing can be compared with this state. Whenever I think of death now, I remember it. Intense crying episodes, it was very bad. Helplessness, a feeling like you will never be able to get out of it. This feeling drags you to suicide.

Anhedonia and anger were expressed by Participant 14:

> I don't want to do anything, I don't get any pleasure in life. Sometimes I go out and people seem like inanimate models to me and I ask myself 'why does the world exist?' I wish an earthquake would hit and everybody would die and life would end altogether. Imagine how much I don't want life.

Anger had an important place in the descriptions of the participants. They delineated an intense anger and aggressiveness towards others around, anger at self, and irritability about even small things. They expressed that they were shouting at their family members including their spouses and children or at other people around including their doctors and they were swearing frequently. Their anger outbursts were hurting their loved ones. Participant 7 stated that he decided to receive treatment upon realizing that he was offending people around him. Participant 11 stated that she was irritated even by her son's growing nails. Participant 6 was irritated by light and noise. Participant 10 expressed that he was extremely aggressive towards people around him during his depressive episodes. He delineated this affective state: "At those times (depressive episodes), I felt like swearing if someone said 'good morning!' … I was always waiting for someone to say something to me so that I would make her or him regret the day she or he was born."

The participants who had more persistent depression experienced exhaustion and helplessness about intense and persevering emotional suffering due to depression. For instance, Participant 14 who had a depression history of ten years described her exhaustion:

> I don't have the power to fight anymore. I fought so much to motivate myself. Let's say I don't want to get up out of the bed in the morning and I am feeling distressed; I used to make coffee, I used to listen to music to boost my morale. I can't do it anymore. I am tired. I don't want it anymore.

On the other hand, the participants who had a single episode of depression described a past experience that was painful but eventually ameliorated. For example, Participant 6 talked about few years of depression:

> I was having depressive symptoms for one and half years before my hospitalization. I was feeling hopeless, I didn't want to do anything. I was feeling very exhausted. I normally used to meet with my friends and chat with them, but, I didn't even want to watch TV, I didn't even want to look at my phone. … I was very bad at that time. … It happened once in my life.

In brief, affective experiences of disorder included intense emotional experiences such as loss of interest and pleasure, feeling empty, numbness, unhappiness, anger, and tearfulness. Participants especially emphasized feelings of anger. It was also observed that the participants with a more persistent disorder felt exhaustion and helplessness about intense emotions they were experiencing for a long time.

Cognitive Experiences of Disorder

Cognitive experiences of disorder theme included suicidal thoughts and a tendency to commit suicide, self-criticism, self-blaming, rumination, cognitive biases such as pessimism, and interpretations of self, others, and future only in negative ways. Sometimes, negative interpretations of self, others and future were so strong that the participant felt trapped and could not find a way out. Negative self-concept was observed in the majority of the participants. Specifically, believing one is incompetent was observed very frequently. It was difficult to differentiate whether it was the disorder or the internalization of mental illness stigma that caused negative self-concept in the participants. Two factors seemed to contribute to the formation of negative self-concept in the participants. One of the factors is the cognitive inclination to interpret one’s self negatively due to the depressive state. Believing one is incompetent is also one of the three pillars in Beck’s (1987) cognitive triad model of depression. The other is the internalization of negative stereotypes about people with depression, that is, believing one is incompetent because of a widely held belief that people with depression are incompetent. This has also been mentioned in the progressive model of self-stigma as the application stage (Corrigan, Rafacz, Rüsch, 2011). Both of these factors seemed to contribute to the formation of negative self-concept in the participants. The two factors that cause low self-esteem seemed to be intertwined and impossible to differentiate. The effects of both depression experience and the internalization of stigma on the self-concept were scrutinized more in challenge to self-esteem theme.

Participant 13 stated that pessimistic thoughts can even lead one to commit suicide: “The thought of ‘I won’t be able to get out of this’, this thought, this state. It’s like it will stay with me forever, it will never pass. This thought can drag you to suicide.” Participant 2 mentioned the tendency to interpret others’ actions in negative ways: “I used to believe that my peers were excluding me. I was very touchy about their actions.” The following excerpt from Participant 7 can also illustrate self-doubting and pessimism in the cognitive experience of depression:

> I doubt whether I am competent. Am I incompetent in regards to my family, my children, my job…? I get into such a state of pessimism. … I wonder if I will ever be able to solve my problems. If I can,

> when? So late? This is what I experience very frequently, I mean, not every week but two or three times a month.

Briefly, cognitive experiences of disorder included suicidal thoughts, self-criticism and self-blaming, negative self-concept, and cognitive biases such as pessimism and interpretations only in negative ways. Negative self-concept was observed in the majority of the participants. The two factors that seemed to contribute negative self-concept in the participants was the cognitive inclination to view oneself in negative ways in depression and the internalization of negative stereotypes in society about the individuals with depressive disorders.

Somatic Experiences of Disorder

The participants' bodily experiences in relation to depression were grouped under somatic experiences of disorder subordinate theme. The experiences could be physical, physiological, or sensual. Frequently mentioned somatic experiences of depression were shaking of the hands and feet, tension in muscles, difficulty breathing, pain in the head, shoulders, neck or chest, heaviness in the heart, difficulty falling asleep or feeling sleepy all the time, tiredness, difficulty concentrating and maintaining attention, and loss of appetite. The participants used the word *sıkıntı* to describe the distress and uneasiness inside them (*içimde*). Though not common; loss of consciousness, fainting, having herpes zoster and acne, and the hair turning white were also reported by some of the participants.

The somatic experiences in relation to depression were described by Participant 12: "You can't do the things you can normally do. Weakness, fatigue... you can't concentrate. The weakness affects your eyes. I feel like I'm stepping on a void. You can't concentrate and you can't reflect your personality." and by Participant 4: "The breath... a problem in breathing, pain in the heart. I can't express myself, pain in my shoulders and head.". Similarly, Participant 9 shared her somatic experience that:

> They (the doctors) said my nerves were all frayed. I had herpes zoster without even realizing it. We thought something I ate made me sick, something like skin rash on my back. We then realized that it was herpes zoster. I had rashes all around. My hair, it suddenly turned white in a very short period of time.

It was observed that the participants used the word *sıkıntı* to refer the distress, uneasiness, and tightness. They used phrases such as "when sıkıntı comes," "sıkıntı happens," "sıkıntı begins," "having sıkıntı," and "at the moment of sıkıntı." They delineated *sıkıntı* as something comes to their chest area from time to time. Participant 13 used the word *sıkıntı* when describing somatic suffering in depression: "Sıkıntı comes here (chest), and I feel tight inside. My head feels like it is about to crack. It is a feeling like panic at that moment, and it's like I am about to die."

In summary, the participants experienced bodily sensations in relation to depression such as shaking of the hands and feet, pains in different parts of the body, tension in muscles, fatigue, difficulty in breathing, and heaviness in the heart. The participants frequently used the word *sıkıntı* to describe the distress inside them.

Effects of the Disorder on Other Domains

The final subordinate theme was effects of the disorder on other domains. This subordinate theme encapsulated the effects of depression in various domains of the participants' lives, including occupational domain, financial domain, educational domain, daily life, and social domain.

Several participants noted how their occupational life was affected by their depression experience. They reported a drop in functionality and productivity, and a consequent difficulty in performing their job. Some had to quit work because of the disorder-related difficulties, while others continued working in a limited way. Thus, they had financial difficulties as well. The following excerpt reflects how Participant 13 experienced such difficulties:

> I was going to work as a nurse, I was going to buy a house, a car for myself... I wasn't going to deal with people, you know. I was going to be confident socially, I was going to have money, to say the least. But I got ill and I couldn't work…. It has affected my life, I mean, I feel regret, anger, hate towards the past now.

Some of the participants pointed out that their education was jeopardized by their disorder and this had life-span consequences. The following excerpt from Participant 2 exemplifies this situation:

> Hasn't it affected me? Of course, it has affected. I could have been an architect, a doctor. But I couldn't… There was no (nation-wide) university entrance exam at that time. We could take the exam of the

> university we wanted to attend. I could have studied at an architecture department or something like that…

Social life of the participants was also restricted due to the experience of disorder. Since they were preoccupied with the disorder, they participated less in conversations and activities. They reported a tendency to withdraw into their shells. Participant 2 said that “Your dialogue with people weakens. You don’t even want to see your mother or your father.” Shortly, social life of the participants was jeopardized by the experience of disorder.

Finally, participants indicated that their daily life was also affected by the disorder. Participants’ daily routines and tasks were hindered. The participants had difficulty with doing housework, fulfilling daily religious duties, and taking care of their children. Participants’ families were influenced by the difficulties as well.

In summary, the participants were affected by the experience of disorder in various domains of their lives such as occupational domain, financial domain, educational domain, social domain, and daily life.

Others’ Reactions

The second superordinate theme that emerged from the interviews was *others’ reactions.* This theme included other people’s reactions towards the participant, towards the participant’s disorder, and towards people with depression in general. Others can be anyone, unknown people in the society, or known people such as neighbors, colleagues, friends, or family members. The reactions were narrated by the participants, as the participants experienced them personally. This theme had three subordinate themes, which were *intentional attacks, unintentional insults,* and *minimization and disbelief.* It seemed interesting that the participants only reported negative reactions and behaviors that others had in regards to depression and people with depression.

Intentional Attacks

Others’ behaviors or verbal and nonverbal expressions that conveyed an intentionally malevolent and discriminatory attitude towards the participants were included under this subordinate theme. Stated differently, actions that were purposefully discriminatory and anything that aimed to hurt the participants were included under the intentional attacks theme.

It became evident from the interviews that attitudes towards the individuals with depressive disorder were highly stigmatizing and extremely negative. Based on the accounts of the participants, intentional attacks included treating the person with depressive disorder as insane and abnormal, treating the participant as inferior, despising, disdaining, and derogating the participant, labeling the participant with common stereotypes regarding the mentally ill, and socially excluding the participant. The attitudes came out covertly or overtly in the sentences or the behaviors of people. Briefly, the three components of stigma, which are stereotypes, prejudice and discrimination, were expressed in people's attitudes and came out in different ways.

Participant 8 narrated how she was discriminated against due to her depressive disorder:

> When you are diagnosed with depression, people don't treat you like a human being, they talk to you by ridiculing you. It's what happened to me all the time. They always ridiculed me, for instance when I asked something seriously, let's say I asked their age, they didn't tell me their actual age, but told me a different age by laughing. But I ask something serious, you respond me by making fun of me. This has bothered me a lot. They have never taken me seriously. I was never taken serious in my family, in my social environment. They never wanted to listen to me when I speak. When I speak, they interrupted me and moved on to another topic. Interrupting has affected me so much, and it still affects me.

Negative attitudes towards the individuals with depressive disorders appeared as verbal, nonverbal, and behavioral attacks. Verbal attacks occurred in daily conversations and came from loved ones such as family members and friends. Verbal attacks appeared as jokes, ridiculing, or criticism and were intended to hurt according to the participant. The following excerpt illustrates the verbal attacks that Participant 3 faced:

> They say 'you are insane' to my face, whether it is a joke or not. I have psychiatric disability report of 40%. They say '40% is not enough for you, you should be 46%.' … My sister's son hasn't done his military service, he is a deserter. My sister sometimes jokes with him saying 'you better go and stay in the asylum like your aunt.' I encounter such attitudes.

Behavioral attacks towards individuals with depressive disorders were excluding the participant from a social environment or social group due to her or his depressive disorder, gossiping about the participant’s depressive disorder, calling the participant names such as *crazy, insane,* and *sick,* and assaulting the participant physically.

The excerpt below reveals the blatant discrimination experiences of Participant 12, who was a religious official (imam):

> The mosque community initially wanted me as their imam. Then a beating incident happened. Seven or eight people punched me up after the night prayer. They are psychopaths, they have disordered personalities, and they tease everybody like that. Then we had a judicial process. The mosque community said ‘we don’t want this imam, he is psychologically troubled, insane.’ I was too much affected by the fact that such worthless people were critical about me and I could not react to them, endured in silence.

Some of the participants also reported that they received comments implying they are not preferred in marriage issues. They noted that individuals with depressive disorders are not preferred in society as future wife, husband, daughter in law or son in law. Participant 6 underlined the multiplied stigmatization of individuals with depressive disorders due to hospitalization: “The society judges especially those who were hospitalized. Let’s say one has a son who were hospitalized due to his depressive disorder, the other says implying his hospitalization: ‘I don’t give away my daughter to him in marriage.’”

To summarize, the verbal, nonverbal and behavioral attacks intended to hurt the participant due to her or his depressive disorder –according to the participant- were grouped into the subordinate theme of intentional attacks. The participant was intentionally discriminated against because of her or his disorder. Although some attacks were intentional and overt, others could be unintentional in the form of subtle comments and insults.

Unintentional Insults

Others’ manners, verbal comments, questions, and behaviors that did not appear to be intentional, but were nonetheless insensitive, rude, or inconsiderate towards the situation of the participant were coded as unintentional insults. Even though such comments seemed to be unintended, they actually scorned and outraged the participants and hurt their feelings. They had a hidden insulting message, though not intended. Such unintentional insults seemed to stem from the societal conceptualization of individuals with depressive disorders and reflect what people think about depressive disorders in negatively stereotypic ways. Different from intentional attacks, unintentional insults do not seem to have a malevolent aim to hurt and were very difficult to prove from the participants' point of view.

Unintentional insults included changes in facial expressions upon hearing the participant's diagnosis, treating the participant different than other people, ignoring the participant's disorder, keeping the participant's disorder as a secret and therefore leaving the participant helpless, assuming that the participant would be unstable, being intolerant towards the participant due to her or his depressive disorder.

Participant 12's family, for example, wanted to ignore the participant's condition. He disclosed about this: "I had had a terrible headache, (they said) don't tell anyone, don't talk about it with anybody, I had such reactions. (They said) it's a disadvantage for you. They (his family) ignored it." Participant 8 explained what she experienced when she disclosed her diagnosis:

> I can't stay in closed spaces for too long. Let's say I'm at a hospital, waiting in line, talking to the others in line. You talk and talk, you disclose yourself. Suddenly, you say that 'I will wait outside, you may come with me if you wish. I can't stay in closed areas for long, I am a psychiatric patient.' Their faces change at that moment.

People's comments about the participant's situation sometimes had an insulting tone, although they seemed innocent to the people themselves. Also, people's questions that stemmed from curiosity or an effort to understand the situation of the participant could sometimes be very hurtful for the participants. Such comments and questions occurred on a daily basis and bothered the participants very much.

Participant 14's interactions with her parents in law exemplified this issue:

> The other day, my mother in law asked me when I would get better. Maybe she didn't say it with ill will, but it made me feel bad. … Or my father in law, he asks me how I am, I can't say I am fine because I am already distressed, I keep silent and he says "you have to say I am good".

Labeling the individuals with depressive disorders seemed to occur without awareness and in line with the stereotypes about the people with depressive disorder in the society. According to the interviews, people seemed to perceive the individuals with depressive disorders in stereotypic ways. Weakness, incapability, lack of social skills, foolishness, and dangerousness were the stereotypes that were mentioned during the interviews.

In summary, unintentional insults included comments, questions, or behaviors that conveyed insensitivity, rudeness, and tactlessness regarding the participants' situation, but did not seem to be intentional. Such unintentional insults were hard to prove because of their latent nature, and left the participants unable to express their experiences.

Minimization and Disbelief

Others' manners or verbal comments that minimized the participant's depressive experience or that implied disbelief in the participants' depressive disorder were included in minimization and disbelief theme. The depressive experience of the participants was minimized and their disorder was regarded as trivial and insignificant by other people. On some occasions, people did not believe that the participants actually had a disorder. Depressive disorders of the participants were not regarded as serious as physical disorders, and sometimes were not even accepted as a disorder. Experiential reality of the participants was rejected through minimization and disbelief. Minimization and disbelief were often accompanied by blaming the participants for their depressive experience. They were accused of making up the symptoms. Minimization and disbelief reflected a mindset that trivialized and delegitimized depressive disorders. Those who minimized and disbelieved in depressive disorders or the participants' experiences were not intentionally attacking the participants or were not unintentionally insulting them. Rather, this was their mindset. This mindset, however, was harmful for the participants as much as intentional attacks and unintentional insults.

Minimization and disbelief seemed to stem from lack of knowledge and comprehension about the participant's situation. People who minimized and disbelieved in the depressive experience of the participant usually did not understand and misinterpreted the participant's situation. Thus, minimization and disbelief were accompanied by accusation, blaming, and attribution of responsibility of the situation to the participant. Others seemed to believe that the symptomatology was not caused by the disorder and that the participant made the symptoms up for secondary gain. In other words, the symptoms were perceived as willful. Some of the participants were accused of feigning their disorder as an excuse. Such attitudes left the participants invalidated, helpless, and frustrated.

The tendency to attribute the responsibility of the disorder to the participant and covertly blaming the participant can be seen in the following quotation from Participant 14:

> I didn’t use to disclose because they criticize. Now, I share, but not everything. I don’t tell everything because they criticize. The society doesn’t understand this sorrow. One cannot know this sorrow unless they live with it. (they say) ‘There’s nothing to be distressed about. … ’ I would hold on if I could. Do I want to suffer? Do I have to suffer? Do I crave suffering? No! But.. (they don’t understand)

Similarly, Participant 3 mentioned the attribution of responsibility and covert blaming: “They say ‘you are overwhelming yourself, it’s about how you think, it’s a problem that will end in your brain. You want it, you make yourself crazy.’” Participant 4 expressed how her spouse minimized her depressive experience: “When I need his support, he always says ‘stop whining to me.’ He doesn’t want to listen to me. … He assumes that I do it (disorder) on purpose.”

Compared to physical disorders, individuals with psychological disorders were more prone to disbelief and accusation according to the participants. Since psychological disorders are not as visible as physical disorders, people seemed to approach psychological disorders with skepticism and invalidated their experience. Participants 10’s experiences can exemplify this situation: “They do not believe you are sick. Do you need to bleed to make people believe that you are not well? Do you need to get very sick physically? … When you say ‘I am sick’, people expect a physical illness or something visible.” Participant 14 commented on the same issue in the following excerpt:

> It’s a very difficult disorder, it means not enjoying life. My mother says ‘you need to force yourself; you are making yourself think, you are focusing on it (the disorder).’ May God forgive me but I wish I had cancer. If I had cancer, either I would be treated and gotten well, or I would die. People would affirm that I am *sick* in that case. Let’s say you have cancer or a broken leg, people admit that you cannot stand up, you have a broken leg. But people don’t see psychological disorders like this.

Participants also encountered advice giving frequently. Those who interpreted the participant’s condition in their own way gave advice that were far from the participant’s reality. Such suggestions were destructive rather than constructive. Giving advice, although with good intentions, invalidated and minimized the experiences of the participants and caused feelings of frustration.

The below excerpt illustrates how giving advice made Participant 14 feel:

> They say that ‘tell yourself I will get well, think positive.’ Am I stupid? I already say such things to myself. But when you are choked with the distress, it doesn’t matter how much you say to yourself ‘I will get well.’ You live through the pain, and you lose confidence in life.

Another thought behind minimization and disbelief regarding depression experiences was that the person’s own incompetency caused the disorder. Some people embraced the belief that individuals with depressive disorders can treat themselves. If they were still sick, it was their own fault. One does not need to use medication to treat depression, because it is all in the head. Such a point of view made the participants feel inadequate and guilty. Such comments were perceived as criticisms on the part of the participants. Also, this point of view led the participants to either hide their situation or to disclose selectively.

In summary, minimization and disbelief included verbal comments or attitudes that trivialized and delegitimized participants’ disorder. Others minimized participants’ depressive experiences and disbelieved that the participants actually had a disorder. They also accused the participants regarding their depressive disorder, attributed the full responsibility of the disorder to the participants, gave advice based on their own interpretations, and invalidated the experience of the participants. The condition of having a depressive disorder was delegitimized and attributed to the participants’ incompetency. Such experiences, as well as the disorder itself, also had significant effects on the participants’ self-perception.

Effects of Disorder Experiences and Others’ Reactions on Self

The third superordinate theme abstracted from the interviews was *effects of disorder experiences and others’ reactions on self.* This theme mainly represented the effects of the disorder and others’ reactions on the participant. Others’ reactions, the disorder itself, and the state of being diagnosed had an effect on the participants, especially on their self-esteem. These factors usually challenged the participants’ self-esteem, made the participants hide their disorder, led them to disconnect from others, caused them to anticipate future stigmatization and have feelings of resentment. Consequently, the five subordinate themes under this superordinate theme were *challenge to self-esteem, secrecy, disconnection, anticipation of stigma,* and *resentment.*

Challenge to Self-Esteem

This subordinate theme reflected how the participants' self-esteem was damaged by the state of being diagnosed with depressive disorder, by the experience of depression itself, and by others' stigmatizing reactions. The participants reported that they felt different, inadequate, like a loser, half-human, deficient, and useless since they had depressive disorders. They compared themselves with others around, they felt more and more incompetent, and their self-concept was damaged increasingly. Some had difficulty accepting the diagnosis of depressive disorder. Some of the participants described themselves with extremely negative adjectives such as idiot, worthless, and guilty. Their attitudes towards themselves were also negative. They humiliated and undervalued themselves, blamed themselves, and attributed the full responsibility of their disorder to themselves. The participants seemed to internalize the negative societal conceptualization of individuals with depressive disorders and therefore they seemed to experience lowering in self-esteem. Low self-esteem can also be a cognitive symptom of depression. It was difficult to differentiate the effects of the cognitive experience of the disorder and the effect of the stigma on low self-esteem. Rather, the effects seemed to be mixed and seemed to perpetuate each other.

When Participant 6 was hospitalized due to her major depressive attack, it was her first psychiatric hospitalization. She even did not receive psychiatric treatment as out-patient before. She had difficulty in accepting the diagnosis of depressive disorder as well as the hospitalization due to depressive disorder. She felt very incompetent and she thought she failed in life. She stated that when she was hospitalized, she kept asking herself "How did I end up here? How did I end up this situation?" Her self-esteem was severely challenged by these experiences.

The feelings of inadequacy and blaming oneself can be exemplified in the following excerpt by Participant 9:

> At that time nobody around me had psychological treatment, nobody in my social environment, to my knowledge. I felt weird, I thought

> that I must have gone mad. (I thought) "Everybody can deal with their problems except me, I can't manage them, I get support, I use medications. I am not enough."

