Relationship between Recovery, Hope and Internalized Stigma Resistance among Patients with Depressive Disorders

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Abstract

*Although recovery is the aim for psychiatric professionals and their patients, this journey may be faced by hopelessness, negative cognition and reduced stigma resistance. A little had been done about recovery, hope and stigma resistance among Egyptian patients with depressive disorders. **Objective:** Determine levels of recovery, hope and stigma resistance among patients with depressive disorders, and investigate the relationship between them. **Settings:** The Outpatient Clinic of El-Maamoura Hospital for Psychiatric Medicine, and the Psychiatric Outpatient Clinic of the Main University Hospital. **Subjects**: A convenience sample of 150 outpatients with depressive disorders. **Tools:** Five tools were used; a Socio-Demographic and Clinical Data Structured Interview Schedule for Patients with Depressive Disorders, Hamilton Rating Scale for Depression (HRSD-17), Recovery Assessment Scale-Revised (RAS-R), Beck Hopelessness Scale (BHS), and Stigma Resistance Subscale of the Internalized Stigma of Mental Illness Scale. **Results:** The findings revealed that 76% of patients had moderate level of recovery, 36.7% of patients had moderate level of depression, and 33.3% of the studied patients had no hopelessness, and 67.3% of patients had moderate level of internalized stigma resistance. Significant negative correlations were found between depression and recovery (r= - 0.191, p=0.019), between recovery and hopelessness (r= -0.741, p=0.000), and between hopelessness and internalized stigma resistance (r= -0.685, p=0.000). A statistically significant positive correlation was also found between recovery and internalized stigma resistance (r = 0.653, p=0.000). **Conclusion:** Recovery was found to be correlated positively with hope and internalized stigma resistance and negatively with depression. **Recommendations:** Psychiatric nurses should assess the presence of recovery, hope and stigma resistance among psychiatric patients periodically and investigate their levels. Future empirical studies to investigate the effect of specific therapeutic techniques for increasing hope level and stigma resistance abilities among depressed patient on their recovery level.*

<u>**Keywords:**</u> Depressive Disorders; Hope; Psychiatric Nursing; Recovery; Stigma Resistance.

Introduction

Research has increasingly revealed that outcomes for persons with severe mental illness encompass a wide range of possibilities and challenges. Among these challenges is recovery (Yanos, Roe, Markus, & Lysaker. 2008). It has been defined as an ongoing personal process aims to allow people to have a satisfying life despite the limitations posed by their mental illness (Hogan, 2003).

For many people with mental disorders, including depressive ones, the concept of recovery is about staying in control of their life rather than the elusive

state of return to premorbid level of functioning. Emphasizing resilience and controlling over problems and life, rather than focusing on just treating or managing symptoms, has been called the recovery model (Jacob, 2015).

Previous studies highlight a number of factors play an important role in the dynamic process of recovery. Having hope, reestablishment of a positive identity, finding meaning in life, and taking responsibility for one's life, having high self-esteem, social support and resisting stigma are among these factors (Brown& Kandirikirira, 2007; Corrigan, & Phelan, 2004).

Hopelessness, negative self-examination, pessimism and other negative thoughts cause the depressive feelings, so patients with depressive disorders always see the negative side and assume that they fail in whatever they do (Sadock B, Sadock V, Ruiz 2014).). As a positive psychological capital, hope is often thought to be a protective factor that can be used by these patients to face risks and prevent feelings of helplessness and pessimism that arise from illness (Coşkun, & Altun, 2018). Having a sense of hope can also contribute to one's belief that the recovery is feasible and can enhance one's motivation to engage in the recovery process (Park& Chen, 2016).

However, internalized stigma is considered to be a key determinant of hope (Acharya, & Agius, 2017; Dewedar, Harfush, & Gemeay, 2018). For some researchers, internalized stigma reduces a person's hope and self-esteem, leading to negative outcomes related to recovery (Yanos, Roe, Markus, & Lysaker, 2008; Abdisa, Fekadu, Girma, Shibiru, Tilahun, Mohamed & Tsegaye, 2020). On the other hand, greater stigma resistance is positively associated with greater sense of agency and mastery, self-esteem, empowerment, quality of life. It has been also identified to facilitate the recovery in different psychotic disorders, including depressive disorders (Brohan, Gauci, Sartorius, Thornicroft, & GAMIAN– Europe Study Group 2011; Firmin, Luther, L., Lysaker, Minor, & Salyers, 2016).

Although recovery is the aim for psychiatric professionals and their patients, this journey may be faced by many obstacles arising from the nature of depressive disorders, such as hopelessness, negative cognition and reduced stigma resistance. Therefore, research evidences suggest that not all people with depressive disorders achieve recovery (Novick, Montgomery, Vorstenbosch, Moneta, Dueñas & Haro, 2017).

From both clinical and research perspectives, a little had been done about recovery, hope and stigma resistance among Egyptian patients with depressive disorders. Yet, it is of great importance to properly and adequately assess recovery, hope and stigma resistance levels among depression sufferers. On one hand, this might help psychiatric nurses understand how some patients with depressive disorders remain hopeful while resisting their internalized stigma, and how being positive and hopeful can enhance their recovery process. On the other hand, this study may serve as a preliminary step for developing psychiatric nursing strategies to increase hope and stigma resistance levels, which in turn can contribute to a successful recovery journey for patients with depressive disorders.

Aims of the Study

This study aims to determine levels of recovery, hope and internalized stigma resistance among patients with depressive

disorders, and investigate the relationship between them.

Research Questions

- What are the levels of recovery, hope and internalized stigma resistance among patients with depressive disorders?

- What is the relationship between recovery, hope and internalized stigma resistance among patients with depressive disorders?

Materials and Method
Materials
Design: A descriptive correlational research design was followed in this study.

Settings: This study was conducted in two settings:

1. **The Outpatient Clinic of El-Maamoura Hospital for Psychiatric Medicine, Alexandria:** It is affiliated to the Ministry of Health and Population.

2. **The Psychiatric Outpatient Clinic of the Main University Hospital, Alexandria:** It is affiliated to Alexandria University; Ministry of Higher Education.

Subjects: A convenience sample of 150 outpatients with depressive disorders comprised the study subjects (100 outpatients, from first setting and 50 outpatients from the second setting). They were recruited according to the following inclusion criteria:

- Diagnosed with depressive disorders with no comorbidity for longer than one year, in order to confirm the diagnosis.

- In a stable phase of their illness, evidenced by visiting the clinic for follow up and dispensing medications, with no relapse or hospitalization in the previous month as reported by patients or recorded in the medical charts (to confirm starting the

recovery from the acute phase of illness).

- Able to communicate in a coherent and relevant manner.

Tools: Data of the present study were collected using the following five tools:

Tool I: A Socio-Demographic and Clinical Data Structured Interview Schedule for Patients with Depressive Disorders

This tool was developed to collect data about the study subjects' socio-demographic and clinical characteristics, such as sex, age, marital status, educational level, working status, duration of illness, number of visits to the outpatient clinic, treatment presently prescribed, medication compliance, family history of mental illness, and presence of support during illness.

Tool II: Hamilton Rating Scale for Depression (HRSD-17)

The HRSD-17 is a clinician-rating scale developed by Hamilton (1960) to assess depression severity and changes in depressive symptoms during the past week (Hamilton, 1960). Eight of the 17 items are rated on a 5-point scale (0=absent to 4=very severe), while the remaining 9 items are rated on a 3-point scale (0=absent; 1=doubtful or mild; 2=clearly present).

The total scale score ranges between 0 and 52, with higher total scores indicating increasing depressive symptoms severity. A score from 0 to 7 suggests absence of depression (being normal), from 8 to 13 suggests mild depression, from 14 to 18 suggests moderate depression, from 19 to 22 suggests severe depression, and scores equal or over 23 are indicative of very severe symptoms of depression (Hamilton, 1960).

Tool III: Recovery Assessment Scale-Revised (RAS-R)

This is a 24-item scale developed by Corrigan et al. (2004) to assess various aspects of recovery from mental illness, with a particular emphasis on patient's confidence, hope for the future, perceived control, and self-determination.

Items of the RAS-R are rated on a 5-point Likert scale (from 1=strongly disagree to 5=strongly agree). They cover five

subscales: *personal confidence and hope* (9 items), *willingness to ask for help* (3 items), *goal and success orientation* (5 items), *reliance on others* (4 items), and *no domination by symptoms* (3 items). The total score ranges between 24 and 120, with higher mean scores indicate higher level of recovery.

Tool IV: Beck Hopelessness Scale (BHS)

The BHS was developed by Beck et al. (1974) to measure negative attitudes about the future (Beck, Weissman, Lester, & Trexler, 1974). The scale consists of 20 items in the form of true or false statements, where true=0 and false=1. Items are summed to provide an overall index of hope or its absence. The total score ranges between 0 and 20. A score from 0 to 3 will denote no hopelessness (presence of hope in this study), from 4 to 8 denote mild hopelessness level, from 9 to 14 denote moderate hopelessness level, and from 15 to 20 denote severe hopelessness level.