The damaged self-esteem is also evident in Participant 14's comments:

> My aim is to be able to do something, to achieve something, to be happy, happy for something. I want to be self-confident, you know, my posture is always miserable because I am sick. I want to get rid of it, I want to be strong, you know. I don't want to bow down to anyone.

It was observed that the participants with more persistent depression and those with single episode of depression differed in their self-concept. The participants with more persistent depression described themselves in extremely negative ways. The disorder seemed to become a central part of their self. They spoke in the present tense when describing their self in relation to depression with such statements as "I am stupid, worthless, and guilty." (Participant 4). Participant 14, for instance, pointed out how her present self-concept was altered due to depression experience by saying "I was a totally different person in the past. Now, I don't have any self-esteem, due to the disorder. … I can't feel positive feelings towards myself due to my disorder. I get angry at myself. Why can't I handle it?"

On the other hand, the participants who experienced depression temporarily, answered the question "how do you define yourself" in rather positive ways. They differentiated their self-concept during depression and their present self-concept. They expressed that although they had viewed themselves in negative ways during their depressive episode, they view themselves positively in general. Their use of past tense was noteworthy while describing their self-concept in relation to depression. For instance, Participant 10 said: "I viewed myself as someone useless when my disorder was severe." Similarly, Participant 2 talked about the way he viewed himself negatively in the past due to depression: "(Back then) I used to humiliate and depreciate myself, I used to keep asking 'Am I this person? Who was I? Was I like this? What happened to me?'" Although depression caused questioning oneself in such ways, the negative effects on self-concept seemed to change in time.

In summary, the subordinate theme of challenge to self-esteem represented how the participants' self-esteem were damaged due to the state of being diagnosed with depressive disorder, due the experience of disorder, and due to internalization of stigma towards individuals with depressive disorders. The cognitive inclination in depression to view oneself negatively seemed to interact with and was multiplied by internalization of stigma in formation a negative self-concept in the participants. Negative self-concept was observed in the majority of the participants. Negative self-concept seemed to be temporary in some of the participants while they were more persistent in others. Persistency of depression seemed to be the key factor in the extent to which self-esteem and self-concept was damaged.

Secrecy

The majority of the participants were hiding their diagnosis, treatments, and medications in their social spheres. Most of them told that they disclosed their diagnosis to family members only, as well as some of their friends. They preferred not to disclose it to distant relatives or to the people they interact with by obligation. The participants either totally hid their situations or disclosed them partially. For instance, they tended to describe their disorder in terms of physical health when they talked about the treatments they had received. They described their disorder as insomnia, an ear nose and throat problem, or a problem of blood clot in the brain.

Participant 11 reported that she hides her disorder by saying that “I don’t tell it (her disorder) to anyone. When they say ‘You are too sick, what happened to you?’ I say ‘It is insomnia; it happened because I couldn’t sleep.’ I never give details.” Similarly, Participant 12 disclosed his depressive disorder in physical terms. He said that “My acquaintances know that I received depression treatment, but I deceive them by saying ‘It happened because a blood clot developed in my brain.’. I refrain from their judgment.” Participant 9 talked about her effort to hide her medication. She said that “I was annoyed with using medications. I used to hide my pills at back cabinets so that nobody would find them.”

Some of the participants noted that they hid their disorder to avoid being hurt. As a coping mechanism, they disclosed their disorder only to those who could empathize with them. The below excerpt from Participant 9 can be given as an example to selective disclosure:

> I always give different responses to the question ‘How are you?’. While I can share what happened to me last week with those who can empathize with me, some only hear ‘I’m very well,’ because I don’t expect them to understand me. I don’t tell them that I see my doctor and continue taking medications. I used to try to persuade such people that I’m not crazy. Now, I totally ignore them.

In summary, the participants reported they were hiding their depressive disorder in their social spheres. The participants either totally hid their disorder or disclosed partially. Some of the participants disclosed their disorder in physical terms such as insomnia or blood clot. The participants reported that the reason behind hiding their disorder was to avoid being hurt.

Disconnection

This theme included comments about the participants' social, emotional, mental, and behavioral disconnection from others. The participants felt disconnected and isolated, they were socially withdrawn, and they isolated and excluded themselves, because they experienced stigma, anticipated stigma, or internalized stigma. Stated differently, since the participants received stigmatizing responses from people before, they disconnected from them, they withdrew socially and isolated themselves. Also, since they internalized stigma and entitled themselves to stigma, they anticipated further stigmatization; they withdrew and isolated themselves. Self-isolation was only one side of the coin. In addition, others excluded the participants, which can be regarded as discrimination. Therefore, the state of isolation is a bidirectional process, but only comments regarding self-isolation and self-disconnection were included in the present theme.

Participant 2 explained how he got lost in the feelings of isolation: "When you are depressed, you don't even care about your loved ones. You exclude yourself, you regard yourself as excluded from society."

The participants stated that they withdrew from both loved ones, such as family and friends, and from society. The participants seemed to be avoiding being hurt, criticized, and stigmatized through disconnection. Also, others' lack of understanding about the conditions of the participants seemed to keep them disconnected. Some of the participants reported that they stopped meeting with their friends and others reported that they were about to get divorced. Further disconnection also led to suicidal thoughts. In severe cases, the participants wanted to end their lives at all.

Participant 3 explained her disconnection:

> I don't even want to get out of the house. I don't want to see anybody because they are always taunting me about my disorder all the time.

> So, I don’t go out. … People keep me from going outside. I can’t do anything for the fear that somebody will say something negative.

The experiences of Participant 13 made her alienated and disconnected from the society, and even the city she lives in:

> It makes me alienated from the society I live in. I don’t want to live in Bolu. I want to move to and live in places where people don’t know me. I want to be relaxed. I want to walk outside freely. … I don’t like my relatives except for a few. I don’t want to visit them on holidays because they make innuendos about our (her and her husband) disorder when there is a tiny problem. They know our disorder.

In brief, the participants disconnect from other people due to the reactions they received about their depressive disorder. Disconnection was in social, emotional, mental, and behavioral levels. The participants felt isolated and alienated, withdrew socially, and excluded themselves from social spheres.

Anticipation of Stigma

This theme represented the participants’ anticipation of being stigmatized in daily interactions. The participants reported that they feel anxious while interacting with people because they anticipate to be labeled, offended, judged, excluded, and betrayed. Therefore, they changed their behaviors to hide their disorder. They were aware of the stigmatizing nature of the social conception of depressive disorder; thus, they feared that others would inevitably stigmatize them. They used to anticipate others to have certain stereotypes, prejudice, or discriminative acts against them.

The anticipation of stigma can be exemplified in the quotations of Participant 1 and Participant 11. Participant 1 said: “I wonder whether everybody thinks I’m crazy.” Similarly, Participant 11 said: “I fear that somebody will taunt me about my disorder or utter undesired words, which will hurt me.” The anxiety and discomfort in social settings were also described by Participant 3. She said: “In an unfamiliar social setting, when the topic turns to these issues (disorder), I cannot help but get anxious.” Participant 9 explained how she changed her behaviors due to the anticipation of stigma:

> For instance, somebody wants to visit me, but I don’t want to host them. However, I don’t want to let them think that I’m depressed again, which forces me to accept them. Or, I don’t want to go out, but I get anxious thinking that they will judge me. Eventually, I go out halfheartedly.

In summary, the participants anticipated being stigmatized in daily interactions due to their depressive disorder. They anticipated being labeled, offended, judged, excluded, and betrayed. Therefore, they reported an anxiety while interacting with people, or stated they changed their behaviors in order to avoid stigma.

Resentment

This theme included the participants' feelings of offense in relation to the stigmatizing attitudes of others. The participants felt sad, hurt, demoralized, and irritated when they encountered stigma. Moreover, they bore anger, grudge, and hatred against those who behaved in ways that was discriminating and insulting. Family, friends, and society as a whole created feelings of resentment. The participants mostly did not express these feelings and stayed silent. Some of the participants reported that they even wished to die due to such intense resentment feelings.

Participant 9 talked about the stigma in society and how stigma affected her. She said: "You know it is common in society. They gossip about you: 'She is seeing a psychologist blah blah..' It, of course, makes you sad." Participant 13 described her intense feelings towards stigma: "I remember their ridiculous words. I felt hate, anger, and rage. I used to become full of hatred whenever I remembered their attitude towads my illness. I overcame it a little bit, but such feelings were rather intense in the past." Participant 8 pointed out that one could be more resentful of family members' reactions. She said: "The most hurtful experience was when my family stigmatized me. Even your own child can do it to you."

Summarily, the participants felt offended, sad, demoralized, as well as angry and full of hatred in response to others' stigmatizing reactions. Family, friends, and society as a whole could be responsible for these feelings of the participants.

Meaning Making

The forth superordinate theme was *meaning-making.* This theme consisted of the participants' meaning-making efforts regarding the diagnosis and experience of depressive disorder. The effort to understand and make meaning of the experience was very central for the participants. The participants believed that some factors caused the development of their depressive disorder. The participants also normalized having depressive disorder as physical disorders. The subordinate themes included in this superordinate theme were *perceived causes,* and *normalizing.*

Perceived Causes

This subordinate theme included the participants' perceptions, beliefs, and interpretations about the causal factors regarding depressive disorder. The participants reported that some factors precipitated the development of the depressive disorder in them, and some other factors triggered depression in them. Also, they reported factors related to relapse. It was observed that the participants had a need to make the experience of depression meaningful for them. They made out the meaning of why they suffered from depression.

Some of the factors that precipitated the development of depression were lack of maternal affection in childhood, marriage at an early age, paternal oppression, and difficult living conditions.

Participant 1 reflected on how growing up without his mother contributed to his current psychological problems. He said that "I grew up motherless. Such a deprivation triggers my problems. You will always remain deprived because nothing can substitute for maternal love. You always come across this problem in your life. It affects me very much."

The factors that were disclosed by the participants to have triggered their depression can be categorized as relational factors, stress factors, and health related factors. Relational factors included conflicts with family members, friends, or colleagues, loss of relationship with loved ones, separation, abandonment, loneliness, and lack of social support. Stress factors were comprised of pressure and problems at work, busyness, financial problems, suicide attempt of a family member, facing violence, and being appointed to a work site in a rural area and working there under adverse circumstances. Finally, health related factors were diseases such as high blood pressure and facial paralysis. Some of the participants reported that occurrence of physical health complications such as high blood pressure and facial paralysis caused the development of depressive disorder in them. The factors for relapse indicated by the participants were similar to the triggering factors. The participants reported that their disorder relapsed with sadness and stress.

Participant 9 revealed her insight about her depressive disorder:

> I had been married before. I was exposed to violence by my ex-husband. I had very hard times for three years. Nothing was left from my salary; I was penniless. He was very irresponsible. I suppose those times accounted for my depression because I was doing fine before then. …I don't blame myself too much because there were people that pushed me to this (depression). I am 51 now. I always try to remember what makes me depressive. I realized that my loved ones harshly criticized me following an adverse event, which made me depressed.

In summary, the participants attributed some reasons to the development of depressive disorder in them. They believed some factors precipitated depression in them and some other factors triggered depression in them. For instance, the participants believed that lack of maternal affection in childhood and paternal oppression precipitated depression in them. Moreover, relational factors, stress factors, and health related factors such as separation, pressure at work, and diseases triggered depression in them according to the participants. The participants necessarily made out meaning of why they had depression.

Normalizing

Almost all of the participants normalized experiencing depression and receiving treatment for it. They reported that depressive disorder was like any other physical disorder. It was not something different than cardiovascular diseases, stomach disorders, pains, or dental problems. The participants pointed out that everyone could experience depression at least once in their lives. Also, some of the participants indicated that the majority of people already had depression, whether they knew it or not. Howsoever, the participants normalized having depressive disorder by noting that everybody had a disorder.

Participants 11 normalized having a depressive disorder and receiving treatment for it by saying that "It (depressive disorder) is just one of the disorders. Everybody can have a disorder. It is my disorder, just like somebody has cardiac disease. I don't think I have something adverse." Similarly, Participant 8 said that "If your stomach is sick, you will go to the doctor and take medication. It is the same way for psychiatric medications.” Similarly, Participant 1 normalized his depressive disorder by saying that “You don’t have a deficiency; you just get depression from time to time just as you sometimes have a toothache. Depression doesn’t last all the time; you can’t be in depression every day.”

It was observed that the participants normalized their depressive disorder just after they mentioned the stigmatizing attitudes they encountered due to their depressive disorder. This alignment was noteworthy and gave rise to the thought that normalizing depressive disorder was not only a way of making meaning, but also a cognitive mechanism of coping. Stated differently, the participants needed to normalize their depressive disorder in order to minimize the negative effects of remembering and narrating the stigmatizing experiences. Although they narrated many stigmatizing incidents related to depressive disorder and admitted that they were affected by them, they still normalized their situation. This need to normalize could make sense when it was considered in relation to coping. The following dialogue with Participant 3 can exemplify this nuance:

“Interviewer: How are you affected by such (stigmatizing) statements?

Participant 3: They don’t affect me. It (depressive disorder) is the same as pains in my back or neck. I see my doctor for it just as I see doctors for my pains.”

In summary, the participants normalized the state of being diagnosed with depressive disorder and receiving treatment for it. They likened depressive disorder to physical disorders and stated that they see no difference between psychological disorders and physical disorders. Also, they noted that everybody could experience depression, and people may even be in depression without realizing it. Normalizing could also be a coping mechanism for the participants.

Coping

The final superordinate theme included several coping strategies of the participants to deal with stigma and difficulties of depressive disorder. The participants used social, behavioral, and cognitive coping strategies to cope with their negative emotions caused by the disorder and stigma, as well as to overcome difficulties of the disorder and stigma. In the study, the participants frequently expressed the following strategies: *social support, seeking treatment, stigma resistance,* and *cognitive reframing.*

Social Support

The participants reported that support from others helped them a lot in overcoming their depressive episodes and in dealing with negative emotions caused by depressive disorder. Family members, friends, and colleagues gave verbal, nonverbal, or behavioral support to the participants during difficult times. The support could sometimes even be instrumental, such as giving injections. Moreover, supportive cues the participants received made them feel good and recover fast.

Participant 2 explained how family support affected him:

> I shared it (the disorder) with my spouse. She both helped me recover and supported me emotionally and socially very much. She knew I had a disorder. … I attribute my recovery to the moral support of my family and their belief in me. She (his wife) supported me the most. She used to give me my injections. She was very nice, she may rest in peace.

Similarly, Participant 9 explained the role of family support in her recovery:

> My family had a big role (in my recovery). They took me out walking. … My sister took me out shopping. They bought me new clothes and encouraged me to socialize … They helped me a lot in terms of getting better. I was not alone. If they hadn't supported me, I would probably have gotten over it in a very long time.

Similarly, Participant 7 talked about the effect of support on his recovery:

> Yes, they supported me. My father supported me. When I decided to get hospitalized, everybody around me appreciated it and said I did the right thing. … I was obsessed with the things I was told. I was exaggerating things. Their positive words and support made me relaxed during this time. It could have been quite the opposite. I was already inclined to exaggerate my problems. If they had said negative things, it would have made things worse. Their support really helped me during this period.

Participant 10 also talked about the way his family showed their support: "They were with me all the time and they didn't leave me alone." Apart from family support, support from friends can be exemplified in the words of Participant 2: "When I disclosed my problem to my friends, they recommended me to keep calm and that it was a temporary situation. They also advised me that it came from God, and God would also heal me."

In summary, the participants coped with the difficulties of depression by receiving social support from their family members and friends. The participants received verbal, nonverbal, as well as instrumental support from their loved ones. Supportive others around the participants helped them to overcome during their depressive episode and to recover faster.

Seeking Treatment

The majority of the participants stated that they were coping with their disorder by seeking and receiving treatment. Participants talked about medication, hospitalization, psychotherapy, consulting psychologists and psychiatrists, and adherence to treatment. When they could not cope with their disorder on their own, they sought treatment for it.

Participants 3 explained when she needed treatment to cope with her disorder:

> I wasn't able to deal with it at home on my own. Everybody pestered me, especially my mother. She kept insisting that I should go out, but I wasn't able to. I even came to the hospital with my mother. It went on like this for a while and then I decided to get hospitalized.

Similarly, Participant 11 explained the process of starting her treatment: "I know when it (disorder) comes. It comes with insomnia, anxiety, irritation, and stress. I immediately see my doctor and explain the situation. Then, he prescribes medications."

Participant 5 explained her reasons to seek treatment in the following excerpt:

> You have to seek remedy of your problem with doctors. Let's say you have a problem but you try to solve it on your own, nothing changes. But, when you go to doctors, they prescribe a medication, it becomes the remedy of your problem.

In brief, the participants coped with their depressive disorder by seeking treatment in different ways such as using medications, getting hospitalized, receiving psychotherapy, and so on. They stated the treatments they received helped them to cope with their disorder as well as to recover.

Stigma Resistance

This theme represented the participants' ways of resisting the depression-specific stigma. The participants strongly rejected stigmatization. They reacted overtly and confronted the stigmatizer. They stood up for themselves in the face of stigma by asserting their own opinions, interpretations, and values.

Participant 3 talked about her resistance to stigma by saying that “It doesn’t affect me. I say ‘Yes, I am insane and pleased to be hospitalized!’ At least I became aware of my condition and then recovered. I could have been worse by now.” Participant 3, who encountered stigma by her family on many occasions, perhaps developed a mechanism of resisting to it and resisting stigma became the way of protecting self-esteem for her in the face of stigma.

Similarly, Participant 8 narrated many incident which she was stigmatized. She learnt to cope with stigma in time. The way she coped with stigma was by resisting it. It can be exemplified in the following quotation from her:

> I have never believed that I am insane because I disclosed everything that I experienced to a psychologist in Zonguldak. When I told (the psychologist) the way my family and social environment referred to me (as insane), she just said ‘When they refer to you like that, you will say I am not crazy!’ I still remember it. Since then, I always tell such stigmatizers that I am not insane, but that I have a psychological disorder and I get help for what I can’t handle on my own. I constantly repeat (to myself) ‘I am not crazy. I have a disorder. I went to a doctor for what I couldn’t deal with on my own, I am receiving treatment for it.

Apart from reacting overtly, the participants also used *ignoring* as a resistance mechanism. They seemed totally indifferent to stigma, which helped them to cope with it. It is evident in the following quotation from Participant 10: “I have encountered it (stigma) before. I don’t care about it. What happens to me today may happen to them in the future.”

In summary, the participants coped with stigma by resisting it. They reacted overtly to the stigmatizer and asserted their own opinions and values. Some of the participants, on the other hand, did not react overtly but ignored stigma. Ignoring also helped them to cope with stigma.

Cognitive Reframing

Cognitive reframing represented a process of change in the participants’ conceptualizations of the disorder. There was a shift in the participants’ perspectives in relation to the diagnosis. They re-analyzed and re-addressed their situations, which helped them cope. One of the ways participants reframed their situation was by using downward social comparison. The participants compared themselves with those who suffer from psychological disorders much more than they do. Hence, they found themselves in a better situation and felt healthier. Such a coping strategy was especially associated with being hospitalized. Cognitive reframing relieved the participants, led them to feel grateful for their situation, and helped them to cope with their disorder and the associated stigma.

For Participant 6, being hospitalized was a negative life event, therefore she had difficulty accepting it. However, after reframing her situation, she protected self-esteem and eventually coped better. She talked about the shift in her perspective after being hospitalized:

> When I saw people at the hospital, I thanked God and prayed more for being healthy because I was just hospitalized for psychological reasons. Yet, people there were hospitalized for physiological reasons and barely got better. That wasn't the case for me because I could recover faster and resume my life within a year. I could maintain my social activities and do whatever I want. For example, I could go to Istanbul, stay with my friend, or meet my loved ones. I didn't have such problems.

Another way of reframing the experience of depressive disorder was considering it a call for help rather than a disorder and a chance for getting well. Accordingly, the participants didn't consider their disorder as something negative. Such a point of view also helped them to cope with the stereotypes associated with depressive disorders.

Participant 8 explained her point of view in the following excerpt:

> It's not something negative in my life. It's just a call for help from doctors for what I cannot cope with alone. Overall, it's not something bad, but people around me don't regard it like this, which bothers me. … We have conversations with other patients here (mental health unit) and advise each other that we aren't insane, but we come here just for receiving treatment. It's kind of what we do. We definitely aren't insane, but we have a disorder and what we are doing here is just to seek relevant treatment.

Another way of reframing was to deploy a religious point of view towards depressive disorder. Some of the participants conceptualized their disorder in religious terms and saw their depressive disorder as a test of God. This way of making meaning relieved them and helped them cope with the disorder and the associated stigma. Participant 12, who struggled with suicidal thoughts and wishes during a depressive period, focused on the meaning of his disorder from a religious point of view. He thought that his disorder was a test of God. He said "I wanted to commit suicide in my first place of duty. But I thought that the world is a place where we humans are tested. We will be held accountable for our actions." The reframing that Participant 12 experienced protected him against suicide.

The final way of reframing was focusing on advantages of being diagnosed with depressive disorder. The diagnosis of depressive disorder helped the participants identify what they were experiencing and realize what happened to them. The participants reported that before the diagnosis, they did not know what they were experiencing and what was happening to them. Therefore, they felt uncertainty and panic. Knowing their disorder gave them a sense of mastery and control over the disorder. Also, knowing their disorder helped them obtain an integrated sense of self and realize that their disorder was a part of them. In addition, knowing their disorder gave them the chance to seek and get the treatment they needed. In short, the participants viewed the state of being diagnosed with depressive disorder as a positive life event that enabled them to know themselves better, seek treatment for their disorder, and to recover. This reframing of depressive disorder apparently helped the participants to cope with their disorder better. Participant 11 explained this situation: "I know what my disorder is. When I am anxious and nervous, I realize that my disorder is getting worse and immediately see my doctor. … I know the disorder is a part of me. There are people who don't know their disorders."

In summary, the participants cognitively reframed the disorder by re-addressing their overall situations in the way of contributing to their emotional states and coping processes. The participants reported several ways of reframing their diagnosis. The participants re-addressed their situation by comparing themselves with those who are in worse situations, by viewing their diagnosis as a call for help for what they could not cope with or as an opportunity to know themselves better, and by deploying a religious point of view. The ways of cognitive reframing helped the participants to minimize negative emotions associated with disorder and stigma, and to protect self-esteem in the face of disorder and stigma. Consequently, the new ways of framing helped the participants to cope better with depressive disorder and stigma.

CHAPTER 4

DISCUSSION

The aim of the present study was to explore the stigma experiences and coping orientations of individuals diagnosed with depressive disorders in Turkey. Interpretative phenomenological analysis of the interviews with 14 participants revealed five superordinate and eighteen subordinate themes. The superordinate themes were *the experience of disorder, others' reactions, effects of disorder experiences and others' reactions on self, meaning-making,* and *coping.*

The present study found that the participants experienced depressive disorder in three psychological levels, which were emotional, cognitive, and physiological levels. The participants experienced difficulties and effects of depressive disorder in daily life and social, occupational, and educational domains. They were faced with stigmatizing and discriminatory attacks and insults, whether intentional or not, in their interactions with others. Others also minimized the participants' depressive disorder, disbelieved their experience, and accused them for the disorder. The participants were adversely affected by disorder experiences as well as others' stigmatizing reactions in several ways, especially in regards to their self-esteem. The participants' self-esteem dropped as a consequence of experiencing depressive disorder and facing the stigma. Moreover, the participants tended to hide their depressive disorder in their social spheres. Based on the past experiences of stigmatization, the participants anticipated being stigmatized in their future interactions with people, showed social withdrawal, and isolated themselves. Thus, they became disconnected from people. In addition, the participants felt offended, sad, and angry in response to the stigma they encountered. The effort to make meaning of such a challenging experience was very central for the participants. They attributed their depressive disorder to various causes. Also, almost all of the participants tended to normalize having depressive disorder and to liken depressive disorders to physical disorders. The participants used a number of coping strategies to deal with the disorder as well as the stigma they encountered. Most of the participants received support from family members or friends to overcome depressive episodes. The majority of the participants sought and received treatment to cope with their disorder. In addition, the participants shifted their perspective about having a depressive disorder as a way of coping with it. They tried to see the advantages of their diagnosis or viewed the disorder as a test of God rather than a disease, which helped them cope better with their situation. In addition, some of the participants overtly reacted to and confronted the stigmatizer to cope with the stigma.

According to the first superordinate theme, *the experience of disorder,* the participants talked about three aspects of depression: affective, cognitive, and somatic. The participants delineated emotional experiences in depression, such as alienation and numbness, loss of interest, and loss of pleasure. They emphasized the intensity of such emotions during depressive episodes. Descriptions of *affective experience of disorder* overlap with the affective symptoms of several types of depressive disorders documented in the Diagnostic and Statistical Manual of Mental Disorders – 5th Edition. In the DSM, major depressive disorder is defined with the symptoms of either depressed mood or loss of interest and pleasure during a 2-week period. Depressed mood is characterized by feeling sad, empty, and hopeless, and tearfulness (American Psychiatric Association, 2013, p. 160). The participants of the present study reported feelings of hopelessness and emptiness, as well as guilt and tearfulness; however, they did not report a feeling of sadness as an experience of depression. They described the feeling of sadness as a response to stigma, not as an experience of the disorder itself. Emotional reactions to stigma were discussed in detail in *resentment* theme.

In addition, feelings of anger were much more prominent in the descriptions of the participants. Almost all of the participants expressed how angry and aggressive they were feeling during their depressive episodes. They mentioned that they were shouting and swearing at people around and they got irritated with and angry about small things. Some of the participants even noted that they struggled with the feelings of anger and aggressiveness for a while and they decided to receive treatment when they noticed that they were offending others around them. This finding was consistent with the findings of Granek (2006), who emphasized the role of anger in depression. Granek (2006) argued that depression is primarily a relational phenomenon and anger bears a significant place in the experience of depression. Similarly, Sayar and colleagues (2000) found that anger attacks are prevalent (49%) among Turkish adults with depression. Anger, however, was not listed among diagnostic criteria of major depressive disorder or persistent depressive disorder in the DSM-5. The irritable mood was noted for children and adolescents, but was not generalized to adults experiencing major depression (American Psychiatric Association, 2013, p. 160). The reason for this difference can be the fact that DSM relies heavily on the medical model, which views psychological disorders as purely biological phenomenon and leaves no room for social, relational, and societal explanations (Engel, 1992). This might have given rise to the fact that affective criteria of depression are relatively overlooked in the DSM compared to somatic criteria, and do not contain anger. However, qualitative studies exploring depression experience emphasized social and relational aspects of the experience (Granek, 2006; Rhodes, Hackney, & Smith, 2019). The present qualitative study also explored the role of anger. It was found that anger in relationships and affective experiences in general have an important role in the experience of depression.

According to research findings, men experience depression different from classic depression criteria. Depressed men present predominantly externalizing symptoms such as bursts of anger and irritation due to socially accepted roles of men, rather than *vulnerable* symptoms such as sadness or crying (Rice, Fallon, & Aucote, 2013). Male depression is characterized with anger and aggression manifestations along with risky behaviors and emotional withdrawal (Rice et al., 2013). Male gender is associated with masculinity in Turkey as well. There were male participants in the present study and anger was especially apparent in their expressions. Predominance of anger among overall affective experience in the participants makes sense when those cultural factors are considered.

The participants in the present study described *cognitive experiences of the disorder* as suicidal thoughts and tendencies; self-criticism and self-blaming; negative thoughts about self, others, and the future; and negative self-concept. These findings regarding cognitive experiences of the disorder are consistent with the diagnostic criteria of depression in the DSM (American Psychiatric Association, 2013, p. 161). Granek (2006) also underlined self-criticism and self-loathing in the experience of depression. It was also found that the participants of the present study adopted a pessimistic thinking style and focused on the negative sides of the events only. They failed to recognize their strengths and the positive aspects of the events. They felt that they would stay depressed forever. This finding was similar to Aaron Beck’s cognitive triad (1987). Beck suggested that individuals who are depressed engage in negative thoughts in three areas: self, world, and future. They often view themselves as unlovable or deficient. They believe that they are worthless and blameworthy, and attribute unpleasant experiences to their presumed deficits. Beck (1987) also proposed that individuals with depression develop cognitive distortions, such as magnification and minimization. That is to say, individuals with depression tend to exaggerate the significance of adverse events whereas they underplay the significance of positive events. These cognitive distortions were also observed in the majority of the participants. They believed that they were incompetent, and used extremely negative adjectives when describing themselves or their selves at the time of depressive episodes. They used words such as idiot, worthless, useless, guilty, deficient, loser, and stupid to describe themselves. They stated that they felt worthless, and they often humiliated themselves.

The finding of the study regarding negative self-concept showed a substantial similarity with depressed people’s negative self-schema proposed by Aaron Beck (1987). Beck believed that depressed people held a negative self-schema since their childhood. Adverse childhood experiences, such as criticism or abuse, lead to the formation of negative self-schema. Beck characterizes depressed people with self-blaming for adverse events outside of their control and pessimism in believing that such events will continue forever (Beck, 1987).

Negative thoughts about self seemed to be parallel with the occurrence of depressive episodes. Some of the participants adopted negative thoughts about themselves during depressive episodes, but they viewed themselves more positively at other times. Yet, other participants talked about a stable negative self-concept. Those who had a stable negative self-concept, however, experienced more persistent depression. Stated differently, those who suffered from depression for a long time had a more stable negative self-concept. This finding can be related to the alteration of self in chronic depression (Rhodes & Smith, 2010). Rhodes and Smith (2010) argued that depression does not only change emotions, thoughts, and action capacities but also the experience of being the same person over time. Chronic depression shapes and challenges self-esteem (Moore & Garland, 2003). A continuous battle with depression and unending failure to recover lead to a perception of self that is disordered or sick, which then becomes a major part of the self-concept over time. It becomes difficult to detach from such an undesired part of the self. Ultimately, participants with persistent depression may have difficulty viewing themselves as independent from their disorder.

The participants also described bodily experiences including, but not limited to, shaking of the hands and feet, tension in muscles, difficulty breathing, bodily pain, sleep problems, concentration problems, and loss of appetite. These somatic experiences of depression are consistent with diagnostic criteria of major depressive disorder in the DSM (American Psychiatric Association, 2013, p. 161). Moreover, in a study exploring idioms of distress used by depressed Turkish women living in the Netherlands, it was found that distress is characterized by various physical complaints, such as “headache, neck and shoulder pains, pressure in the chest, stomach ache, tingling sensations in arms and legs, back pain, and heart palpitations” (Borra, 2011, p. 667). Physical complaints of depression reported in the present study were almost the same with the physical complaints reported in Borra’s study.

The participants of the present study also used the Turkish word *sıkıntı* when describing a somatic distress and uneasiness inside them (*içimde).* Borra (2011) also noted that Turkish women use words *sıkıntı* and *bunalım* to express their feelings of distress. *Sıkıntı* included feelings of tension or pressure in the chest and feelings of suffocation or choking (Borra, 2011). The use of this idiom by Turkish people when reporting their somatic complaints has been previously reported in the literature. Gailly (1997), who investigated the psychological distress and health problems of Turkish migrants in Belgium, found that adult Turks particularly reported *sıkıntı* (tightness or oppressed) and backache. Similarly, Mirdal (1985) investigated physical, psychological, and social conditions of Turkish women living in Denmark. She found that Turkish women reported many somatic complaints and *sıkıntı* was reported by 71% of the participants. It can be concluded that the word *sıkıntı* refers to a somatic aspect of depression for Turkish people.

Culture can help explain such frequent use of the idiom *sıkıntı* by the participants. Distress is not openly expressed in some cultures. Through normative definitions of what is desirable or undesirable, culture creates appropriate ways of articulating distress (Baarnhielm, 2003). Somatic symptoms are such a way of presenting emotional distress (Baarnhielm, 2003). From this perspective, somatization can be a physical idiom of distress to communicate personal problems

(Kleinman, 1988, p. 57) that is normative and adaptive in some cultures. Turkey is considered as a tight society in which indirect expression of emotions is valued (Hofstede, 1991; Cimilli, 1997). Also, *deviant* behavior is not tolerated in tight societies including Turkey (Gelfand et al., 2011). Open expression of distress is avoided and physical complaints attract more attention than psychological complaints in Turkey. Stigma associated with psychological disorders also contributes to this situation. Mental illness is regarded as a *deviation* from normality and psychological disorders are stigmatized and associated with embarrassment more than physical disorders (Alonso et al., 2008; Corrigan, 2000). Therefore, somatic symptoms may help normalize emotional distress and attract attention of others while avoiding stigma in Turkey. From this point of view, it can be argued that somatic experiences of depression are at the forefront in tight societies including Turkey. Therefore, somatic complaints of the participants such as *sıkıntı* can be considered as a culturally accepted way of articulating depressive suffering in Turkey.

The participants of the present study indicated that their occupational and educational lives were jeopardized, they had financial difficulties, and their daily routines and social life were restricted due to the experience of depressive disorder. This finding is consistent with the DSM criteria for major depressive disorder indicating that “the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2013, p. 161). In individuals with milder depression, functioning may appear normal but requires increased effort (American Psychiatric Association, 2013, p. 163). If depression lasts longer, such restrictions can bring about life-long consequences. The authors of the DSM also pointed out that depressed individuals may have difficulty satisfying their basic self-care needs (American Psychiatric Association, 2013, p. 167). It can be concluded that depressive disorder causes marked disability and creates major problems in individuals’ lives; therefore, development of appropriate social and clinical interventions is crucial.

The second superordinate theme of the present study was *others’ reactions.* Others’ reactions to the participants and their depressive disorder were grouped under this theme, which revealed three subordinate themes: intentional attacks, unintentional insults, and minimization and disbelief. The comments included in this theme showed that there definitely is mental illness stigma. Stangor and Crandal (2003, p. 18) argued that mental illnesses are universally stigmatized health conditions. The findings of the present study supported this argument. The participants narrated various stigma experiences of mental illness. Three components of stigma, stereotypes, prejudice, and discrimination, became evident in the narrations of the participants. Stigma experiences of the participants included being labeled with common mental illness stereotypes, such as *insane, dangerous, crazy,* and *incapable,* being treated as inferior, being judged, ridiculed, and humiliated, being rejected, and being discriminated. Others' stigmatizing reactions were differentiated in intentionality based on the participants' evaluations. For example, the participants considered abovementioned reactions intentional. On the other hand, the participants evaluated some other reactions as unintentional behaviors carrying no aim to hurt them. They were, nevertheless, offended by such reactions, which were still insulting and stigmatizing. For instance, being treated differently, being exposed to tactless comments and curious questions, others' attempt to keep the participant's disorder as a secret as if it was something shameful, and others' intolerant behaviors towards the participant were some of the unintentional reactions that the participants encountered. Both intentional attacks and unintentional insults demonstrated that mental illness stigma is deeply embedded in culture and shapes people's behaviors. Because such reactions seemed to stem from the societal conceptualization of individuals with depressive disorders, which was highly stigmatizing, as discussed in introduction part. While some were intentionally labeling, humiliating, and discriminating those with mental illness; others hold stigmatizing attitudes towards individuals with depressive disorders without conscious awareness.

Researchers who previously investigated mental illness stigma also reported responses and reactions towards individuals with mental illness, such as devaluation, stereotyping, biased judgments, and unfavorable behaviors (Biernat & Dovidio, 2003, p. 103; Farina, 1982). Stereotypes regarding individuals with mental illness included sickness, incompetence, character weakness, worthlessness, dangerousness, coldness, and being unpredictable (Corrigan & Kleinlein, 2005, p. 16; Crumpton, Weinstein, Acker, & Annis, 1967). Thirty two percent of the responders in the General Social Survey (GSS) believed that someone with major depression would be dangerous (Pescosolido et al., 2010). Similarly, 50.5 % of the participants of a study in Turkey indicated that individuals with depression would be dangerous (Taşkın et al., 2006). The stereotypes reported in the present study, such as being *weak, sick,* *incapable, insane,* and *dangerous,* correspond to such stereotypes of individuals with mental illness and depressed people.

The participants in the present study stated that they were rejected and avoided due to their depressive disorder. They were excluded from social spheres. Some of the participants even stated that they were not considered as prospective partners due to their depressive disorder. This finding of the study is not surprising when similar findings in the literature are considered. It has been reported by several researchers that people desire to socially distance themselves from individuals with depressive disorders. GSS report revealed that 47% of the responders were unwilling to work with someone with major depression and 53% were unwilling to marry such people (Pescosolido et al., 2010). According to the results of a study conducted in Turkey, responders reported that they would not marry with someone with depression (75%), that they would not like it if they had a neighbor with depression (50%), and that they would not rent their house to someone with depression (57%) (Taşkın et al., 2006). Just as it is reported in national and international literature, people's tendency to socially distance themselves from individuals with depressive disorders was evident in the present study as well. Desire of social distance and acts of rejection, exclusion, and discrimination were included under intentional attacks theme in the present study.

Minimization and disbelief was the final subordinate theme under the superordinate theme of others' reactions. Apart from intentional attacks and unintentional insults, the participants also faced minimization and disbelief. The depressive experience of the participants was minimized and their disorder was regarded as trivial and insignificant. Moreover, they did not believe the validity of the participants' depressive experience so that they approached the participants with skepticism. They perceived the symptoms of the participants as exaggerated, made up, and willful. Therefore, they covertly blamed the participants for their situation. The findings of the present study regarding minimization, disbelief, and blaming were parallel with the findings in the relevant literature. Hinshaw and Stire (2008) found that depression could be stigmatized more than other psychological disorders if the symptoms were perceived as willful by the public. Similarly, when participants with depression had a chance to talk about their depression with others, they were told that they had so much to be glad (Y-Garcia et al., 2012). The participants in the same study expressed that they were told it (depression) is all in their heads. The findings of another study that investigated the responses to individuals with depressive disorders when they sought help for their depression from their families or friends showed that some family members rejected the validity of the participant's depression (Griffiths et al., 2011). It can be concluded that there is such a skeptical and accusatory mindset behind minimization and disbelief. It is as devastating as intentional attacks and unintentional insults for individuals with depressive disorders. It delegitimizes the "disorder" status of depressive disorders and it leaves individuals with depressive disorders invalidated, disappointed, frustrated, and helpless.

Reactions such as minimization and disbelief appear to be specific to depressive disorders. Such reactions were not reported for individuals with psychotic disorders. Public reactions to psychotic disorders included misunderstanding, social distance, negative labeling and stereotyping, and discriminatory behaviors (Burke et al., 2016; Wood et al., 2018). Individuals with depressive disorders, however, were more prone to minimization, disbelief, and accusation. People were more likely to blame individuals with depression if their depression could not be explained by a sufficiently severe source of distress (Barney et al., 2009). The reason why people with depressive and psychotic disorders receive different reactions might be related to the difference in causal attributions. Development of schizophrenia-spectrum disorders is attributed more to biological causes while development of depressive disorders is attributed more to usual ups and downs of life (Pescosolido et al., 2010).

Effects of disorder experiences and others' reactions on self was another superordinate theme of the present study. It encapsulated the effects of the disorder itself, others' reactions, and the internalization of mental health stigma on the participants. The participants' self-esteem was seriously challenged and severely damaged by the diagnosis and experience of depressive disorder. Self-concepts of the participants were damaged and reshaped by the disorder experience. The participants felt themselves different, inadequate, like a loser, half-human, deficient, and useless due to their disorders. They described themselves as an idiot, worthless, and guilty due to the diagnosis. The finding of the present study regarding self-esteem and self-concept was parallel with previous research. Researchers previously reported that internalization of stigma causes lower self-esteem and is a threat to the well-being of individuals with mental illness (Wahl, 1999). Individuals with mental illness believe that they are valued less because of their mental disorder (Link & Phelan, 2001). It seems that self-esteem of individuals with depressive disorders are at risk in depression experience and their self-definitions are challenged to a great extent.

It also seems that two factors interacted and contributed to formation of negative self-concept in the participants. First, negative thoughts about oneself and low self-esteem are cognitive symptoms of depressive disorders (Beck, 1987). Secondly, society conceptualizes individuals with depression with extremely negative stereotypes, such as *sick, weak, incapable, worthless*, and *dangerous* (Corrigan & Kleinlein, 2005, p. 16; Crumpton et al., 1967). Internalization of such stereotypes by the participants seems to be another contributor to negative self-concept in the participants. Stated differently, one is already inclined to interpret herself or himself negatively and has a negative self-concept as a part of depression experience. This inclination is multiplied with internalized stigma. These two factors seemed to be mixed and they perpetuated each other. This interaction also seems to be specific to depressive disorders, which might make depression difficult to treat.

The participants of the present study differed in terms of how much they internalized public stigma of depressive disorders and how much their self-esteem was damaged. All of the participants were aware of public stigma of mental illness; however, not all of them suffered from significant harm due to stigma. According to stage model of stigma proposed by Corrigan, Rafacz, and Rüsch (2011), individuals internalize stigma through a series of successive stages. In the awareness stage, a person with mental illness is aware of the public stigma about mental illnesses. In the agreement stage, the person agrees with the public stigma and endorses that negative stereotypes are true about people with mental illness. In the application stage, the person applies the stereotypes to herself or himself. Finally, the person suffers from significant harm because of decreases in self-esteem and self-efficacy, which constitutes the harm stage. This model is applicable to the participants of the present study and explains why each participant did not experience loss of significant self-esteem.

Depression persistency seemed to be another key factor in the degree to which a participant internalized public stigma. The participants with more persistent depression internalized public stigma more as it became evident in their self-descriptions, self-criticism, and self-blame. Their self-descriptions were in line with the stereotypes of the depressed. In addition, they criticized and blamed themselves in line with the stigmatizing attitudes towards individuals with depressive disorders in society. However, the participants with temporary depression expressed less self-stigmatizing thoughts. A quantitative study explored that the participants who had significantly longer duration of mental disorder, had significantly higher levels of internalized stigma of mental illness (Yeşil & Han-Almış, 2016). Longer duration of disorder may bring about higher internalized stigma via damaged self-esteem and self-efficacy (Yeşil & Han Almış, 2016). The present study supports this finding that the participants with persistent depression may have experienced more stigmatizing incidents and had more time to internalize stigma. Therefore, they may lose self-esteem more than those with temporary depression. Longer duration of depression appears as a risk factor for individuals with depressive disorders regarding self-stigma.

The participants with more persistent depression and those with single episode of depression differed in describing their self-concepts. The participants with temporary depression expressed that although they adopted negative views about themselves during their depressive episodes, they viewed themselves positively in general. On the other hand, participants with persistent depression described themselves in persistently negative ways. They had difficulty thinking about a self that is independent from their disorder. The deeply rooted *sick self* could be about experiencing a progressive sense of failure and worthlessness while trying to cope with persistent depression. Also, they might have had more time to internalize public stigma. The formation of new selves, such as a sick self, could be about alteration of self in depression experience (Rhodes & Smith, 2010). The experience of being the same person over time is challenged in depression experience.

The experiences of new selves and identities reported in the present study were quite similar with emergence of new selves and identities in depression experience reported in the literature. Participants with depression frequently reported loss of self in qualitative studies (Ridge, 2009, p. 64). Loss of self involves loss of former abilities, identities, and relationships (Ridge, 2009, p. 64). Previous sense of self is lost in depression and this loss occurs in both personal and public domains. The participant loses her or his sense of being the same person and former identity in social spheres. Then, she or he begins to be represented with her or his disorder in society: *psychiatric patient*. She or he carries this identity in the view of public whether she or he wants it or not. This identity becomes an inseparable part of her or him. Sick self and the identity of psychiatric patient become integral to the participants. Similarly, Manning (1994), for instance, suffered from severe depression and reflected on losing her pre-illness sense of self and struggling to find a post-illness sense of self. Her post-illness sense of self had lots of shame and many failures in life. Styron (1990, pp. 64-65) mentioned the duality of self in the experience of depression. While the first self is his struggling part, the second self is fed up by depression. Karp and Birk (2013, p. 34) also pointed out how depression initiated new and unfamiliar identities, such as mental illness identity. While depression is a very private experience, it becomes public with mental illness identity. It becomes an identity that one cannot separate herself or himself from. Everybody begins to know about one's psychiatric history. Therefore, it can be concluded that depression initiates the formation of new selves and identities, if lasts long. The present study had a heterogeneous sample of individuals with temporary and persistent depression. Therefore, findings revealed diverse effects of depressive disorder and stigma on self and identity. In future research, distinctive experiences of individuals with persistent depression should be examined closer regarding self and identity.