Tool V: Stigma Resistance Subscale of the Internalized Stigma of Mental Illness Scale

The Internalized Stigma of Mental Illness (ISMI) scale was developed by Ritsher et al. (2003) to measure the level and nature of internalized stigma of mental illness. It consists of 29 items grouped into 5 subscales; *Alienation* (6 items), *Stereotype Endorsement* (7 items), *Discrimination Experience* (5 items), *Social Withdrawal* (6 items), and *Stigma Resistance* (5 items) Ritsher, Otilingam, & Grajales, 2003).

The present study focuses on stigma resistance, so patients responded only to the 5 items pertaining to the Stigma Resistance Subscale. This subscale measures a person's ability to resist or be unaffected by internalized stigma. Its score is produced by adding together the 5 answered items and dividing by 5. It ranges between 5 and 20. prior studies identified a cut-off point at 2.5 and above on the mean item score of the Stigma Resistance Subscale to define moderate to high stigma resistance, and less than 2.5 for low stigma resistance (Sibitz,

Unger, Woppmann, Zidek, & Amering, 2011; Bifftu, Dachew, & Tiruneh, 2014).

Method

I- Administrative steps:

- An official approval from the Research Ethics Committee, Faculty of Nursing, Alexandria University was obtained before conducting the study.
- Official written permissions to conduct the study were obtained from the General Secretariat of Mental Health, and Director of EL-Maamoura Hospital for Psychiatric Medicine and Sector Director of Alexandria University Hospitals.

II- Preparation of study tools and the pilot study:

- Tool I was developed and Arabic translation of tools II (HRSD-17), III (RAS-R), IV (BHS) and V (Stigma Resistance Subscale of the ISMI Scale) was done.
- The translated study tools were tested for content validity by 5 experts in the field of psychiatric nursing. They proved to be valid.
- A pilot study was conducted on 10 outpatients with depressive disorders who meet the inclusion criteria to assess the clarity and applicability of study tools. It proved that study tools were clear, understood and applicable.
- Reliability of tools II, III, IV and V were tested using Cronbach's alpha method on a sample of 20 outpatients with depressive disorders who meet the inclusion criteria of the study subjects. All studied tools proved to be reliable (Cronbach's alphas for tool II=0.730, tool III=0.742, tool IV=0.824, and tool V=0.946.

III- Actual study:

- In each setting, all patients' medical charts were screened to identify patients who meet the predetermined inclusion criteria.
- Patients who meet the predetermined criteria were recruited as study subjects.

- After establishing rapport, explaining the purpose of the study and obtaining an informed written consent, each patient was interviewed individually in order to apply all study tools.
- The total numbers of subjects recruited from the Outpatient Clinic of El-Maamoura Hospital and the Psychiatric Outpatient Clinic of the Main University Hospital were 100 and 50 outpatients respectively.
- Adequate precautions to prevent spread of COVID-19 infection were taken during each patient's interview.
- The data collection started from the first of January 2020 to the mid of March 2020. Yet, data collection was stopped due to closing outpatients' clinics as a result of COVID-19 pandemic. Then, it was resumed again in the first of July 2020 to the mid of September 2020.

Ethical considerations:

- Informed written consent was obtained from each patient and/or caregiver after explanation of the aim of the study.
- Patient's privacy was respected.
- The patient's right to refuse to participate in the study or withdraw at any time was emphasized.
- Data confidentiality was assured.

Statistical Analysis:

Data were analyzed using Statistical Package for Social Sciences (SPSS, Version 25). Qualitative data were described using number and percent. Quantitative data were described using range, mean and standard deviation. Pearson coefficient is used to correlate between two normally distributed quantitative variables. Levels of significance of the obtained results were p-value equal to or less than 0.05 and p-value equal to or less than 0.01.

Results:

Table (1) presents the socio-demographic characteristics of the studied patients. It was noted that one half of studied patients were males and the other half were females (50% each). Their age ranged between 21 and 59 years, with a mean age of 36.91 ± 10.11 years. It can be noticed that the greatest percentages of patients were in the age group ranging between 30 to less than 40 years (45.3%), were married (65.3%), had basic education (42%), were housewives (46.7%), were living in urban areas (93.3%), were living with their families (95.3%) and reported their income was sufficient (74%).