Other effects of disorder experience and others' reactions on the participants included *secrecy, disconnection, anticipation of stigma*, and *resentment*. It is noteworthy that some of the participants described their depressive disorder in physical terms, such as blood clot or insomnia, in order to keep it as a secret. The need to physicalize the mental disorder can be explained with the need to avoid shame. Alonso and colleagues (2008) found that individuals suffering from mental illnesses reported much more explicit discrimination and embarrassment than individuals with physical illnesses. Some of the participants reported that they disclosed their disorder selectively only to those whom they perceived as trustworthy. Although selective disclosure is included in secrecy part in the present study, it was conceptualized as a behavioral coping mechanism in some studies (Ilic et al., 2014). The coping aspect of selective disclosure was also relevant for the participants. The participants avoided adverse reactions of people through selective disclosure.

The participants also anticipated being stigmatized; being labeled, offended, judged, excluded, and betrayed in daily interactions due to their depressive disorder. Correlational studies revealed that experiences of discrimination due to one's mental illness are associated with increased anticipated discrimination and stigma and greater internalized stigma (Quinn, Williams, & Weisz, 2015). Also, the participants who internalized mental illness stigma anticipated more stigma because they deemed themselves deserving of such stigma. Such an anticipation may have led them to change their behaviors and adopt behaviors that evoke further stigmatization. This process is called self-fulfilling prophecy. Self-fulfilling prophecy is defined as a process where individuals are more likely to behave in ways that confirm those stereotypes about themselves once they are aware of them. This creates a cycle that constantly perpetuates stigma (Ottati, Bodenhausen, & Newman, 2005, p. 111).

Disconnection was another effect of the disorder and others' reactions towards the participants. The participants felt disconnected and isolated; they were socially withdrawn; and they isolated and excluded themselves because they experienced stigma, anticipated stigma, or internalized stigma. It was suggested by Karp (1996, p. 597) that depression is an illness of isolation and disconnection, and awareness of the stigma attached to mental illnesses leads to further disconnection. It was also reported that internalization of stigma correlates positively with self-isolation (Livingston & Boyd, 2010) and hinders help-seeking behavior (Barney, Griffiths, Jorm, & Christensen, 2006). Therefore, stigma related variables such as internalized stigma contribute to a state of disconnection, specifically in individuals with depressive disorders. Disconnection may also stem from depressive experience itself since depression is characterized by disconnection from relationships (Karp, 1996; Hetherington & Stoppard, 2002). The contribution of both the disorder itself and the stigma to disconnection in individuals with depressive disorders seems to be mixed.

Finally, the participants were offended in relation to the stigmatizing attitudes of others. The participants felt sad, hurt, demoralized, and irritated when they encountered stigma. Family, friends, and society created feelings of resentment. This finding is consistent with the findings that family members and friends along with overall society display stigmatizing attitudes towards individuals with mental illness (Arkar & Eker, 1992), and individuals with mental illness get disappointed and upset owing to their stigmatizing attitudes (Griffiths et al., 2011).

The fourth superordinate theme of the present study was *meaning-making*. It consisted of the participants' meaning-making efforts regarding the diagnosis itself, the causes of the disorder, and experience of depressive disorder. Meaning-making is at the heart of mental illness experience (Karp & Birk, 2013, p. 28). The participants reported factors that have triggered their depression such as relational factors, such as separation, abandonment, loneliness, and lack of social support; stress factors, such as pressure and problems at work, financial problems, suicide attempt of a family member, and facing violence; and health-related factors such as high blood pressure. Similarly, Mazure (1998) suggested that 80% of depressive episodes were preceded by major life events. Kessler (1997) reported precipitating events, such as disasters and widowhood. Paykel (2003) pointed out relational factors where depression is often triggered by separations and bereavements. Ziebland (2006) also reported that people experience difficult life events and losses before the onset of depression. Finally, according to DSM-5, stressful life events, such as chronic diseases or disabling medical conditions may be precipitants of major depressive disorder (American Psychiatric Association, 2013, p. 166). Depression had a place and explanation in the participants' story and they had opinions about why they suffered.

The participants also made meaning of having depressive disorder by *normalizing* it. They reported that depressive disorder was like any other physical disorder. Deeming psychological disorders as equivalent to physical disorders was in line with the medical model which adopts the argument that mental illnesses originate from brain's biological dysfunctions (Ilic et al., 2014). The medical model has been not only a scientific model for mental illnesses but also a dominant folk model in Western societies (Engel, 1992). Similarly, the participants' normalizing their diagnosis and equating it to physical disorders in the present study may be an indication that the medical model is also gaining acceptance and popularity among the general public in Turkey. Yet, this might be a premature conclusion due to low generalizability of the present findings. In addition, normalizing may also be a cognitive coping strategy for the participants, because they normalized their depressive disorder just after talking about the stigmatizing attitudes they encountered. Ilic and colleagues (2014) reported that normalization was a cognitive coping strategy used to manage a stigmatized identity, such as *mental illness* identity.

The final superordinate theme of the present study was *coping.* To overcome difficulties of the disorder and stigma, the participants received social support, sought treatment, resisted stigma, and reframed the state of having depressive disorder cognitively. Social support helped the participants a lot in overcoming their depressive episodes. Thoits (2011) reviewed the relevant literature and concluded that impact of stress is buffered by perceived social support. Also, overall well-being is positively correlated with social support (Yalçın, 2015). It was found in the 2007 Australian National Survey of Mental Health and Well-being that higher social support was closely associated with lower levels of past year depression (Werner-Seidler et al., 2017). Individuals who recovered from major depression reported higher perceived emotional support from family and friends (Nasser & Overholser, 2005). Park and colleagues (2015) pointed out the need to create strong social support systems against depression. Therefore, social support has a significant place in coping resources of individuals with depressive disorders.

Seeking treatment was another way of coping with the disorder. The participants sought treatments through medication, hospitalization, and psychotherapy and they adhered to treatment. The participants narrated advantages of receiving treatment for their depressive disorder. Seeking treatment was an adaptive coping strategy for the participants. As many research findings indicate, treatments such as cognitive behavioral therapy, behavioral therapy, interpersonal therapy, antidepressant medications, group therapies, and outpatient and inpatient treatment programs were found to be effective in treating depression (Driessen et al., 2019; Hetrick et al., 2015; Keller et al., 2000; Mulrow et al., 2000; Pampallona et al., 2004). Therefore, seeking and receiving treatment is an effective way of coping with depressive disorders.

The participants also coped with stigma of mental illness by resisting it. They rejected stigma by overtly reacting to and confronting the stigmatizer. They asserted their own opinions, interpretations, and values in the face of stigma. Stigma resistance theme was similar to the coping response of challenging reported by Link and colleagues (1989). Accordingly, challenging involves direct and active confrontation of mental illness stigma and disagreeing with stigma explicitly (Link et al., 2002). Stigma resistance is defined as an ongoing and active process in which one uses her or his experiences, knowledge, and sets of skills at personal, peer, and public levels (Firmin et al., 2017). Stigma resistance helps to develop a positive identity for individuals with mental illness. Stigma resistance at the personal level refers to not believing stigma and challenging stigmatizing thoughts, proving stigma wrong by empowering self and maintaining recovery, and developing a meaningful identity apart from mental illness. Stigma resistance at the peer level refers to helping others fight stigma, and at the public level involves education, disclosing one’s lived experience, advocacy, and challenging stigma. (Firmin et al., 2017). Stigma resistance is also conceptualized as actively challenging and deflecting stigma (Thoits, 2011), being unaffected by stigmatized attitudes (Ritsher & Phelan, 2004), and holding a positive illness identity (King et al., 2007). The participants of the present study, similarly, used several stigma resistance strategies, such as challenging stigmatizing thoughts, education, and being unaffected by stigma. Yet, positive illness identity was not observed among the participants. Although stigma resistance was conceptualized in some of the studies as a broad construct including but not limited to coping (Thoits & Link, 2015), it was considered as a form coping in the present study.

Contrary to the expectation, stigma resistance was not dependent on the level of self-stigma among the participants. It was observed that the participants internalized the stigma associated with depressive disorders in different stages according to progressive model of self-stigma (Corrigan, Rafacz, & Rüsch, 2011). Some of the participants were only in the awareness stage of public stigma about depressive disorders while some of them proceeded to agreement stage in which they agreed with the public stigma and endorsed it. Some others proceeded to application and harm stages in which they applied negative stereotypes to themselves and consequently, suffered from significant harm. It was expected that the participants who were in early stages of the self-stigma model would resist stigma more. Interestingly, the participants highly criticizing, blaming, and stigmatizing themselves showed reactions to stigma from others and defended themselves. Stigma resistance worked effectively as a behavioral coping mechanism for them.

Finally, the participants coped with the adverse effects of the diagnosis by cognitively reframing the experience of having depressive disorder. The participants re-analyzed and re-addressed their situation in a way that helped them cope better. For instance, they compared themselves with those who suffer from psychological disorders much more than they do and they found themselves in a better situation. Ilic and colleagues (2014) reported that selective downward comparison with others who are worse off is a cognitive strategy employed by individuals with mental illness to improve self-esteem. Downward social comparisons also provide a relief from disequilibrium and regulate negative emotions.

In addition, some of the participants deployed a religious point of view to depressive disorders and conceptualized their disorder as a test of God and as fate, which relieved them via acceptance and decreased feelings of incompetency.

Religious coping also helped the participants by preventing suicide. Religious coping is a strategy used by individuals with depressive disorder and refers to the use of religious beliefs to cope with stressful and difficult life circumstances (Kataria et al., 2016). Religious beliefs provide a meaning for difficult life experiences and a purpose to cope with them. In a study conducted in India, it was found that the participants who responded to treatment were those who employed positive religious coping more (Kataria et al., 2016). Similarly, in another study, it was found that positive religious coping buffered major depressive disorder in individuals with chronic conditions in communities using religious coping, such as Caribbean Blacks (Assari, 2014). According to public surveys, almost 90% of people in Turkey identify themselves as religious (Çarkoğlu & Kalaycıoğlu, 2009). Therefore, religion plays an important role in adding meaning to mental illnesses as well as in coping with it. Considering the high percentage of people who identify as religious in Turkey, religious understandings and coping should be taken into account in psychotherapy as well.

In summary, mental illness stigma was identified as a prominent issue embedded in Turkish cultural context for individuals with depressive disorders. Such individuals are represented with negative stereotypes, such as weak, sick, incapable, crazy, foolish, and dangerous. They encounter negative reactions, such as dislike, derogation, inferiority, prejudice, discriminations, insults, accusation, minimization, and disbelief. Individuals with depressive disorders encounter the difficulties of both mental illness stigma and depressive disorder itself. They have to cope with these difficulties simultaneously. Moreover, internalized stigma of mental illness makes things more complicated. A depressive mind is a fertile ground where self-stigmatizing thoughts can reproduce. Individual efforts to tackle stigma of mental illness are valuable, but societal conceptions about mental illnesses and depression can make it more difficult for depressed individuals to cope.

The most striking finding of the present study was people’s reactions to depressive disorders, including accusation, minimization, and disbelief. Depression was not seen as a medical condition or as serious as physical diseases or as schizophrenia-spectrum disorders. Those who have schizophrenia-spectrum disorders are perceived as dangerous, others want to keep their social distance from them, and they face discrimination rather than disbelief (Burke et al., 2016; Wood et al., 2018). Depressive disorders, on the other hand, may not even be acknowledged as disorder.

Depressive disorders are rather “all in your head” conditions among public. Individuals with depressive disorders are told that they do not need medications and they can treat themselves on their own. It is implied that depression originates from their own incompetency rather than a medical cause, like in schizophrenia. The findings of the present study, therefore, contributed to the relevant literature by emphasizing unique difficulties of individuals with depressive disorders.

Clinical Implications

The present study aimed to investigate the experiences of individuals with depressive disorders living in Turkey. Mental illness stigma was identified as a prominent issue, affecting individuals with depressive disorders in their social interactions. People may even stigmatize individuals with depressive disorders without being consciously aware of it. Clinicians and other mental health staff may also stigmatize individuals with depressive disorders consciously or unconsciously. Li and colleagues (2014) reported that people with mental illness experience mental illness stigma even in healthcare settings. Therefore, clinicians and other staff should be aware of their own conceptions about depressive disorder and should consider whether they have stigmatizing views of individuals with depressive disorders. Clinicians and other mental health staff might want to learn about micro-aggressions defined by Sue (2010). As suggested by Sue, microaggressions do not consist only of blatant physical or verbal assaults, but also take the form of behaviors, comments, or questions that have subtle insulting messages. Microaggression can also dismiss thoughts, feelings, and the experiential reality of individuals (Sue, 2010). Therefore, psychotherapists should be aware of their assumptions, beliefs, and feelings regarding individuals with depressive disorders while working with them.

Stigma and related issues should be discussed with individuals with depressive disorders when they arise during psychotherapy. Stigma is a risk factor in the prognosis and outcome of depression. Therefore, therapists should explore whether clients encounter stigmatizing attitudes in family, among friends, in the workplace, at school, or among public. If so, therapists should invite the clients to talk about how they feel about and cope with stigma. The therapist can especially explore whether the client faces attitudes of accusation, minimization, and disbelief. Experiential reality of clients about depressive disorder and their feelings should be validated. It should also be explored whether clients internalize the accusations, minimization, and disbelief, and whether they criticize and blame themselves. Clients should be empowered in developing a positive and confirming self and identity.

Psychotherapists should pay special attention to internalized stigma of mental illness. Internalized stigma is a greater threat to clients' wellbeing than stigma itself, because it may lead to a negative self-concept, isolation, and a negative prognosis of disorder. According to the stage model of self-stigma (Corrigan, Rafacz, & Rüsch, 2011), individuals stigmatize themselves in different degrees. Although they may be aware of the stigma among public, they may not agree with the stigma or internalize the stigma. Only those who apply stigma to themselves suffer from significant harm such as losses of self-esteem, self-efficacy, confidence in one's future, self-isolation, and failing to pursue life-enhancing opportunities (Corrigan, 1998; Corrigan, Rafacz, & Rüsch, 2011). Therefore, therapists should explore in which stage clients are regarding self-stigma and build clinical interventions according to the self-stigma stage of the client. The issues related to clients' self-concepts should be addressed during the therapy sessions. Namely, the way the disorder and stigma shape their sense of self should be addressed and clients should be supported in a way that they can develop a positive and confirming sense of self.

Therapists should pay attention to cultural idioms of distress, such as *sıkıntı*. It was found in the present study and in previous research that individuals in Turkey tend to express somatic suffering in depression with the word *sıkıntı* (Borra, 2011; Gailly, 1997; Mirdal, 1985). They refer to an inner distress and uneasiness with the phrase *içimde bir sıkıntı.* The use of this idiom might point to somatic symptoms in depressive disorder and a possible depressive episode in clients. The use of this idiom should call clinicians' attention to a possible depressive episode when they work with clients in Turkey.

The way clients see and interpret their disorder and how they make meaning of the disorder should be discussed with clients as well. Clients who interpret their disorder in religious ways may benefit from religious coping. The most prevalent religion in Turkey is Islam. IPSOS, which is a public opinion specialist company, published a report on religion and global trends and reported that 82% of population in Turkey is Muslim (IPSOS, 2016). According to Islamic doctrines, the world is a place of test, difficulties of life are tests of God, suicide is a strictly forbidden act, and Muslim should believe in fate, accept their fate and rely on God when they face difficulties. Such doctrines may shape the interpretations of individuals with depressive disorders regarding their disorder experience. Having depressive disorder can be conceptualized as a test of God and a fate, which may prevent individuals with depressive disorders from viewing their disorder as their fault or as a consequence of their incompetency. Rather, they may view depression as a test coming from God. Accordingly, individuals with depressive disorders may accept what comes from God and pray for recovery. This pattern of reframing depressive disorder and coping with it is a culture-specific pattern and should be kept in mind when working with Muslim clients. Clients who identify themselves as Muslim and interpret their depressive disorder in religious terms might benefit from such religious coping styles. Therefore, clinicians in Turkey should be informed about religious coping strategies used in Turkish cultural context and adaptive strategies should be promoted.

Finally, apart from therapeutic interventions, psychoeducation programs and peer groups can be helpful for individuals with depressive disorders to prevent internalization of stigma. As discussed, individuals with depressive disorders carry the risk of self-stigma. Psychoeducation programs that inform participants about depressive disorders, stigma, self-stigma, and coping ways with them can reduce negative feelings about the disorder. Such programs can target self-stigmatizing beliefs, enhance quality of life, and thus empower individuals with depressive disorders. In addition, peer groups consisting of individuals with similar experiences also empower individuals with depressive disorders by enabling them to experience universality of their experience and to learn from each other about how to cope with disorder and stigma. Psychoeducation programs and peer groups were found to be effective in reducing internalized stigma in individuals with mental illnesses including depressed older adults (Conner et al., 2015; Ivezic, Sesar, & Muzinic, 2017; Lucksted et al., 2011).

Limitations and Strengths of the Study

The present study has certain limitations. First of all, this study consisted of a sample of individuals with both persistent and temporary depression. During data collection and analysis processes, it was realized that experiences of individuals with persistent and temporary depression differed to a great extent. Whether participants experienced persistent or single episode of depression affected the degree to which their self-concepts was shaped by the disorder, encountered and internalized stigma, and the degree to which their self-esteem was damaged by the disorder and stigma. Even though the author of the present study tried to differentiate the effects of different types of depression, a more homogenous sample might have provided more detailed results. Therefore, future research should focus on experiences of individuals with persistent and temporary depression separately.

Moreover, it was realized that one of the questions asked during interviews was consistently misunderstood by the participants. They were asked whether their feelings, thoughts, and beliefs about themselves changed when they were first diagnosed with depressive disorder. Although the word *belief* referred to their beliefs about themselves, the participants understand this word as religious beliefs and said that their beliefs did not change. Some of the participants shifted the interview to religious issues after this question. The researcher tried to clarify the intended meaning of the word and repeated the question by paraphrasing it, but the participants consistently misunderstood it.

Finally, the present study recruited a sample consisting of individuals who were hospitalized due to a depressive disorder. Hospitalization history was one of the inclusion criteria, because it was thought that it would provide a sample for which stigma was more salient. Yet, the stigma of hospitalization might have interfered with the results, because hospitalization can be a stigmatized condition on its own. When one is hospitalized due to a psychiatric condition, she or he might be exposed to mental illness stigma regardless of her or his diagnosis. Therefore, the stigma found in this study might partially be the stigma of hospitalization.

On the other hand, the present study has many strengths. This was the first known study examining lived experiences of individuals diagnosed with depressive disorders from their own perspectives regarding stigma associated with depressive disorders in Turkish cultural context. Raising voices of individuals with depressive disorders in Turkey, this study attempted to make their experiences visible to clinicians and other mental health professionals. Hopefully, this study will pave the way for further investigations in this subject. Also, this study presents and draws attention to unique issues and difficulties of individuals with depressive disorders. Future research should continue to explore issues and difficulties specific to depressive disorders.

In conclusion, this study investigated stigma experiences of individuals with depressive disorders in Turkey with a qualitative methodology. Stigma was identified as a prominent issue in lives of individuals with depressive disorders. Individuals with depressive disorders needed to cope with stigma along with the disorder itself, which made the process more complicated. They internalized public stigma in differing levels and suffered more harm as a consequence. Mental illness stigma in Turkey still stands as a prominent problem embedded within culture, which should be tackled.

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APPENDICES

APPENDIX A: DEMOGRAPHIC FORM

1. Cinsiyetiniz: Kadın ☐ Erkek ☐

   Diğer ☐ (lütfen belirtiniz: …………………..………….)
2. Yaşınız: ………
3. Mesleğiniz: ……………………........................
4. Medeni durumunuz: Evli ☐ Bekar ☐ Boşanmış ☐

   Dul ☐
5. Eğitim durumunuz: (en son aldığınız diplomaya göre)

   İlkokul ☐ Ortaokul ☐ Lise ☐ Üniversite ☐

   Yüksek Lisans ☐ Doktora ☐

6. Kendinizi hangi sosyo-ekonomik seviyeye ait hissediyorsunuz?

Düşük ☐ Orta ☐ Yüksek ☐

7. Aylık geliriniz (ortalama): ……………………………
8. Nerede yaşıyorsunuz? (ilçe ya da semt ve il) :

   ………………………………………….
9. Kim/kimler ile yaşıyorsunuz:

   ………………………………………………………...
10. Fiziksel rahatsızlığınız/rahatsızlıklarınız var mı? Varsa yazınız.

    Evet ☐ (………………………………)

    Hayır ☐
11. Tanı aldığınız psikolojik rahatsızlığınız/rahatsızlıklarınız var mı? Varsa hepsini yazınız.

Evet ☐ (……………………………………………………………)

Hayır ☐

12. (Varsa) Tanı aldığınız psikolojik rahatsızlığınız ne kadar süredir var? (ay/yıl olarak yazınız)

    …………………………

13. (Varsa) Tanı aldığınız psikolojik rahatsızlığınız/rahatsızlıklarınız için psikiyatri servisinde kalarak tedavi aldınız mı? Evetse, kaç defa ve ne kadar süre olduğunu yazınız.

    Evet ☐ (………………………………………………………..)

    Hayır ☐

14. (Varsa) Tanı aldığınız psikolojik rahatsızlığınız için kullandığınız ilaç(lar) nedir, ne kadar süredir kullanıyorsunuz/kullandınız?

    ………………………………………………………………..

APPENDIX B: BECK DEPRESSION INVENTORY-I

Aşağıda gruplar halinde bazı cümleler yazılıdır. Her gruptaki cümleleri dikkatle okuyunuz. BUGÜN DÂHİL, GEÇEN HAFTA içinde kendinizi nasıl hissettiğinizi en iyi anlatan cümleyi seçiniz. Seçmiş olduğunuz cümlenin yanındaki numarayı daire içine alınız. Seçiminizi yapmadan önce gruptaki cümlelerin hepsini dikkatle okuyunuz. Eğer bir grupta durumunuzu tarif eden birden fazla cümle varsa her birini daire içine alarak işaretleyiniz.

1. 0 Kendimi üzüntülü ve sıkıntılı hissetmiyorum.
   1 Kendimi üzüntülü ve sıkıntılı hissediyorum.
   2 Hep üzüntülü ve sıkıntılıyım. Bundan kurtulamıyorum.
   3 O kadar üzüntülü ve sıkıntılıyım ki artık dayanamıyorum.

2. 0 Gelecek hakkında umutsuz ve karamsar değilim.
   1 Gelecek hakkında karamsarım.
   2 Gelecekten beklediğim hiç bir şey yok.
   3 Geleceğim hakkında umutsuzum ve sanki hiçbir şey düzelmeyecekmiş gibi geliyor.

3. 0 Kendimi başarısız bir insan olarak görmüyorum.
   1 Çevremdeki birçok kişiden daha çok başarısızlıklarım olmuş gibi hissediyorum.
   2 Geçmişe baktığımda başarısızlıklarla dolu olduğunu görüyorum.
   3 Kendimi tümüyle başarısız bir kişi olarak görüyorum.

4. 0 Birçok şeyden eskisi kadar zevk alıyorum.
   1 Eskiden olduğu gibi her şeyden hoşlanmıyorum.
   2 Artık hiçbir şey bana tam anlamıyla zevk vermiyor.
   3 Her şeyden sıkılıyorum.

5. 0 Kendimi herhangi bir şekilde suçlu hissetmiyorum.
   1 Kendimi zaman zaman suçlu hissediyorum.
   2 Çoğu zaman kendimi suçlu hissediyorum.
   3 Kendimi her zaman suçlu hissediyorum.

6. 0 Bana cezalandırılmışım gibi gelmiyor.
   1 Cezalandırılabileceğimi seziyorum.
   2 Cezalandırılmayı bekliyorum.
   3 Cezalandırıldığımı hissediyorum.

7. 0 Kendimden memnunum.
1 Kendi kendimden pek memnun değilim.
2 Kendime çok kızıyorum.
3 Kendimden nefret ediyorum.

8. 0 Başkalarından daha kötü olduğumu sanmıyorum.
1 Zayıf yanlarım veya hatalarım için kendi kendimi eleştiririm.
2 Hatalarımdan dolayı her zaman kendimi kabahatli bulurum.
3 Her aksilik karşısında kendimi kabahatli bulurum.

9. 0 Kendimi öldürmek gibi bir düşüncem yok.
1 Zaman zaman kendimi öldürmeyi düşündüğüm oluyor fakat yapamıyorum.
2 Kendimi öldürmek isterdim.
3 Fırsatını bulsam kendimi öldürürüm.

10. 0 Her zamankinden fazla içimden ağlamak gelmiyor.
1 Zaman zaman içimden ağlamak geliyor.
2 Çoğu zaman ağlıyorum.
3 Eskiden ağlayabilirdim şimdi istesem de ağlayamıyorum.

11. 0 Şimdi her zaman olduğundan sinirli değilim.
1 Eskisine kıyasla daha kolay kızıyor ve sinirleniyorum.
2 Şimdi hep sinirliyim.
3 Bir zamanlar beni sinirlendiren şeyler şimdi hiç sinirlendirmiyor.

12. 0 Başkaları ile görüşmek, konuşmak isteğimi kaybetmedim.
1 Başkaları ile eskisinden daha az konuşmak, görüşmek istiyorum.
2 Başkaları ile konuşma görüşme isteğimi kaybettim.
3 Hiç kimseyle görüşüp konuşmak istemiyorum.

13. 0 Eskiden olduğu kadar kolay karar verebiliyorum.
1 Eskiden olduğu kadar kolay karar veremiyorum.
2 Karar verirken eskisine kıyasla çok güçlük çekiyorum.
3 Artık hiç karar veremiyorum.

14. 0 Aynada kendime baktığımda bir değişiklik görmüyorum.
1 Daha yaşlanmışım ve çirkinleşmişim gibi geliyor.
2 Görünüşümün çok değiştiğini ve daha çirkinleştiğimi hissediyorum.

3 Kendimi çok çirkin buluyorum.

15. 0 Eskisi kadar iyi çalışabiliyorum.
1 Bir şeyler yapabilmek için gayret göstermek gerekiyor.
2 Herhangi bir şeyi yapabilmek için kendimi çok zorlamak gerekiyor.
3 Hiçbir şey yapamıyorum.

16. 0 Her zamanki gibi iyi uyuyabiliyorum.
1 Eskiden olduğu gibi uyuyamıyorum.
2 Her zamankinden 1-2 saat daha erken uyanıyorum ve tekrar uyuyamıyorum.
3 Her zamankinden çok daha erken uyanıyorum ve tekrar uyuyamıyorum.

17. 0 Her zamankinden daha çabuk yorulmuyorum.
1 Her zamankinden daha çabuk yoruluyorum.
2 Yaptığım hemen her şey beni yoruyor.
3 Kendimi hiçbir şey yapamayacak kadar yorgun hissediyorum.

18. 0 İştahım her zamanki gibi.
1 İştahım eskisi kadar iyi değil.
2 İştahım çok azaldı.
3 Artık hiç iştahım yok.

19. 0 Son zamanlarda kilo vermedim.
1 İki kilodan fazla kilo verdim.
2 Dört kilodan fazla kilo verdim.
3 Altı kilodan fazla kilo verdim.

Daha az yiyerek kilo vermeye çalışıyorum
Evet ☐ Hayır ☐

20. 0 Sağlığım beni fazla endişelendirmiyor.
1 Ağrı, sancı, mide bozukluğu veya kabızlık gibi rahatsızlıklar beni endişelendiriyor.
2 Sağlığım beni endişelendirdiği için başka şeyleri düşünmek zorlaşıyor.
3 Sağlığım hakkında o kadar endişeliyim ki başka hiçbir şey düşünemiyorum.

21. 0 Son zamanlarda cinsel konulara olan ilgimde bir değişme fark etmedim.
1 Cinsel konulara eskisinden daha az ilgiliyim.
2 Cinsel konularla şimdi çok daha az ilgiliyim.
3 Cinsel konulara olan ilgimi tamamen kaybettim.

APPENDIX C: INTERVIEW QUESTIONS

1) Tanı
   a) Rahatsızlıklarınızdan dolayı bir tanı aldıysanız ne tanısı aldınız?
   b) Rahatsızlığınız nasıl başladı?
   c) Tanı alma süreciniz nasıl oldu?
   d) Tanı konduktan sonraki süreç nasıl oldu?
   e) (Majör Depresif Bozukluk için) kaç kez bu rahatsızlığı geçirdiniz?
      - Bu atakların şiddet derecesi nasıldı?
      - Bu atakların süresi ne kadardı?
      - Ataklar arasında ne kadar süre vardı?
   f) Başka tanınız var mı?
      - Varsa bu tanı/tanılar nedir?
      - Bu tanınızın depresyonunuz üzerinde etkisi nedir?
2) Tanının Anlamlandırılması
   a) Depresyon tanısı almak sizin için ne anlama geliyor?
   b) Depresyon tanısı almak hayatınızı nasıl etkiledi/etkiliyor?
3) Tanının Benlik Üzerindeki Etkileri
   a) Kendinizi nasıl biri olarak görüyorsunuz?
      - Kendinizle ilgili düşünceleriniz nelerdir?
      - Kendinizle ilgili inançlarınız nelerdir?
      - Kendinizle ilgili duygularınız nelerdir?
   b) Kendinizle ilgili duygu, düşünce ve inançlarınızın zaman zaman değiştiği oldu mu?
      - Olduysa bu değişimi neye bağlıyorsunuz?
   c) İlk kez tanı aldıktan sonra kendinizle ilgili duygu, düşünce ve inançlarınızda bir değişiklik oldu mu? Nasıl değişiklikler oldu?
   d) Hayatta ulaşmak istediğiniz hedefleriniz nelerdir?
      - Bu hedeflerinize ulaşmanızı kolaylaştıracak veya zorlaştıracak şeyler neler olabilir?
4) Sosyal Etkiler
   a) Depresyon tanısı aldığınızı çevrenizdekilerle paylaşıyor musunuz?

        - Evetse, kimlerle paylaşıyorsunuz?
            - Paylaştığınızda nasıl tepkiler alıyorsunuz?
        - Hayırsa, paylaşsanız nasıl tepkiler alacağınızı düşünüyorsunuz?
    b) Ailenizin depresyon tanısı almanız ile ilgili nasıl bir tavrı var?
        - Bu sizi nasıl etkiliyor?
    c) Sosyal çevrenizin (arkadaşlar) depresyon tanısı almanız ile ilgili nasıl bir tavrı var?
        - Bu sizi nasıl etkiliyor?
    d) Toplumda depresyon tanısı olan kişilere karşı nasıl bir tavır var?
        - Bu sizi nasıl etkiliyor?
    e) Depresyon tanınızdan ötürü (aile, iş, eğitim ortamlarında, sosyal ortamlarda) hiç olumsuz bir muamele ile karşılaştınız mı?
        - Karşılaştıysanız nasıl baş ettiniz?
    f) Depresyon tanınızdan ötürü (aile, iş, eğitim ortamlarında, sosyal ortamlarda) hiç açıktan açığa bir ayrımcılık ile karşılaştınız mı?
        - Karşılaştıysanız nasıl baş ettiniz?
    g) Depresyon tanınızdan ötürü (aile, iş, eğitim ortamlarında, sosyal ortamlarda) kasıtsız veya alttan alta olan ama size kendinizi kötü hissettiren bir muamele ile karşılaştınız mı?
        - Karşılaştıysanız nasıl baş ettiniz?

5) Damgalama
    a) Toplumda depresyon hastaları hakkında ne düşünülüyor?
    b) Toplumda depresyon hastalarına karşı nasıl bir muamele var?
6) İçselleştirilmiş Damgalama
    a) Siz, toplumda görülen bu genel fikre/fikirlere katılıyor musunuz?
    b) Sizce, bu düşünceler sizin için ne kadar uygun?
    c) Bu düşüncelerin sizin için geçerli olduğunu düşündüğünüzden dolayı hiç bir şeyden vazgeçtiğiniz/kendinizi geri çektiğiniz oldu mu? (örneğin iş başvurusu, evlilik teklifi, yeni eve çıkma vs.)
    d) Çevreden aldığınız olumsuz tavırlar sizin kendinizle ilgili duygu, düşünce ve inançlarınızı değiştirdi mi?
        - Değiştirdiyse bu değişim ne yönde oldu?

APPENDIX D: INFORMED CONSENT FORM

Bu araştırma, Orta Doğu Teknik Üniversitesi'nde Klinik Psikoloji Yüksek Lisans Programı öğrencilerinden Meryem Nur Şener tarafından, Doç. Dr. Deniz Canel-Çınarbaş danışmanlığında yürütülmektedir. Bu form sizi araştırma hakkında bilgilendirmek için hazırlanmıştır.

Çalışmanın Amacı Nedir?

Araştırmanın amacı, depresif bozukluk tanısına sahip bireylerin, toplumdaki ruhsal bozukluklar ile eşleştirilen damgalamayı nasıl deneyimlediklerini ve bu damgalamayı nasıl içselleştirdiklerini anlamaktır.

Bize Nasıl Yardımcı Olmanızı İsteyeceğiz?

Araştırmaya katılmayı kabul ederseniz, sizinle yaklaşık bir saat sürecek bir görüşme yapılarak kişisel deneyimleriniz ile ilgili açık uçlu sorular cevaplamanız beklenecektir. Görüşmeler, daha sonra analiz edilmek üzere ses kaydına alınacaktır.

Sizden Topladığımız Bilgileri Nasıl Kullanacağız?

Araştırmaya katılımınız tamamen gönüllülük esasına dayanmaktadır. Araştırmada sizden kimlik veya kurum belirleyici hiçbir bilgi istenmemektedir. Cevaplarınız tamamıyla gizli tutulacak ve sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan elde edilecek bilgiler toplu halde değerlendirilecek ve bilimsel yayınlarda kullanılacaktır.

Katılımınızla İlgili Bilmeniz Gerekenler:

Görüşme sırasında yöneltilecek olan sorular genel olarak rahatsızlık verici olmamakla birlikte, herhangi bir nedenden dolayı kendinizi rahatsız hissederseniz görüşmeyi bitirebilirsiniz. Böyle bir durumda görüşmeyi yürüten kişiye çalışmadan çıkmak istediğinizi söylemeniz yeterli olacaktır. Böyle bir durumda, sağladığınız bilgiler çalışmaya dahil edilmeyecektir.

Araştırmayla ilgili daha fazla bilgi almak isterseniz:

Bu çalışmaya katıldığınız için teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak isterseniz, Psikoloji Bölümü öğretim üyesi Doç. Dr. Deniz Canel-

Çınarbaş (e-posta: dcanel@metu.edu.tr), Klinik Psikoloji yüksek lisans öğrencisi Meryem Nur Şener (e-posta: meryem.sener@metu.edu.tr) ya da psikolog Didem Yağcı Yetkiner (e-posta: dyagci2002@yahoo.com) ile iletişim kurabilirsiniz.

Yukarıdaki bilgileri okudum ve bu çalışmaya tamamen gönüllü olarak katılıyorum.

(Formu doldurup imzaladıktan sonra uygulayıcıya geri veriniz).

İsim Soyisim Tarih İmza

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APPENDIX E: DEBRIEFING FORM

Bu araştırma, daha önce de belirtildiği gibi, Orta Doğu Teknik Üniversitesi'nde Klinik Psikoloji programında yüksek lisans öğrencisi Meryem Nur Şener tarafından, Doç. Dr. Deniz Canel-Çınarbaş danışmanlığındaki yüksek lisans tezi kapsamında yürütülmektedir. Araştırmanın amacı, depresif bozukluk tanısına sahip bireylerin, toplumdaki ruhsal bozukluklar ile eşleştirilen damgalamayı nasıl deneyimlediklerinin ve bu damgalamayı nasıl içselleştirdiklerinin daha iyi anlaşılmasına katkıda bulunmaktır.

Size yöneltilmiş olan sorular, tanı alma sürecinizi, bu tanıyı nasıl anlamlandırdığınızı, aldığınız tanının benlik üzerindeki etkilerini, aldığınız tanının sosyal etkilerini, damgalama ve içselleştirilmiş damgalamayı nasıl deneyimlediğinizi anlamak amacıyla hazırlanmıştır. Görüşmeler sırasında elde edilen veriler niteliksel olarak analiz edilecek ve Türkiye'de yaşayan depresif bozukluk tanısı almış olan bireylerin deneyimlerine ışık tutacaktır. Bu çalışma en genel anlamda, ruhsal bozukluklar ile eşleştirilen damgalama ve içselleştirilmiş damgalama hakkında farkındalık uyandırmayı amaçlamaktadır

Bu çalışmanın sonuçlarının Mayıs 2019'a dek elde edilmesi planlanmaktadır. Sizlerden elde edilen veriler, kimlik bilgilerinizi gizli tutacak şekilde, sadece bilimsel araştırma ve yazılarda kullanılacaktır. Çalışmanın sağlıklı ilerleyebilmesi ve bulguların güvenilir olması için çalışmaya katılacağını bildiğiniz diğer kişilerle çalışma ile ilgili detaylı bilgi paylaşımında bulunmamanızı dileriz. Bu araştırmaya katıldığınız için çok teşekkür ederiz.

Araştırmanın sonuçlarını öğrenmek ya da daha fazla bilgi almak için aşağıdaki isimlere başvurabilirsiniz.

Doç. Dr. Deniz Canel-Çınarbaş (dcanel@metu.edu.tr)

Psk. Meryem Nur Şener (meryem.sener@metu.edu.tr)

Uzm. Psk. Didem Yağcı Yetkiner (dyagci2002@yahoo.com)

APPENDIX F: QUOTATIONS

“Ya hasta olduğumu şey ediyorum ruhen bir çöküntü geliyor kendini boşlukta buluyorsun.” (Participant 2)

“Sürekli kafamda böyle düşünceler, olumsuz düşünceler yani. Kötü bir şey olacakmış gibi başıma bir şey gelecekmiş gibi. İşte hep olumsuz yani böyle ölüm korkusu gibi.” (Participant 13)

“Bunlar şiddetli değildi. İkincisi şiddetliydi göğsüme ağrı geldi böyle. İkincisinde de uyuyamamaya başlayınca.” (Participant 11)

“İşte o psikolojikmen nedenden dolayı ben işten ayrılmak zorunda kaldım.” (Participant 3)

“Mesela herkes seni dışlıyor o zaman sahip çıkılacağı yerde çıkmıyor.” (Participant 11)

“Mesela kayınvalidem geçen bana şey diyor sen ne zaman düzeleceksin belki kötü niyetle demedi ama bana kötü hissettiriyor” (Participant 14)

“Toplum anlamıyor ki bu derdi yaşamayan bilmiyor ne var sıkılacak. … Ben hayran mıyım acı çekmeye ben mecbur muyum acı çekmeye ben hasret miyim yoo ama işte” (Participant 14)

“İşte kendimi böyle yarım insan gibi hissettim.” (Participant 1)

“Hiç de paylaşmadım senden başka.” (Participant 11)

“Sosyal bir insandım. Çevremle barışıktım. Kendi yakınlarımdan böle şeyler görünce bütün insanlardan uzaklaştım.” (Participant 10)

“Bu konuda bilinçli de değil. … Toplum çok takıyordu yani bir doktora gitmek duyulursa edilirse ne olur bu düşünceler vardı.” (Participant 9)

“İlk başlarda tepkiler aldım ilk başlarda canım sıkılıyordu böyle aşırı derecede canım sıkılıyordu.” (Participant 12)

“Ben daha önce evlendim, boşandım. Önceki eşimden şiddet gördüm. Bayağı üç yıl çok aşırı zor günler yaşadım. … Zannediyorum temelleri orada atıldı bana depresyonun. Ondan öncesinde bir şey yoktu çünkü.” (Participant 9)

“Sonuçta bu da bir rahatsızlık. Her insanın başına gelebiliyor.” (Participant 10)

“Tabi ailemin de çok önemli rolü var burada. Sürekli gezdirdiler işte. .... Ablam alışverişe çıkarttı. … Yani toparlanmamda onların da yardımı da oldu, tek başıma değil. Yani onlarla almasaydım belki o zamanlar belki çok uzun sürede geçirirdim, atlatırdım.” (Participant 9)

“Ben zaten sürekli ilaç kullanıyorum. Sürekli kontrol altındayım ben. İlacım bittikçe yazdırıyorum ilacı alıyorum.” (Participant 8)

“Ben deliysem deliyim diyorum. Ben memnunum diyorum hastaneye yatmaktan diyorum.” (Participant 3)

“Biz deli değiliz biz sadece buraya bir tedavi olmaya geldik. Bizim sürecimiz bu. Biz deli değiliz sonuçta bizim bir rahatsızlığımız var biz bu rahatsızlığımızın tedavisini görüyoruz.” (Participant 8)

The Experience of Disorder

Affective Experiences of Disorder

“İlk şey de baya ağır geçirdim. Onda da sürekli yolda giderken bile durup dururken ağlama nöbeti geliyordu. Birisi selam verecek diye böyle endişeli geziyordum. Selam verse kavga etmek istiyordum.” (Participant 10)

“Ama böyle kendimi bir tuhaf hissediyorum oturuyorum sanki bana oturduğum yerde sanki için böyle eriyor mu desem sanki ölüm şeysi girmiş içime o derece. O derece kötü hissediyorum kendimi o zamanları hatırlıyorum da hiçbir şeyle onu kıyaslayamam yani şu an. Şu anda ölsem hani ölme şeysine gelsem o an hemen aklıma gelir yani. Böyle yoğun bir nasıl desem ağlama, böyle çok kötüydü ya, çaresizlik bu durumdan hiç kurtulamayacakmışım gibi o duygu zaten intihara sürüklüyor.” (Participant 13)

“Hiçbir şey zaten yapmak da istemiyorum zevk almıyorum hayattan yani bazen dışarıya çıkıyorum insanlar bana maket gibi geliyor artık diyorum ki niye var bu dünya keşke diyorum deprem olsa herkes ölse bitse dünya diyorum yani hani o derece istemiyorum hayatı.” (Participant 14)

“Yani o dönemde sabah biri günaydın dese küfretmiş gibi geliyordu bana. …. Yani sürekli biri bir şey desin de ölümüne gireyim diye bekliyordum yani. Aşırı bir agresiflik vardı o zaman.” (Participant 10)

“Artık benim savaşacak gücüm kalmadı çünkü hakikaten çok uğraştım yani hani kendimi motive etmek mesela şey yapardım sabah kalkmak canım istemiyor değil mi mesela sıkıntı geliyor hemen gider bir kahve yaparım mesela kendime moralim olsun müzik açarım bir şey artık onu da yapamıyorum yoruldum vücut istemiyor yani” (Participant 14)

“Hastaneye yatmadan önce zaten 1,5 sene önce psikolojim bozulmaya başlamıştı yani bayağı bir şey olmaya başlamıştım yani umutsuzluğa bir şeyler canım yapmak istemiyordu dediğim gibi kolum kalkmıyordu yataktan kalkasım gelmiyordu yani hiçbir şey yapasım gelmiyordu normalde böyle arkadaşlarıma gider otururum muhabbet eden bir insandım televizyon dahi hiç izleyesim gelmiyordu telefona bile bakasım gelmiyordu sanki bardak almak bile bana zor geliyordu yani elimdeki bardağı hani bırakmak bile zor geliyordu o derecedeydim o zaman isteksizdim hiçbir şekilde.” (Participant 6)

Cognitive Experiences of Disorder

“Ondan hiç çıkamayacağım bu düşünceden bu halden hiç çıkamayacağım düşüncesi sanki bende sürekli kalacak geçmeyecek o düşünce seni o zaman intihara sürükleme oluyor yani.” (Participant 13)

“Yani kendi emsallerim sanki beni dışlıyormuş gibi gördüm yani, çünkü hastalığın belirtileri. Acaba benim hastalığım için bir şey mi konuştu, adam yüzüme baksa nem kapıyorduk gülse nem kapıyorduk.” (Participant 2)

“Acaba diyorum yetersiz miyim aileme karşı çocuklarıma karşı ve sorumluluklarımda yetersiz mi kalıyorum ki işle ilgili yetersiz mi kalıyorum ki bu tarzda böyle karamsarlık çöküyor üzerime. … Acaba diyorum çözemeyecek miyim? Çözersem de çok geç mi çözülecek bu sorunlar gibi fikirler geliyor. En sık yaşadığım yani en sık derken böyle her hafta değil de belki 2-3 ayda bir yaşadığım şey bu.” (Participant 7)