Table (2) shows the clinical characteristics of studied patients. The duration of illness ranged from one to 20 years, with a mean duration of 5.78 ± 5.124 years. Most of patients (78.7%) had duration of illness from less than 5 years to less than 10years.More than one half of patients visiting the outpatient clinic for 20 times and more 53.3%.

Those who had a positive family history of mental illness constituted 24.6% of the study sample. Only 20.7% of the studied patients were previously hospitalized. All the studied patients previously received psychiatric treatments and currently on antidepressant medications. Most of the studied patients (81.3%) were compliant with their medications.

Table (3) presents distribution of the studied patients according to their levels and mean scores of depressions. It is obvious that 36.7% of the studied patients had moderate level of depression, followed by those who had severe level (27.3%), while 24.0% of patients had mild level and only 12.0 % had very severe level of depression.

The total score of depression among the studied patients ranged between 7 and 29, with a mean score of 16.50 ± 5.569 and a mean percentage score of 31.73%.

Table (4) illustrates distribution of the studied patients according to their total levels and mean scores of recoveries. Concerning levels of recovery, 76 % of the studied patients had moderate level of recovery, 18.7% had low level and only

5.3% had high level of recovery. Looking at the total mean score of recovery, the studied patients had a total score between 54 and 99, with a mean score of 82.23±12.57, and a mean percentage score of 68.52%.

As regards the subscales of recovery, the highest percentage of the studied patients had moderate levels of "reliance on others" (66.0%), "personal confidence and hope" (55.3%) and "not dominated by symptoms" (44%).

On the other hand, the highest percentage of the studied patients had low level of "willingness to ask for help"(66%). It was also found that the highest percentage of the studied patients recorded high level on "goal and success orientation" (54.7%).

Table (5) shows distribution of the studied patients according to their total levels and mean scores of hopelessness. It was found that 33.3% of the studied patients were hopeful (had no hopelessness), 32.7% had mild hopelessness, 18% had moderate hopelessness and only 16% had severe level of hopelessness. The total score of hopelessness ranged between 2 to 19, with a mean of 7.38±5.30 and a mean percent score of 36.9%.

Table (6) presents distribution of the studied patients according to their total levels and mean scores of stigma resistance. It was found that 67.3% of patients had moderate level of stigma resistance, while 26% of them had low level and only 6.7% had high stigma resistance. The total score of stigma resistance ranged from 6 to 19, with a mean score of 14.05±2.905 and a mean percent score of 70.25%.

Table (7) illustrates the correlation matrix between the studied patients' total mean scores of depression, recovery, hopelessness, and stigma resistance. A statistically significant negative correlation was found between depression and recovery (r= - 0.191, p=0.019). On the other hand, a statistically significant positive correlation was found between depression and hopelessness (r= 0.298, p=0.000). The table also shows that depression was negatively

but not significantly correlated with stigma resistance (r= - 0.009, p=0.912).

Regarding the correlation between recovery and hopelessness, Pearson correlation coefficient showed a statistically significant negative correlation between them (r= - 0.741, p=0.000). A statistically significant positive correlation was also found between recovery and stigma resistance (r = 0.653, p= 0.000).

Concerning the correlation between hopelessness and stigma resistance, a statistically significant negative correlation was found between them (r= -0.685, p=0.000).

Discussion:

Recently, a transition in the understanding of recovery from a clinical-based perspective that focuses on symptoms and functioning to a more consumer-oriented one that focuses on personal recovery has occurred (Yu et al, 2020). Therefore, the present study was carried out to determine level of recovery, and also levels of hope and internalized stigma resistance among patients with depressive disorders, in addition to investigate the relationship between them.

Findings of the present study showed that about two thirds of the studied patients had moderate level of recovery. These results are different from those results reported by Emad, (2012) who found that generally the level of recovery among patients with depression in Gaza Strip was low, and Novick et al. (2017) who found that only half of patients achieved recovery. The results of the current study may be related to the patients' compliance with medications where most of the studied patients were compliant. Being compliant with medication regimen can provide the best outcomes for patients and increase the likelihood to achieve full recovery. Previous studies supported these results (Ho et al., 2015; Lam et al., 2016; Novick et al., 2017).