Somatic Experiences of Disorder

“Çünkü yapabileceklerini yapamıyorsun halsizlik yorgunluk adapte olamıyorsun halsizlik gözlerine vuruyor ayaklarım sanki boşlukta basıyormuşum gibi geliyor kafayı adapte edemiyorsun kişiliğini yansıtamıyorsun yani.” (Participant 12)

“İşte nefes, onu söyledim. Nefes almada sorun kalpte bir ağrı. Hani kendimi ifade edemiyorum. Omuzlarımda ağrı, baş ağrısı.” (Participant 4)

“Yani sinirlerimin çok yıprandığı söylenmişti. Mesela zona geçirmişim ben farkında değilim. Bir şey dokundu diye düşünüyoruz. Sırtımda öyle çıban gibi bir şeyler. O zonaymış meğer. Her yerimi sivilce bastı. Saçlarım birden kısa bir zamanda beyazladı.” (Participant 9)

“Ya burama (göğüs bölgesi) böyle sıkıntı geliyor, içime darlık geliyor, mideme sanki böyle, sonra başım sanki böyle çatlıyormuş gibi, sanki böyle o anda panik gibi desem, ölecekmişim gibi bir his canım çıkacakmış gibi öyle bir his yani o.” (Participant 13)

Effects of Disorder on Other Domains

“Ya işte ben o zaman hemşire olacaktım kendime ev alacaktım araba alacaktım işte kendime göre ne bileyim hani kimseyle muhatap olmayacaktım kendi sosyal şeyim fazla olacaktı param olacaktı en azından. Ama bu olay olduktan sonra hastalanınca çalışamadım zaten hiç, … Yani benim hayatımı etkiledi yani ben çok şu anda pişmanlık var sinir yani sinir derken geçmişe yönelik kin nefret duygular hepsi karışık yani” (Participant 13)

“Etkilemez olur mu mesela mimar olacağım vakit doktor olacağım vakit olamadık olduk mu olamadık. Bizim zamanımızda üniversite şeysi yoktu 70 71 mezunuyum ben, tercih ettiğimiz okulda giriyorduk imtihana istediğimiz okula gidebiliyorduk yani. Öyleydi üniversite şeysi falan yoktu sınav falan yoktu girdiğimiz okulda sınava tabi tutuluyorduk mimarlığa gidebiliyordum bir şeye gidebiliyordum.” (Participant 2)

“Ondan sonra insanlarla diyaloğun zayıflıyor ondan sonra depresyon halinde insan kimseyle görüşmek istemez bazısı annesiyle babasıyla görüşmek istemez.” (Participant 2)

Others’ Reactions

Intentional Attacks

“Böyle depresyon tanısı verildiği zaman insana yeni sizi insan yerine koymayıp böyle dalga geçer gibi konuşma- benle hep öyle yapıldı zaten. Hep benle dalga geçer gibi mesela ben ciddi anlamda bir şey soruyorum karşımdaki kişiye o bana şaka ile atıyorum mesela yaşını soruyorum yaşını bana gülerek gerçek yaşını söylemiyor, farklı söylüyor. Benle dalga geçer gibi. Ama ben ona mesela ciddi bir şey soruyorum ama sen benle dalga geçer gibi cevap veriyorsun bu beni çok rahatsız ediyor işte o zamanlar. Hiç beni ciddiye almadılar. Hiç ciddiyete alınmadım yani hem ailemin içinde hem çevremin içinde. Beni kimse böyle dinlemek istemedi konuştuğum zaman beni dinlemek istemiyorlardı. Ki halen de öyle mesela ben konuşuyorum bir şey anlattığım zaman hemen konuştuğum kelimeyi bölüyorlar ve kesiyorlar kendileri başka bir konuya geçiyorlar. Söz kesme yani. Yani bu beni çok etkilemiştir. Halen de etkiliyor diyebilirim.” (Participant 8)

“Delisin diye şaka gerçek konuşanlar da oluyor karşımda. %40 rapor almıştım ben o zaman psikiyatriden, artık % 40 yetmez sen %46'lık olman lazım diyorlar. … Kardeşimin oğlu da askere gitmedi asker kaçaklığı yapıyor, bazen kardeşim takılıyor aynı teyzen gibi sen de deli hastanesine yatsan iyi olur bilmem ne şöyle böyle diye. Tavırlarla da karşılaşıyorum yani” (Participant 3)

“Cemaatin beni ilk önce isteyip de sonradan bir başımdan darp meselesi geçti 7-8 kişi darp etti yatsı namazından çıktıktan sonra onlar da psikopat yani kişilik bozukluğu var ondan sonra herkese sataşır böyle şey olarak mahkeme süreci falan şey yaptım cemaatimin biz bunu istemiyoruz psikolojik olarak kafa deli aslında beş para etmeyen insanların benim hakkımda eleştirel olması ve onlara karşı bir tepki göstermeyişim içime atışım bu yönde beni etkiledi yani” (Participant 12)

“Özellikle hastanede yatmaya kesinlikle olumsuz bakan var onu söyleyeyim ben hastanede yatanlara olumsuz diye bakıyorlar bu insan hastanede yatmış oğlu var mesela kızımı mı vereceğim diyen insanlar oluyor” (Participant 6)

Unintentional Insults

“Başım ağrıyordu aşırı derecede kimseye deme bak kimseye söyleme gibi böyle tepkiler aldım yani senin aleyhine olur diye, örtbas edici.” (Participant 12)

“Atıyorum toplumda ben mesela fazla kapalı alanda duramam. Derim mesela bir yere giderim atıyorum hastaneye gittiğim zaman dışarıda derim ki yanımda mesela sıra bekliyorsun baktım ki sıra dışarıya çıkarım bir anda hiç tanımadığın bir insanla konuşursun ya, o konuştuğun zaman açılıyorsun açılıyorsun diyorsun ki bir anda ben dışarıya çıkıyorum mesela sıram daha gelmemiş, e diyorsun istersen sen de gel ben pek fazla kapalı alanda duramıyorum çünkü rahatsızım psikiyatrik hastası dediğim zaman o anda o insanların yüz ifadesi zaten değişiyor.” (Participant 8)

“Mesela kayınvalidem geçen bana şey diyor sen ne zaman düzeleceksin belki kötü niyetle demedi ama bana kötü hissettiriyor. … Ya da mesela kayınpederim diyor ki bana nasılsın iyiyim diyemiyorum çünkü zaten sıkıntılıyım rahatsızım sonra bir şey demiyorum iyiyim diyeceksin diyor” (Participant 14)

Minimization and Disbelief

“Yani önceden paylaşmıyordum çünkü eleştiriyorlar ama şimdi söylüyorum mesela bazı şeyleri ama her şeyi de açık açık söyleyemiyorum çünkü eleştiriyorlar yani toplumun anlamıyor ki bu derdi yaşamayan bilmiyor ne var sıkılacak e yapma e yapmayıver e ne olacak e zaten duruversem ben duracağım ben hayran mıyım acı çekmeye ben mecbur muyum acı çekmeye ben hasret miyim yoo ama işte” (Participant 14)

“Sen kendini bunaltıyorsun diyorlar. Kendi beyninde bitecek sorun diyorlar. Hep kendin istiyorsun kendini deli ediyorsun diyorlar başka bir şey demiyorlar ki.” (Participant 3)

“Sürekli bana mızmızlanıp durma, hani bir derdimi paylaşayım uff hani dinlemek istemez. O çok var mesela. İşte yaşananlar olsun filan anlatayım diyeyim sıkılır dinlemez şey yapar yani … Yani çok şey yapmıyor mahsus yapıyormuşum gibi.” (Participant 4)

“Hasta olduğunuza da inanmıyorlar. Hasta olduğunuza inandırmak için ille bir tarafınızdan kan mı akması lazım. Ağzın burnun birbirine mi karışsın? … Hastayım dediğiniz zaman karşınızdaki insan fiziksel bir rahatsızlık veya göreceli bir şey bekliyor.” (Participant 10)

“Çok zor bir hastalık zevk alamamak hayattan yaşamdan tat alamamak annem hani diyor zorlayacaksın kendini sen hep düşünüyorsun hani düşüncelerini şey yapma sen artık eve kendini odaklanmışsın yani bence çok zor ya ben dedim ya Allah’ım affetsin keşke dedim kanser olsam yani çünkü dedim ki kanser olsaydım dedim ya tedavi olur düzelirdim ya da ölür giderdim bir de insanlar o zaman daha çok hasta gözüyle bakıyor çünkü bir şey var ve kanser ya da bacağın kırık değil mi bu hasta kalkamaz bacağı kırık ama bu gibi hastalıklara insanlar bu gözle bakmıyor” (Participant 14)

“Var e biz de diyorlar mesela iyileşeceğim de iyi düşüne ben zaten bunları salak mıyım bunları kendime zaten söylüyorum ama o sıkıntı falan geldiği zaman rahatsızlık beni bunalttığı zaman sen ne kadar iyileşeceğim dersen de yaşıyorsun o anı güvenin kalmıyor ki hayata” (Participant 14)

Effects of Disorder Experiences and Others’ Reactions on Self

Challenge to Self-Esteem

“İlk hastaneye yattığım zaman o zamanlar zaten ben buraya nasıl düştüm nasıl bu duruma geldim” (Participant 6)

“O zamanlar şeydi. Çevremde hiç kimse depresyon yani psikolojik tedavi görmemiş, yakın çevremde hiç kimse yok benim bildiğim. Bir garip olmuştum yani ben delirdim herhalde falan gibi öyle düşünmüştüm yani herkes kendi sorununu kendisi aşabiliyor, ben bunları beceremiyorum. Destek alıyorum. Neden herkes bir şeylerle baş edebiliyor, ben bu konuda eksiğim diyordum, baş edemiyorum. İlaç kullanıyorum.” (Participant 9)

“Bir şeyler başarmak herhalde hedefim o yani hani bir şeyleri yapabilmek hani mutlu olmak bir şeyden mutlu olmak kendime güvenimin gelmesini çok istiyorum hani mesela ben de böyle şuan mesela rahatsız olduğum için hep böyle böyle duruyorum mesela ezik ezik bir kere ondan kurtulmak istiyorum yani güçlü olmak istiyorum hani kimseye benim de eyvallahım olmasın yani” (Participant 14)

“dedim ya gerizekalı, değersiz, suçlu yani nasıl anlatayım ya” (Participant 4)

“Şu an ama benim mesela farklı bir insanken farklı bir insan oldum şu an mesela özgüvenim falan hiç kalmadı benim. Normalde aslında daha böyle şeydim. Yani hastalık yüzünden. … Ya şu an hastalığımdan dolayı çok olumlu duygu hissedemiyorum kendime yönelik yani. Kendime kızıyorum işte niye ben yapamıyorum” (Participant 14)

“Rahatsızlıkların yoğun olduğu dönemlerde oldu. Yani işe yaramaz birisi gibi gördüğüm gibi de oldu.” (Participant 10)

“Kendimi aşağılıyordum yani şey diyordum küçümsüyordum yani kendimi küçümsüyordum ya ben bu muyum ben neydim böyle miydim gibi ben böyle biri miydim bana ne oldu” (Participant 2)

Secrecy

“Kimseye söylemem. Neden yakalandın sen de bir kötü hastaydın dedikleri zaman bana ben uykusuzluktan yakalandım diyorum. Şöyle oldu da böyle oldu da demem yani.” (Participant 11)

“Depresyon tedavisi aldığım çevremde biliniyor ama ben bir noktada yalan söylemiş oluyorum pıhtı olduğundan bahsediyorum çünkü yanlış algılanıyor şey olarak damar zamanında pıhtı atmış falan diyerekten” (Participant 12)

“İlaç kullanmak da beni rahatsız ediyordu yani ilaçlarımı gizli saklı yerlere koyup oralardan içiyordum. Yani bir gelen giden olursa ilacı görmesin diye” (Participant 9)

“Nasılsın diyorlar çok iyiyim diyorum mesela birisine. Öbürküne diyorum ki ben geçen hafta gene dozuttum şöyle oldu böyle oldu, paylaşabiliyorum. Öbürkünden beni anlamasını beklemiyorum artık doktora gittim demiyorum ilaç içiyorum demiyorum. Bir de onu ikna etmeye çalışıyordum ne gerek var.” (Participant 9)

Disconnection

“Tabi depresyon halinde en yakınını en sevdiğini tanımıyorsun şey etmiyorsun yani dışlıyorsun kendini dışlanmış gibi görüyorsun toplumdan.” (Participant 2)

“Evden çıkasım gelmiyor kimsenin yüzüne bakasım gelmiyor çünkü aynı ithamları hep yüzüne vuruyorlar. Evden dışarı çıkmıyorum. … İşte dışarı çıkmamamı engelliyorlar yani bir insan bir şey söyleyecek diye şey yapamıyorsun” (Participant 3)

“Beni toplumdan soğutuyor işte mesela Bolu’da yaşamak istemiyorum gideyim beni hiç tanımayan insanların orada yaşayayım diyorum rahat hareket edeyim dışarıya rahat çıkayım. … Kendi akrabalarımızı baba tarafını sevmiyorum çoğunu, bir anne tarafından birkaç kişiyi seviyorum. … Bayramda bile gitmek istemiyorum çünkü en ufak bir şeyde bir konuda bir hastalık bir şey çıkıyor bir de millet duymuş bizim hasta olduğumuzu” (Participant 13)

Anticipation of Stigma

“Herkes deli gözüyle mi bakıyor?” (Participant 1)

“Mesela sabah bir gün bir yüzüme kakar (rahatsızlığımı) bir ağır laf söyler gücüme gider” (Participant 11)

“Mesela yabancı bir ortama girdiğin zaman böyle konu çıktığı zaman insan ne kadar olsa tedirgin oluyor yani” (Participant 3)

“Mesela bana misafir gelmek istiyor ben kabul etmek istemiyorum ama hemen diyorum ki benim bunalıma girdi diye düşünürler öyle farklı düşünmesinler diye kabul ediyorum veya bir yere gitmek istemiyorum bir de yanlış düşünürler. Bu şekilde yaptığım var.” (Participant 9)

Resentment

“Toplumumuzda da vardır ya bu. İşte psikoloğa gidiyor bilmem ne diye alışılagelmiş bir şey ve tabi o insanı üzdü yani.” (Participant 9)

“İşte saçma söyledikleri laflar falan aklıma geliyor yani nefret kin öfke hepsi var yani. İşte o hastayken yakın çevredeki insanların tutumları davranışları aklıma geldikçe nefret duygusu. Tabi şimdi biraz aştım da önceden daha çoktu.” (Participant 13)

“Zaten en çok yaralayan beni en çok da ailemin içindeki kişiler. Ki kendi doğurduğunuz bile bunu yansıtabiliyor size.” (Participant 8)

Meaning Making

Perceived Causes

“Bizim temelde var hocam ben annesiz büyüdüm onun sorunları böyle ta oradan tetikliyor bir tarafın yoksun kalıyor yani o anne sevgisini hiçbir şey tutmuyor bu illa ki bir yerde gelip o sorunla karşılaşıyorsun o çok etkiliyor beni.” (Participant 1)

“Ben daha önce evlendim, boşandım. Önceki eşimden şiddet gördüm. Bayağı üç yıl çok aşırı zor günler yaşadım. Yani hiç maaşımı göremiyordum. Elimde 5 kuruş yoktu. Çok sorumsuz bir insandı. Zannediyorum temelleri orada atıldı bana depresyonun. Ondan öncesinde bir şey yoktu çünkü. … Ben de kendimi fazla suçlamıyorum. Çünkü beni bu şeye iten insanlar var normalde ben böyle değilim yani 51 yaşındayım hayatımı şöyle bir gözler önüne seriyorum. Depresyona girdiğim zamanlarda ya bir olay olmuş ve arkasından da sevdiğim insanlardan eleştiri almışım.” (Participant 9)

Normalizing

“Mesela o da bir hastalık. Her insanda bir hastalık olabiliyor. Mesela kalp hastası nasıl kalp hastasıysa o da benim bir hastalığım. Ben kötü bir şey görmüyorum kendimde.” (Participant 11)

“Mesela nasıl bir mideniz rahatsızsa doktora nasıl gidip ilaç kullanıyorsanız ben bu psikiyatri ilacını da öyle görüyorum.” (Participant 8)

“Yani bir noksanlığın yok ara sıra dişinin ağrıması gibi senin hastalığın geliyor mesela depresyon her an gelmez her gün de depresyonda olmazsın.” (Participant 1)

“Interviewer: Anladım. Peki, bu tarz söylemler sizi nasıl etkiliyor?

Participant 3: Beni şey yapmıyor yani. Nasıl belimde ağrı varsa boynumda ağrı varsa aynı şekilde ona da geliyorum yani.” (Participant 3)

Coping

Social Support

“Eşimle paylaştım o benim hem iyileşmeme şey oldu hem manevi hem sosyal bakımdan çok şey oldu çok destek oldu. Eşim de biliyordu durumumu yani benim hasta olduğumu. Ondan sonra ailemin bana olan itimadına manevi desteğini bağlıyorum en çok o (eş) şey etti iğneyi falan o vurdu yani rahmetli iyiydi yani.” (Participant 2)

"Tabi ailemin de çok önemli rolü var burada. sürekli gezdirdiler işte. .... Ablam alışverişe çıkarttı. yeni giysiler, şu bu yok saçını kes boyat şunu yap bunu yap yani toparlanmamda onların da yardımı da oldu, tek başıma değil. Yani onlarla almasaydım belki o zamanlar belki çok uzun sürede geçirirdim, atlatırdım." (Participant 9)

"Desteklediler. Babam da destekledi yani çevremde söylediğim insanların tamamı iyi yaptığım yönünde hatta İlk hastaneye gelme kararını aldıktan sonra çevremdekilerin takdir ettiğini biliyorum. … Çünkü söylenenleri çok çabuk kafaya takan ve büyütebilen bir yapıdaydım. O süreç içinde onların tabi olumlu sözleri, desteklemeleri Bir rahatlığa vesile oldu. Tam tersi de olabilirdi çünkü zaten sorunları büyütmeye hazırım o zemin hazırlanmış durumda. Belki negatif şeyler söylenmiş olsaydı belki daha içinden çıkılmaz bir hal alacaktı. İyi oldu yani o süreçte onların destekleri." (Participant 7)

"Ama sürekli yanımdalardı. Yalnız bırakmadılar." (Participant 10)

"Mesela aynı arkadaşımla paylaştığım da derdimi söylüyordum yani mesela hocama söylüyordum o benim bir durum var nasıl edeyim İşte (isim) o da diyordu sakin ol şey yap dünya işi geçer derdi veren de Allah dermanı veren de şifa bulursun şey tepkiler alıyordum yani." (Participant 2)

Seeking Treatment

"Evde baş edemedim kendi kendime. Herkes üstüme geliyor annem falan. Kızım dışarı çık, anne dışarı çıkamıyorum diyordum yani. Buraya hastaneye bile geldiğimde annemle birlikte geldim hatta. Bu şekilde devam edince ben kendim dedim ben yatacağım dedim." (Participant 3)

"Kendimin ne olduğunu şey yapıyorum yani başlıyor uykusuzluk kaygı sinir stres. Ondan gidiyorum hocaya hocam diyorum böyle böyle ben uyuyamıyorum artık ne olacak diyorum hemen yazıyor ilaçlarımı." (Participant 11)

"Dermanı da ne edeceksin, doktorla şunla bunla geçiriyorsun, bak söylemesi ayıp bir yerin kaşınıyor devamlı kaşı dur ama doktora gidiyorsun adam bir ilaç veriyor bir şey veriyor o tedavisini görüyor. Yapılıyor yani bir şeyler." (Participant 5)

Stigma Resistance

“Etkilemiyor ben deliysem deliyim diyorum. Ben memnunum diyorum hastaneye yatmaktan diyorum. En azından durumumu gördüm iyileştim. Başka daha kötü de olabilirdim yani.” (Participant 3)

“Ben deli olduğuma hiçbir zaman inanmadım. Neden inanmadım çünkü ben Zonguldak'ta psikologla konuştum, böyle böyle konuştum, anlattım ailemin ve çevremin bana bu tür lakapta bulunduğunu söylediğim zaman bana sadece şu kelimeyi söyledi, sana bir daha öyle bir şey dedikleri zaman ben deli değilim bunu diyeceksin dedi. Ki halen o kelime benim kulağımda küpedir. Ben deli değilim ben sadece rahatsızım psikolojik rahatsızım kendim baş edemediğim şeylerin tedavisini görüyorum ben deli değilim. Ben bunu kendime sürekli söylerim ben deli değilim ben halen de diyorum. Ben rahatsızım kendi baş edemediği tedavimi elimden geldiğince baş edemedim ve bir doktora gittim tedavi aşamasındayım.” (Participant 8)

“Karşılaştım. O kadar önemsemiyorum. Bugün bana yarın ona belli olmaz.” (Participant 10)

Cognitive Reframing

“Hastanede yatmamı tabi değişmemi yani buradaki durumdan dolayı çünkü ben oradaki insanları görünce sağlıklı olduğuma daha çok dua ettim çünkü ben sağlıklı bir insandım sadece oradaki yatmamın sebebi üzüntüden psikolojik olaraktı ama oradaki insanları görünce çünkü onların öyle iyileşmek durumu kolay kolay yok ama benim öyle bir şeyim yok bir sene sonra kendimi toparlayıp hayatıma dönme durumum var yani sosyal faaliyetimde sıkıntı yok istediğim zaman İstanbul'a gidebilirim şehir dışına çıkabilirim tatile gidebilirim bugün gitmek istiyorsam arkadaşımla gidebilirim yakın arkadaşımda kalabilirim öyle evde bir şeyim yok ama zaten çok güvendiğim yakın olduğum insanlarla kalırım öyle bir şey yok yani böyle sıkı yok öyle bir şey yaşamıyorum.” (Participant 6)

“Benim hayatımda aslında kötü bir şey değil. Bir yardım, kendim başa çıkamadığım şeyi bir doktor yardımıyla bana yardım edip yardımcı olması.

Yani bir kötü bir şey değil yani ama çevremdekiler bunu böyle algılamıyor, o beni çok rahatsız ediyor. … Ben mesela burada hastalarla birlikte konuşurken biz deli değiliz biz sadece buraya bir tedavi olmaya geldik. Bizim sürecimiz bu. Biz deli değiliz sonuçta bizim bir rahatsızlığımız var biz bu rahatsızlığımızın tedavisini görüyoruz." (Participant 8)

"Kendimi intihar etme düşüncelerim ilk görev yerinde olmuştu daralmam olmuştu ya inancım sayesinde dünyanın imtihan yeri olduğunu bir gün yaptıklarımızın hesabının sorulacağını düşündüm." (Participant 12)

"Mesela hastalığımın ne olduğunu biliyorum. Kaygı olduğu zaman, sinirli olduğum zaman başladı benim hastalığım deyip hemen doktora gidebiliyorum. … Artık bir parçası olduğunu biliyorum tabi hastalığın. O hastalığı bilemeyenler de var mesela." (Participant 11)

APPENDIX G: TURKISH SUMMARY / TÜRKÇE ÖZET

TÜRKİYE'DE DEPRESİF BOZUKLUK TANISINA SAHİP BİREYLERİN DAMGALANMA DENEYİMLERİNE İLİŞKİN NİTEL BİR İNCELEME

1. GİRİŞ

1.1. Damgalama ve Kendini Damgalama

Damgalama (stigma), ilk defa 1963'te Goffman tarafından, kişide ayırıcı bir özellik (işaret) tanımlanması ve kişinin bu işarete sahip olması sonucu değersizleştirilmesi olarak tanımlanan sosyal bir olgudur. Damgalanan kişi, taşıdığı işaretten dolayı *kusurlu* olarak görülür ve bu nedenle *normalden eksik* kabul edilir (Goffman, 1963). Dünya Sağlık Örgütü (2001, s.) damgalamayı resmi olarak kişinin sahip olması neticesinde reddedilme, ayrımcılığa uğrama ve toplumun birtakım alanlarından dışlanma gibi sonuçlarla karşı karşıya kalacağı bir utanç, ayıp ve kınama işareti olarak tanımlamaktadır.

Kendini damgalama, damgalamanın üç bileşeni –bilişsel, duygusal ve davranışsal- damgalanan grubun üyeleri tarafından kendi benliklerine uygulandığında gerçekleşir. Diğer bir ifadeyle kendini damgalama, toplumsal damgalamanın damgalanan grubun bireyleri tarafından içselleştirilmesidir (Corrigan & Kleinlein, 2005, s. 16-17).

Corrigan, Rafacz ve Rüsch (2011), dört aşamadan oluşan ve ilerleyen aşamalarda toplumsal damgalamanın içselleştirilmesine, öz-saygının düşmesine ve umudun kaybına sebep olan bir kendini damgalama modeli öne sürmüştür. Bu modele göre, damgalamanın içselleştirilmesi bir dizi ardışık aşamadan oluşur. Farkındalık aşamasında psikolojik bozukluğa sahip olan bir birey, psikolojik bozukluklar hakkındaki toplumsal damgalamanın farkındadır. Kabul aşamasında, birey toplumsal damgalamayı kabul eder ve olumsuz basmakalıp yargıların psikolojik bozukluğa sahip bireyleri için doğru olduğuna hak verir. Uygulama aşamasında birey basmakalıp yargıları kendine uygular. En sonunda birey öz-saygı ve öz-yeterlilikteki düşüşler nedeniyle ciddi zarar görür, bu da zarar aşamasıdır.

Psikolojik bozukluklara sahip kişiler özellikle kabul ve uygulama aşamalarında farklı deneyimlere sahip olabilirler ve zarar aşamasından kaçınabilirler. Bu modelin önemi damgalanan gruplardan gelen bireylerin neden öz-saygılarını kaybetmediklerini, öz-yeterliliklerinin düşmediğini ya da kişisel zarar yaşamadıklarını açıklamasından gelmektedir (Corrigan & Rao, 2012). Aşamalar ilerledikçe, özellikle zarar aşamasında kendini damgalama hayat hedeflerinin başarılmasını ciddi derecede engeller. Düşük öz-saygı kişinin kendisini fırsatları yakalamaya layık olmadığını, görevleri yerine getirmeye yetkin olmadığını hissetmesine yol açar. Bu durum kişinin hayat hedeflerini gerçekleştirme çabasını baltalar ve kişinin hayatında ciddi sorunlara yol açar.

1.2.Psikolojik Bozukluklara Yönelik Damgalama

Psikolojik bozukluklar evrensel olarak damgalanan sağlık durumlarıdır (Stangor & Crandal, 2003, s. 18). Hem psikolojik bozuklukların belirtileri, hem de psikolojik bozukluk etiketi toplumun bu durumu *normalden sapma* olarak görmesine neden olmuştur (Corrigan, 2000). Çalışma bulguları göstermiştir ki psikolojik bozukluk etiketini taşıyan bireyler toplumda sıklıkla reddedilme, değersizleştirilme, etiketlenme ve olumsuz davranışlar gibi tepkilerle karşılaşmaktadır (Link & Phealn, 2013; Biernat & Dovidio, 2003, s. 103, Farina, 1982). Psikolojik bozukluğa sahip kişiler toplumda hastalıklılık, yetersizlik, karakter zayıflığı, değersizlik, tehlikelilik, soğukluk, tahmin edilemezlik ve samimiyetsizlik gibi basmakalıp yargılarla resmedilirler (Corrigan & Kleinlein, 2005, s. 16; Crumpton, Weinstein, Acker, Annis, 1967).

Psikolojik bozukluklara yönelik damgalamanın içselleştirilmesi, ilgili kişiler için toplumdaki damgalamanın kendisinden daha büyük bir tehdit olarak ortaya çıkmaktadır. Çalışma bulguları göstermiştir ki öz-saygının düşmesi psikolojik bozukluklara sahip kişiler için ciddi bir sorundur (Wahl, 1999). Psikolojik bozukluklara sahip bireyler, psikolojik bozukluklarından dolayı daha az değerli olduklarına inanmaktadır (Link & Phelan, 2001). Kendini damgalamanın ümit ve öz-yeterlilik seviyesi, amaç duygusu, hayat kalitesi, sosyal destek, iş yaşamına katılım ve sağlık hizmetlerinden yararlanma ile negatif yönde ilişki içinde olduğu bulunmuştur. Diğer yandan, kendini damgalama eğilimi kendini soyutlama, psikiyatrik belirti seviyesi ve tedaviye uyumsuzluk ile pozitif yönlü bir ilişki içindedir (Livingston & Boyd, 2010; Corrigan & Rao, 2012).

1.3. Damgalanma ve Başa Çıkma

Link ve arkadaşları psikolojik bozukluklara yönelik damgalanmaya karşı geliştirilen başa çıkma stratejileri üzerine çalışmış ve gizleme, eğitme, içe çekilme, meydan okuma ve uzaklaşma gibi bir dizi başa çıkma yöntemi rapor etmişlerdir (Link ve ark., 1989; Link, Mirotznik & Cullen, 1991). Gizleme, kişinin psikolojik bozukluk tanısını gizlemesi anlamına gelmektedir. Eğitme, damgalayıcı basmakalıp yargılara karşılık vermek için kişinin damgalayan insanlara bilgi vermesidir. İçe çekilme, potansiyel olarak damgalayıcı durumlardan kaçınmayı ifade eder. Meydan okuma, damgalayıcı davranışlarla doğrudan yüzleşmek ve damgalayıcı tutumlarla hemfikir olmadığına işaret etmek anlamına gelmektedir. Uzaklaşma ise kişinin kendisini bilişsel olarak damgalanan gruptan ayırması ve 'ben onlar gibi değilim' demesidir (Link ve ark., 2002). Bu başa çıkma stratejileri psikolojik bozukluklara yönelik damgalama ile karşılaşan bireyler tarafından kullanılmaktadır.

1.4. Depresif Bozukluklar ve Damgalama

Depresyon nitel çalışmalarda belirtiler, benlik ve kimlik açısından geniş ölçüde çalışılmış olmasına rağmen depresif bozukluklara sahip bireylerin damgalama deneyimlerini inceleyen çalışmalar görece azdır. Bir nitel çalışmada depresif bozukluğa sahip bireylerin aileleri ile olan iletişimleri damgalama perspektifinden incelenmiştir (Y-Garcia ve ark., 2012). Sonuçlar depresif bozukluğa sahip bireylerin aileleri ile depresyonları hakkında konuşurken etiketlenmiş, yargılanmış, nutuk çekilmiş ve reddedilmiş hissettiklerini ortaya çıkarmıştır. (Y-Garcia ve ark., 2012). Benzer şekilde depresif bozukluğa sahip bireyler depresyonları hakkında yardım talep ettiklerinde arkadaşlarından ve ailelerinden damgalayıcı tepkiler almaktadır (Griffiths, Crisp, Barney, & Reid, 2011). Bazı aile üyeleri katılımcıların depresif bozukluğunun geçerliliğini kabul etmemekte, bazıları da katılımcıları aşağılamakta, eleştirmekte ve onlarla alay etmektedir. Katılımcılar diğerlerinin onları yargılamasından, acımasından ve reddetmesinden endişe ettiklerini belirtmişlerdir ve depresyon tanılarını paylaşırken utanç hissettiklerini söylemişlerdir (Griffiths, Crisp, Barney, & Reid, 2011). Depresif bozukluğun diğer psikolojik bozukluklardan daha az damgalandığının bulunmasına rağmen, depresyon belirtileri diğerleri tarafından kasıtlı algılanırsa depresif bozukluk daha çok damgalanabilmektedir. Barney ve arkadaşlarının yaptığı bir çalışmada katılımcıların depresif bozukluğu olan bir bireyi, eğer depresyonu yeterli bir sebeple açıklanamıyorsa, daha çok suçlama eğiliminde oldukları bulunmuştur (Barney, Griffiths, Christensen, & Jorm, 2009).

1.5. Çalışmanın Amacı

Özetle, damgalama psikolojik bozukluğa sahip bireylerin yaşamlarında ciddi bir endişe ve stres kaynağıdır. Bu olguyu kültürel bağlam içinde anlamak kültürel açıdan geçerli bilimsel bilgi üretmek için ve psikolojik bozukluğa sahip bireylerin sorunlarına etkin çözümler bulabilmek için gereklidir. Spesifik bir kültür içinde depresif bozukluğa sahip bireylerin deneyimlerine kendi perspektiflerinden odaklanmak, gerekli sosyal ve klinik müdahaleleri geliştirmek için elzemdir. Türkiye kültürel bağlamında psikolojik bozukluklara yönelik damgalamayı inceleyen çalışmalar çoğunlukla nicel çalışmalardır (Çam & Bilge, 2007; Sarıkoç & Öz, 2016). Damgalamayı bireylerin kendi sözlerinden anlamaya çalışan nitel çalışmalar eksik kalmaktadır. Var olan nitel çalışmalar çoğunlukla psikotik bozukluklara sahip bireylerin deneyimlerini incelemiştir (Karancı ve ark., 2019). Türkiye'de depresif bozukluğa sahip bireylerin damgalanma deneyimlerini inceleyen bilinen nitel bir çalışma yoktur. Bu amaçla, bu çalışma Türkiye'de depresif bozukluk tanısı almış olan ve bu bozukluğu deneyimlemiş olan bireylerin damgalanma deneyimlerini ve başa çıkma yollarını anlamayı hedeflemiştir.

2. YÖNTEM

2.1. Yorumlayıcı Olgubilim Analizi

Bu çalışma Yorumlayıcı Olgubilim Analizi (YOA) yöntemini benimsemiştir. YOA bilgi felsefesi açısından olgubilim felsefesine dayanır. Olgubilim, eşyayı olduğu gibi, kendini sunduğu haliyle görme çabasıdır. Bu nedenle, YOA bireylerin kişisel deneyimlerini onların yaşadığı şekliyle keşfetmeyi ve bu deneyimleri nasıl anlamlandırdıklarını anlamayı amaçlar (Smith & Osborn, 2005, s. 25-26).

Yorumlayıcı Olgubilim Analizi, kişisel deneyimin etraflıca incelenmesine olanak sağladığı ve katılımcının kendisini açmasını kolaylaştırdığı için bu çalışmanın yöntemi olarak uygun görülmüştür.

2.2. Katılımcılar

Bu çalışmada da dâhil etme kriterlerine dayanarak ve YOA prensipleri ile uyumlu olarak homojen bir örneklem oluşturulmuştur. Çalışmanın örneklemi en az iki yıl önce majör depresif bozukluk tanısı almış olan ve en az bir kere hastaneye yatış öyküsü olan yetişkin bireylerden ya da süreğen depresif bozukluk tanısı olan ve en az bir kere hastaneye yatış öyküsü olan yetişkin bireylerden oluşmaktadır.

Çalışmaya 9 kadın, 5 erkek katılımcı katılmıştır. Katılımcıların yaşları 33 ve 68 arasında değişmektedir ve yaş ortalaması 46,21'dir. Katılımcıların çoğunluğu kendilerini orta sosyo-ekonomik statüde hissettiklerini belirtmişlerdir. Görüşmeler sırasında Beck Depresyon Envanteri-I ile yapılan ölçümlerde, katılımcıların depresyon seviyelerinin ortalama 20,85 olduğu bulunmuştur.

2.3. Materyaller

Çalışmanın materyalleri demografik form, Beck Depresyon Envanteri-I ve görüşme sorularından oluşmaktadır. Görüşme soruları araştırmacı tarafından YOA prensipleri gözetilerek hazırlanmış ve tez danışmanı tarafından gözden geçirilmiştir. Beş kategoride açık uçlu formatta sorular hazırlanmıştır: tanı, tanının katılımcı için anlamı, tanının katılımcı üzerindeki etkileri, depresif bozukluklarla ilgili damgalama ve içselleştirilmiş damgalama.

2.4. Görüşmeler

Katılımcılarla ortalama 46 dakika süren yarı yapılandırılmış görüşmeler yapılmıştır. Katılımcılarla görüşmeler sırasında orijinal soru listesinde olmayan konular geldiğinde, araştırmacı bu konulara da odaklanmıştır. Görüşmeler katılımcılarla bireysel olarak ve yalıtılmış ortamlarda gerçekleştirilmiştir.

2.5. Prosedür

Orta Doğu Teknik Üniversitesi İnsan Araştırmaları Etik Kurulu’ndan araştırma için etik onay alındıktan sonra katılımcılar iki yolla çalışmaya alınmıştır. Öncelikle, potansiyel katılımcılara tanıdıklar vasıtasıyla ulaşılmış ve çalışmaya katılmaya gönüllü olanlarla görüşmeler yapılmıştır. Daha sonra, araştırmacı gerekli izinleri alarak Bolu İzzet Baysal Ruh Sağlığı ve Hastalıkları Eğitim ve Araştırma Hastanesi ile işbirliği yapmış ve daha önce depresif bozukluk tanısı ile hastanede yatan hastalara ulaşmıştır. Görüşmelere başlamadan önce tüm katılımcılar çalışmanın amaçları hakkında, görüşmede ses kaydı alınacağı hakkında ve cevapların anonim kalacağı ile kimliklerin gizli tutulacağı hakkında bilgilendirilmiştir. Tüm katılımcılar görüşme öncesinde gönüllü katılım formunu imzalamıştır.

2.6. Analiz

YOA, araştırmayı yürütme ve veriyi analiz etme ile ilgili bir dizi ilke sunar. Bu çalışmadaki veri de YOA ilkeleri gözetilerek analiz edilmiştir. Analiz sürecinin sonunda 5 üst tema ve 18 alt tema elde edilmiştir.

3. SONUÇLAR

3.1.Bozukluğun Deneyimlenmesi

İlk üst-tema olan bozukluğun deneyimlenmesi, katılımcıların bozukluğu nasıl deneyimlediklerine dair tasvirlerinden oluşmaktadır. Diğer bir ifadeyle, bu tema katılımcıların depresyonu duygusal, bilişsel ve fizyolojik boyutlarda nasıl deneyimlediklerini; kendilerine dair gözlemlerini içermektedir. Depresyonun duygusal, bilişsel ve fizyolojik olmayan etkileri de bozukluğun diğer alanlardaki etkileri olarak kategorize edilmiştir. Bu üst-temadaki alt-temalar *bozukluğun duygusal deneyimi, bozukluğun bilişsel deneyimi, bozukluğun somatik deneyimi* ve *bozukluğun diğer alanlardaki etkileri*dir.

3.1.1. Bozukluğun Duygusal Deneyimi

Bu alt-tema; katılımcıların ifade ettiği ilgi kaybı, zevk alamama, kendine ve diğerlerine öfke, asabiyet, ağlama, boşluk ve anlamsızlık hisleri, yabancılaşma ve hissizlik gibi duygusal deneyimleri içerir. Mutsuzluk, hüsran, utanç, suçluluk ve kaygı da katılımcılar tarafından sıklıkla ifade edilmiştir. Katılımcıların ifadelerindeki duygu yoğunluğu dikkat çekicidir.

3.1.2. Bozukluğun Bilişsel Deneyimi

Bu alt-tema; intihar düşünceleri, öz-eleştirellik, kendini suçlama ve karamsarlık ve sadece olumsuz yönde yorumlamalar gibi bilişsel çarpıtmaları içerir. Olumsuz benlik algısı, özellikle yetersizlik inancı katılımcıların çoğunda gözlenmiştir.

3.1.3. Bozukluğun Somatik Deneyimi

Katılımcıların depresyonla ilgili bedensel deneyimleri bu alt-temaya toplanmıştır. Sıklıkla bahsedilen somatik deneyimler; el ve ayaklarda titreme, kaslarda gerilme, nefes almada güçlük, baş, omuz, boyun ve göğüs bölgesinde ağrı, kalpte ağırlık, uykuya dalmakta güçlük ya da sürekli uykulu hissetme, yorgunluk, dikkati sürdürmede ve konsantrasyonda zorluk ve iştah kaybıdır. Katılımcılar, depresyonun somatik deneyiminden bahsederken *sıkıntı* kelimesini sıklıkla kullanmış ve bu kelimeyle içlerindeki ıstırap, baskı, darlık ve huzursuzluğu anlatmaya çalışmışlardır.

3.1.4. Bozukluğun Diğer Alanlardaki Etkileri

Son alt-tema, depresif bozukluğun, katılımcıların iş yaşamı, eğitim hayatı, finansal alan, sosyal alan ve günlük yaşam gibi hayat alanlarına olan etkilerini kapsar.

3.2.Diğerlerinin Tepkileri

İkinci üst-tema olan diğerlerinin tepkileri; diğer insanların katılımcılara, katılımcıların depresif bozukluğuna ve genel olarak depresyonda olan bireylere verdikleri tepkileri içermektedir. Bu insanlar toplumdaki herhangi biri olabildiği gibi komşular, iş arkadaşları, arkadaşlar ve aile üyeleri gibi tanınan kişiler de olabilir. Diğerlerinin tepkileri, katılımcılar tarafından, onların deneyimledikleri şekliyle anlatılmıştır. *Kasıtlı ataklar, kasıtsız aşağılamalar* ve *küçültme ve güvensizlik* bu üst-temanın alt-temalarını oluşturmaktadır.

3.2.1. Kasıtlı Ataklar

Diğer insanların kötücül ve ayrımcı niyet içeren davranışları, sözel ya da sözel olmayan ifadeleri kasıtlı ataklar alt-temasına dâhil edilmiştir. Diğer bir ifadeyle, kasıtlı olarak ayrımcı olan hareketler ve katılımcıyı rencide etmeye yönelik her şey, kasıtlı ataklar alt-temasında toplanmıştır.

Katılımcılarla yapılan görüşmelerden anlaşıldığı üzere, toplumda depresif bozukluğa sahip bireylere yönelik tutumlar oldukça olumsuz ve damgalayıcıdır. Katılımcıların ifadelerine dayanarak, kasıtlı ataklar; katılımcıya *deli* muamelesi yapmak, katılımcıyı küçümsemek ve hor görmek, katılımcıyı basmakalıp yargılarla etiketlemek ve katılımcıyı sosyal olarak dışlamak gibi davranışları içerir.

3.2.2. Kasıtsız Aşağılamalar

Diğer insanların kasıtlı olmayan fakat katılımcının durumuna yönelik olarak duyarsız, kaba ve anlayışsız olan tutumları, yorumları, soruları ya da davranışları kasıtsız aşağılamalar olarak kodlanmıştır. Bu yorumlar kasıtsız görünse bile, aslında katılımcıları aşağılamış ve duygularını incitmiştir. Kasıtsız aşağılamalar; katılımcının tanısını öğrenmesi üzerine diğer kişinin yüz ifadesinde olan değişiklik, katılımcıya diğer kişilerden farklı muamele etmek, katılımcının bozukluğunu ört bas etmek ve onun hakkında konuşmamak, katılımcının bozukluğunu sır gibi saklamak, katılımcının dengesiz olacağını varsaymak ve depresif bozukluğundan ötürü katılımcıya tahammül edememek gibi tepkileri içerir.

3.2.3. Küçültme ve Güvensizlik

Diğer insanların katılımcının depresif bozukluğunun önemini azaltan veya katılımcının depresif bozukluğuna dair şüphe ima eden tutum ve yorumları küçültme ve güvensizlik alt-temasına dâhil edilmiştir. Diğerleri tarafından katılımcıların depresyon deneyimi küçültülmüş ve depresif bozukluk önemsiz kabul edilmiştir. Bazı durumlarda insanlar katılımcıların bir bozukluğa sahip olduğuna inanmamıştır.

Katılımcılara göre depresif bozukluk, fiziksel bozukluklar kadar ciddi bir rahatsızlık olarak görülmemekte, hatta bazen bir hastalık olarak kabul edilmemektedir. Küçültme ve güvensizlik nedeniyle, insanlar katılımcıları depresif bozukluğa sahip oldukları için suçlama eğiliminde olmaktadırlar. Katılımcılar, belirtileri kendileri yaratmakla suçlanmaktadırlar. Küçültme ve güvensizlik, depresif bozukluğu önemsizleştiren bir düşünce yapısını yansıtmaktadır.

Küçültme ve güvensizliğin, katılımcının durumu ile ilgili bilgi ve anlayış eksikliğinden ileri geldiği görülmektedir. Katılımcının depresif deneyimini küçülten ya da bu deneyimin geçerliliğine inanmayan insanlar sıklıkla katılımcının durumunu anlamazlar ya da farklı yorumlarlar. Bu nedenle suçlama, itham, sorumluluğu katılımcıya yükleme; küçültme ve güvensizliğe eşlik eder. İnsanlar belirtilerin bir bozukluktan kaynaklanmadığına, katılımcının belirtileri ikincil bir kazanç için yarattığına inanmaya eğilimlidir. Diğer bir ifadeyle, belirtiler kasıtlı algılanmaktadır. Bazı katılımcılar bozukluğu bir bahane olarak ileri sürmekle suçlanmışlardır.

3.3.Bozukluğun Deneyimlenmesinin ve Diğerlerinin Tepkilerinin Benlik Üzerine Etkileri

Üçüncü üst-tema olan bozukluğun deneyimlenmesinin ve diğerlerinin tepkilerinin benlik üzerine etkileri; ilk iki temanın, yani hem bozukluğun kendisinin ve depresif bozukluk tanısı almanın, hem de diğer insanların katılımcıya verdikleri tepkilerin katılımcıların benlik algıları üzerindeki etkilerini kapsar. Bu faktörler özellikle katılımcıların öz-saygıları üzerinde etkilere sahiptir. Hem bozukluğun deneyimlenmesinden hem de diğerlerinden alınan damgalayıcı tepkilerden dolayı dolayı katılımcıların öz-saygıları zedelenmiş, katılımcılar bozukluklarını saklama ihtiyacı hissetmiş, çevrelerinden kopmuş, damgalanma beklentisine girmiş ve gücenme duyguları yaşamışlardır. Bu üst-temaya dâhil olan alt-temalar; *öz-saygının zedelenmesi, saklama, kopuş, damgalanma beklentisi* ve *gücenme*dir.

3.3.1. Öz-Saygının Zedelenmesi

Bu alt-tema, katılımcıların benlik saygılarının depresif bozukluk tanısı almaktan, bozukluğun deneyimlenmesinden ve diğer insanların damgalayıcı tepkilerinden dolayı nasıl zedelendiğini yansıtmaktadır. Katılımcılar depresif bozukluk tanısı aldıklarında farklı, yetersiz, mağlup, yarım insan, eksik ve işe yaramaz hissettiklerini rapor etmişlerdir. Kendilerini çevrelerindeki insanlarla karşılaştırmış ve yetersiz hissetmişler, bunun sonucunda benlik algıları zarar görmüştür. Bazı katılımcılar depresif bozukluk tanısını kabul etmekte zorlanmışlardır. Bazı katılımcılar ise kendilerini değersiz ve suçlu gibi oldukça olumsuz sıfatlarla nitelemişlerdir. Katılımcıların kendilerine yönelik tutumları da olumsuzdur. Kendilerini değersizleştirmiş, aşağılamış ve suçlamış, bozukluğun tüm sorumluluğunu kendilerine atfetmişlerdir. Katılımcılar depresif bozukluklar ile ilgili toplumsal damgalamayı içselleştirmiş ve öz-saygıda düşüş yaşamış görünmektedirler. Düşük öz-saygı depresyonun da belirtilerinden biridir. Düşen öz-saygı üzerinde depresyonun bilişsel deneyiminin ve damgalamanın içselleştirilmesinin etkilerini ayırt etmek zordur. Etkiler, daha çok, iç içe geçmiş ve birbirini pekiştiriyor görünmektedir.

3.3.2. Saklama

Katılımcıların çoğu tanılarını, aldıkları tedavileri ve ilaçları sosyal çevrelerinde sakladıklarını belirtmişlerdir. Katılımcılar tanılarını yalnızca aile üyeleri ve yakın arkadaşlar ile paylaştıklarını, toplumdaki kişiler ve uzak akrabalar ile paylaşmadıklarını ifade etmişlerdir. Katılımcılar tanılarını ta tamamen gizlemekte ya da kısmen paylaşmaktadırlar. Örneğin, katılımcıların bir kısmı bozukluklarını fiziksel terimlerle ifade etmeyi tercih etmektedirler. Bozukluklarını çevreye uyku bozukluğu, kulak-burun-boğaz ile ilgili bir problem ya da beyine pıhtı atması olarak aktarmaktadırlar.

3.3.3. Kopuş

Bu tema katılımcıların diğer insanlardan sosyal, duygusal, zihinsel ve davranışsal olarak kopuşlarını temsil etmektedir. Katılımcılar, damgalama ile ilgili nedenlerle kendilerini diğerlerinden kopmuş hissettiklerini, sosyal olarak içe çekildiklerini ve kendilerini izole ederek dışladıklarını belirtmişlerdir. Diğer bir ifadeyle, katılımcılar diğerlerinden aldıkları damgalayıcı tepkiler nedeniyle onlardan kopmakta, sosyal olarak içe çekilmekte ve kendilerini izole etmektedirler. Ayrıca, damgalamayı içselleştirdikleri ve damgalanmayı bekledikleri için de içe çekilmekte ve kendilerini izole etmektedirler.

3.3.4. Damgalanma Beklentisi

Bu tema katılımcıların günlük iletişimlerindeki damgalanma beklentilerini yansıtmaktadır. Katılımcılar, insanlarla iletişim kurarken etiketlenmekten, rencide edilmekten, yargılanmaktan ve dışlanmaktan kaygılandıklarını ifade etmişlerdir. Katılımcılar depresif bozukluklar hakkındaki toplumsal damgalamanın farkındadırlar ve bu nedenle diğer insanların onlar hakkında belli basmakalıp yargılara, önyargıya ve ayrımcı davranışlara sahip olacağını, onları nihayetinde damgalayacaklarını düşünmektedirler.

3.3.5. Gücenme

Bu tema, katılımcıların diğerlerinin damgalayıcı tutumları karşısında yaşadıkları incinme duygularını yansıtmaktadır. Katılımcılar damgalandıklarında üzgün ve incinmiş hissettiklerini, moral ve sinirlerinin bozulduğunu, onları damgalayanlara karşı öfke ve nefret hisleri ile dolduklarını rapor etmişlerdir. Aile üyeleri, arkadaşlar ve tümden toplum bu hislere sebep olmaktadır.

3.4.Anlamlandırma

Dördüncü üst-tema olan anlamlandırma, katılımcıların depresif bozukluk tanısı almalarını ve bozukluk deneyimini anlamlandırma çabalarını içerir. Deneyimi anlama ve anlamlandırma çabası katılımcılar için esastır. Katılımcılar, bazı faktörlerin onlarda depresyona sebep olduğuna inanmaktadır. Katılımcılar ayrıca depresif bozukluğa sahip olmayı normalleştirmektedirler. Bu üst-tema iki alt-temaya sahiptir: *algılanan sebepler* ve *normalleştirme*.

3.4.1. Algılanan Sebepler

Bu alt-tema, katılımcıların depresif bozuklukları ile ilgili nedensel faktörlere dair algılarını, inançlarını ve yorumlamalarını içermektedir. Katılımcılar, uzak ve yakın bazı faktörlerin onlarda depresyonu tetiklediğine, bazı faktörlerin de nüks ile alakalı olduğuna inanmaktadırlar. Katılımcılara göre, onları depresyona hazırlayan faktörler arasında çocuklukta anne sevgisi yoksunluğu, erken yaşta evlilik, baba baskısı ve zorlu yaşam şartları vardır. Katılımcılar tarafından depresyonlarını tetiklediği düşünülen faktörler ilişkisel faktörler, stres faktörleri ve sağlık ile ilgili faktörler olarak gruplanmıştır. Nüks ile ilgili rapor edilen faktörler, üzüntü ve stres gibi tetikleyici faktörlerin benzerleridir.

3.4.2. Normalleştirme

Katılımcıların büyük çoğunluğu depresyon deneyimini ve bununla ilgili tedavi almayı normalleştirmişlerdir. Depresif bozukluğun fiziksel bozukluklar gibi bir rahatsızlık olduğunu, kalp damar hastalıklarından, mide rahatsızlıklarından, ağrılardan ya da diş problemlerinden farklı olmadığını ifade etmişlerdir. Katılımcılar ayrıca herkesin hayatlarının bir döneminde depresyon geçirebileceğini işaret etmişlerdir. Katılımcılar, herkesin bir rahatsızlığı olduğunu söyleyerek de depresif bozukluğa sahip olmayı normalleştirmişlerdir.

3.5.Başa Çıkma

Son üst-tema olan başa çıkma, katılımcıların damgalanma ve depresif bozukluğun zorlukları ile başa çıkmak için kullandıkları başa çıkma stratejilerini içerir. Katılımcılar, damgalanma ve bozukluğun zorlukları ile başa çıkmak için sosyal, davranışsal ve bilişsel bir dizi başa çıkma stratejileri kullanmışlardır. Bu çalışmada katılımcılar tarafından sıklıkla rapor edilen başa çıkma stratejileri *sosyal destek, tedavi arayışı, damgalanmaya direnç* ve *bilişsel yeniden çerçevelendirme*dir.

3.5.1. Sosyal Destek

Katılımcılar, çevrelerinden aldıkları sosyal desteğin depresif dönemlerini atlatmalarında kendilerine çok yardımı olduğunu ifade etmişlerdir. Aile, arkadaşlar ve iş arkadaşları katılımcılara sözel ve davranışsal destek veren kişilerdir. Katılımcıların aldığı destek, onlara iyi hissettirmiş ve iyileşme süreçlerine katkı sağlamıştır.

3.5.2. Tedavi Arayışı

Katılımcıların büyük çoğunluğu, depresif bozukluk ile tedavisini arayarak ve alarak baş ettiklerini belirtmişlerdir. Tedavi yolları olarak, katılımcılar ilaçlardan, hastaneye yatıştan, psikoterapiden, psikolog ve psikiyatristlere danışmaktan ve tedaviye uyumdan bahsetmişlerdir.

3.5.3. Damgalanmaya Direnç

Bu alt-tema, depresif bozukluklar ile ilişkili damgalamaya karşı katılımcıların gösterdiği direnme yollarını kapsar. Katılımcılar damgalanmaya karşı güçlü şekilde direnmişler, açık şekilde tepki vermişler ve damgalayan kişiyi davranışı ile yüzleştirmişlerdir. Damgalanma karşısında seslerini yükseltmiş ve kendi fikirlerini, yorumlarını ve değerlerini öne sürmüşlerdir.

3.5.4. Bilişsel Yeniden Çerçevelendirme

Bilişsel yeniden çerçevelendirme, katılımcıların depresyonu ele almalarında olan değişim sürecini ifade etmektedir. Katılımcıların tanıları ile ilgili bakış açılarında bir değişim olmuştur. Katılımcılar durumlarını daha iyi başa çıkmalarına yardımcı olacak şekilde yeniden analiz etmiş ve yeniden yorumlamışlardır. Bilişsel yeniden çerçevelendirmenin bir yolu aşağı yönlü sosyal karşılaştırmadır. Katılımcılar kendilerini, kendilerinden daha ağır şekilde psikolojik bozukluklara sahip olanlarla karşılaştırmış, kendilerini daha iyi durumda bulmuş ve daha sağlıklı hissetmişlerdir. Bu yeniden çerçevelendirme katılımcıları rahatlatmış, durumlarına şükretmelerini sağlamış ve hem bozukluk hem de damgalanma ile daha iyi başa çıkmalarına yardımcı olmuştur.

Katılımcılar dini bakış açısı ile de durumlarını yeniden çerçevelendirmişlerdir. Bazı katılımcılar depresif bozukluklarını Tanrıdan gelen bir imtihan olarak görmüştür. Bu anlamlandırma şekli katılımcıları rahatlatmış ve hem bozukluk hem de damgalama ile daha iyi başa çıkmalarına yardımcı olmuştur.

Yeniden çerçevelendirmenin son yolu da tanı almanın avantajlarına odaklanmaktır. Depresif bozukluk tanısı almak katılımcılara ne yaşadıklarını ve onlara ne olduğunu tanımlama ve anlama imkânı vermiştir. Tanı almadan önce katılımcılar neden belli şekilde hissediyor ve ne deneyimliyor olduklarını bilmediklerini ve bu nedenle bir belirsizlik ve panik içinde olduklarını rapor etmişlerdir. Tanılarını bilmek katılımcılara durumları üzerinde bir kontrol hissi vermiştir. Ayrıca, bozukluklarını bilmek katılımcılara onun kendilerinin bir parçası olduğunu düşündürmüş ve bütüncül bir benlik algısı kazanmalarına yardımcı olmuştur. Ek olarak, bozukluklarını bilmek katılımcılara gerekli tedaviyi arama ve alma şansı vermiştir. Kısaca, katılımcılar bu şekilde çerçevelendirdiklerinde depresif bozukluk tanısı almayı olumlu bir hayat olayı olarak görmüşlerdir.

4. TARTIŞMA

İlk üst-tema olan bozukluğun deneyiminde yer alan duygusal, bilişsel ve somatik deneyimleri, depresyonun DSM-5 Tanı Ölçütleri Başvuru El Kitabı'nda (American Psychiatric Association, 2013) listelenen belirtileri ile uyumludur. Katılımcılar *sıkıntı* kelimesini, depresyon deneyiminde olan içlerindeki darlık, baskı ve huzursuzluğu ifade etmek için sıklıkla kullanmışlardır. Benzer şekilde, Borra da (2011) Türk kadınların *sıkıntı* ve *bunalım* kelimelerini somatik acı çekmeyi ifade etmek için kullandıklarını belirtmiştir. *Sıkıntı* kelimesinin Türk bireyler için depresyonun somatik yönünü ifade ettiği sonucuna varılabilir. Ayrıca, psikolojik acı çekiş bazı kültürlerde açıkça ifade edilmez; somatik belirtiler duygusal acıyı ifade etmenin bir yolu olabilir (Baarnhielm, 2003). Türkiye toplumu da duyguların dolaylı yolla ifade edilmesine izin verildiği sıkı toplumlardandır (Hofstede, 1991; Cimilli, 1997). Türkiye kültüründe psikolojik acının açıkça ifade edilmesinden kaçınılır ve fiziksel şikâyetler psikolojik şikâyetlerden daha çok ilgi çeker. Psikolojik bozukluklar ile eşleştirilen damgalama ve utanç da bu durumu pekiştirmektedir. Bu nedenle somatik şikâyetler, kişiyi damgalanmaktan korurken kişinin duygusal acısını normalleştirmeye ve diğerlerinin dikkatini çekmeye yardımcı olur. Bu açıdan bakıldığında, katılımcılar arasında *sıkıntı* kelimesinin bu denli kullanılması, depresyondaki acıyı ifade etmenin kültürel olarak kabul gören bir yolu olduğu için olabilir.

İkinci üst-tema olan diğerlerinin tepkileri kasıtlı ataklar, kasıtsız aşağılamalar ve küçültme ve güvensizlik alt-temalarından oluşur. Katılımcıların damgalanma deneyimleri, alanyazında rapor edilen damgalanma deneyimleri ile tutarlıdır. Psikolojik bozukluğa sahip olan bireylerin değersizleştirildiği, etiketlendiği, yanlı biçimde yargılandığı ve olumsuz muamelelere maruz kaldığı daha önce rapor edilmiştir (Biernat & Dovidio, 2003; Farina, 1982). Küçültme ve güvensizlik alt-teması da alanyazındaki bulgular ile paralellik göstermektedir. Hinshaw ve Stire

(2008), eğer depresyon belirtileri halk tarafından kasıtlı olarak algılanırsa, depresyonun diğer psikolojik bozukluklardan daha çok damgalanabileceğini söylemiştir. Başka bir çalışmada bulunduğuna göre depresif bozukluğa sahip olan bireyler ailelerinden veya arkadaşlarından yardım talep ettiklerinde, depresyonlarının geçerliliğinin reddedildiği bulunmuştur (Griffiths ve ark., 2011). Tüm bu bulgular ve bu çalışmanın küçültme ve güvensizlik bulgusu, depresif bozukluklara yönelik olarak toplumda şüpheci ve suçlayıcı bir bakış açısı olduğunu göstermektedir.

Bozukluğun deneyimlenmesinin ve diğerlerinin tepkilerinin benlik üzerine etkileri diğer bir üst-temadır. Bu tema, damgalamanın içselleştirilmesinin düşük öz-saygıya götürdüğü yönünde bulguları ve psikolojik bozukluklara sahip bireylerin bozuklukları nedeniyle kendilerini daha az değerli hissettiği yönünde bulguları desteklemektedir (Link & Phelan, 2001; Wahl, 1999). Depresyon deneyiminde bireylerin öz-saygıları risk altındadır. Katılımcıların olumsuz benlik algısında iki faktörün etkileşerek etkili olduğu düşünülmektedir. Birincisi, benlik ile ilgili olumsuz düşünceler ve düşük öz-saygı depresif bozukluğun belirtilerinden biridir (Beck, 1987). İkincisi, toplum depresif bozukluğu olan bireyleri hasta, zayıf, yetersiz, değersiz ve tehlikeli gibi olumsuz özellikler ile nitelendirir (Corrigan & Kleinlein, 2005, s. 16; Crumpton ve ark., 1967). Bu olumsuz görüşlerin içselleştirilmesi de katılımcılarda olumsuz benlik algısı oluşumunda ikinci faktördür. Bu iki faktörün etkileri birbirine geçmiş ve birbirini pekiştiriyor görünmektedir. Bu etkileşim depresif bozukluklara özgü görünmekte ve depresyonun tedavisini zorlaştırmaktadır.

Katılımcıların depresif bozukluklarını saklayarak rahatsızlıklarını kan pıhtısı atması ya da uyku bozukluğu gibi fiziksel terimler ile aktarmaları dikkate değerdir. Bozukluğu fizikselleştirmeye yönelik duyulan bu ihtiyaç, utançtan kaçınma ihtiyacı ile açıklanabilir. Alonso ve arkadaşları (2008) psikolojik bozukluklara sahip bireylerin, fiziksel bozukluklara sahip bireylerden daha fazla açıktan ayrımcılık ve utanç rapor ettiğini bulmuştur.

Son üst-tema başa çıkma temasıdır. Katılımcılar bozukluğun ve damgalamanın zorlukları ile başa çıkmak için çevrelerinden sosyal destek almış, tedavi görmüş, damgalanmaya direnmiş ve durumlarını zihinlerinde yeniden çerçevelendirmişlerdir. Sosyal desteğin stres ve depresyon ile başa çıkmada yardımcı olduğu alanyazında rapor edilmektedir (Nasser & Overholser, 2005; Park ve ark., 2015; Thoits, 2011; Werner-Seidler ve ark., 2017; Yalçın, 2015). Çeşitli tedavi yöntemlerinin de depresyon için etkili bulunduğu kanıtlanmıştır (Driessen ve ark., 2019; Hetrick ve ark., 2015; Keller ve ark., 2000; Mulrow ve ark., 2000; Pampallona ve ark., 2004). Damgalanmaya direnç de damgalanma ile savaşma, hak savunuculuğu, anlamlı bir kimlik geliştirme ve diğerlerini eğitmeyi içeren, başa çıkma süreçlerine yardımcı olan tepkilerdir (Firmin ve ark., 2017; King ve ark., 2007; Link ve ark., 1989; Link ve ark., 2002; Ritsher & Phelan, 2004; Thoits & Link, 2015).

Tüm bu bulgular ışığında, klinik ve sosyal müdahaleler için bir dizi öneride bulunulabilir. Depresif bozukluğa sahip bireyler ile çalışan klinisyenler ve diğer çalışanlar, depresif bozukluklar ile ilgili kendi bakış açılarının ve tutumlarının bilinçli veya bilinçsiz bir şekilde damgalayıcı olup olmadığının farkında olmalıdırlar. Damgalama yalnızca açıktan açığa saldırılar ve aşağılamalar şeklinde olmamaktadır. Bu nedenle klinisyenler ve diğer çalışanlar, depresif bozukluğa sahip bireylerle iletişimlerinde bu bireylerin deneyimlerinin geçerliliğini reddeden, önemini küçülten, güvensizlik veya şüphe ima eden ya da bireyleri suçlayıcı ögeler olup olmadığını kontrol etmelidirler. Depresif bozukluğa sahip bireylerle yapılan psikoterapi seanslarında damgalanma ile ilgili deneyimler geldiğinde bunlar ele alınmalı, danışanın deneyimi ve duyguları onaylanmalı ve danışanlar olumlu bir benlik ve kimlik gelişimi için desteklenmelidir. Psikoterapistler içselleştirilmiş damgalanmaya özellikle dikkat etmelidirler. Danışanın damgalamayı ne derecede içselleştirdiği keşfedilmeli ve klinik müdahaleler ona göre ayarlanmalıdır. Psikoterapistler, kültürel ögelere de dikkat etmelidirler. *Sıkıntı* kelimesinin kullanımı olası bir depresif dönemi işaret ediyor olabilir. Depresyonlarını dini bakış açısıyla ele alan danışanların bakış açıları keşfedilmeli, onaylanmalı ve dini başa çıkma stratejilerinden işlevsel olanlar desteklenmelidir. Son olarak, klinik müdahalelerden ayrı olarak, depresif bozukluk tanısına sahip bireyler için kendini damgalamayı önlemeye yönelik psikoeğitim programları geliştirilmeli ve benzer deneyimleri yaşayan bireyler arasında yardımlaşmayı artırmaya yönelik akran grupları oluşturulmalıdır.

Çalışmanın birtakım kısıtlılıkları vardır. Öncelikle bu çalışmanın örnekleminde depresyonu süreğen biçimde deneyimleyen katılımcılar ile geçici biçimde deneyimleyen katılımcılar ayrıştırılmamıştır. Fakat araştırma sürecinde bu iki grubun deneyimlerinin oldukça farklı olabileceği fark edilmiştir. İleride yapılacak çalışmalarda bu iki grubun ayrı ayrı araştırılmasına dikkat edilmelidir. Ayrıca, görüşmeler sırasında sorularda geçen *inanç* kelimesi katılımcılar tarafından yanlış anlaşılmıştır. Son olarak, bu araştırmada depresif bozukluklarla ilgili damgalama araştırılmış olsa da hastaneye yatışın da kendine özgü var olan damgalaması sonuçlara karışmış olabilir.

Bu çalışmanın güçlü yanı, Türkiye kültürel bağlamında depresif bozukluk tanısına sahip bireylerin damgalanma deneyimlerini nitel bir yöntemle keşfeden ilk çalışma olmasıdır.

APPENDIX H: TEZ FOTOKOPİ İZİN FORMU

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Deniz Bilimleri Enstitüsü / Graduate School of Marine Sciences ☐

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TEZİN ADI / TITLE OF THE THESIS (**İngilizce** / English) : A Qualitative Investigation of Stigma Experiences of Individuals with Depressive Disorders in Turkey

TEZİN TÜRÜ / DEGREE: **Yüksek Lisans** / Master ☒ **Doktora** / PhD ☐

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