Moreover, the moderate level of recovery among the studied patients in the current

study may be related to the presence of support where about three quarters of the studied patients received support during their illness. This explanation was consistent with Corrigan et al. (1999) who concluded that persons who find more interpersonal support are likely to experience greater recovery. Furthermore, the concept of recovery is composed of both subjective e.g., self-esteem, hopefulness, meaning in life and objective e.g., symptom experience, interpersonal relationships, and work components (Leamy et al., 2011). On that base, participants' working status in the present study may be a contributing factor for their recovery. In this respect, it was suggested that work instills a sense of pride and self-esteem, expanded social networks, allowing patients to earn money and regain independence (Drake, & Whitley, 2014).

Hope about the future and meaning in life is a central theme of the recovery process. Therefore, sustaining hope by renewing it is an important factor in recovery (Sari et al 2021). The present study showed that about one third of the studied patients were hopeful (had no hopelessness). A study carried out by Sari et al. (2021) determined that depressed patients had lower scores of hopes. Moreover, Pokharel et al. (2016) concluded that the majority of patients had hopelessness. This may be due to manifestation of depressive disorders which includes depressed mood, hopelessness and negative attitudes toward self, world and future.

Patient's level of hope can also be affected by internalized stigma of mental illness as it can lead to decreased hope, self-esteem, and greater severity of depressive symptoms and reduced help-seeking ,so, removing barriers such as the impact of internalized stigma is considered to be a vital step in enhancing recovery (Leonhardt et al,. 2017).

On the other hand, stigma resistance is likely to facilitate the recovery process as it has been identified to play a beneficial role in fighting against the internalization process

of stigma (Sibitz et al., 2011; Brohan et al., 2010b; Firmin et al., 2016).

The present study showed that most of the studied patients had moderate level of internalized stigma resistance, this is similar to that reported by Lien et al. (2015) and (Lau et al,. 2017). In contrarily to a study carried out by Tesfaye et al. who found that half of the participants had stigma resistance (Tesfaye, Kassaw, & Agenagnew,. 2020).

Depression affected recovery as it was negatively correlated with recovery, hope and internalized stigma resistance. According to results, a significant negative correlation was found between depression and recovery (table 7) .This may be because of the nature of symptoms and negative consequences of the disorder.

Regarding the relationship between depression and hope, a statistically significant positive correlation was found between depression and hopelessness (absence of hope). Hopelessness is a core feature in depressed individuals. Individuals who maintain hope are more resilient when faced with stress than those who are hopeless. (Assari, & Lankarani,. 2016). Similar results were also determined by Sari et al., 2021).

Concerning the relationship between depression and internalized stigma resistance, the present study indicated that depression was negatively but not statistically significantly correlated with internalized stigma resistance. This result is contradictory to those of Lau et al., (2017) where participants who were diagnosed with depression were about 4 times less likely to have high stigma resistance because they have greater awareness of their mental illness and a clearer perception of the consequences of mental illness (Lau et al., 2017). Moreover, depression is associated with symptoms such as depressed mood, anhedonia, feelings of worthlessness, etc. (American Psychiatric Association, 2013) with the cognitive tendency to negatively evaluate events or even oneself. So, a patient with depression might feel even more despaired given the public stigmatization and hence, lose the ability to resist stigma." (Lau et al ,.2017).

As for the relationship between recovery and stigma resistance, a statistically significant positive correlation was also found between recovery and internalized stigma resistance. Yanos et al postulated that self-stigma can

degrade a person's identity, reduce hope and self-esteem, and eventually lead one to believe that recovery is not possible (Yanos et al., 2021). Concerning the correlation between hopelessness and internalized stigma resistance, a statistically significant negative correlation was found between them which is consistent with Firmin et al. (2016) who found that stigma resistance was negatively correlated with hopelessness. Un like (Lau,. 2017) who postulated that hope did not correlate with stigma resistance.

Conclusion

According to the findings of the present study, Recovery correlates positively with hope and internalized stigma resistance and correlates negatively with depression.

Recommendations

In line with the findings of the study, the following recommendations are made:
- Psychiatric nurses must assess the presence of recovery, hope and stigma resistance among psychiatric patients periodically and investigate its level.
- Future empirical studies to investigate the effect of specific therapeutic techniques for increasing hope level and stigma resistance abilities among depressed patient on their recovery level.

Table (1): Distribution of the studied patients according to their socio-demographic characteristics (n=150)

Patients' socio-demographic characteristics	(n=150)	
	No.	**%**
Sex		
Female	75	50.0
Male	75	50.0
Age (in years)		
20 –	35	23.3
30 –	68	45.3
40 –	28	18.7
50 > 60	19	12.7
Min. – Max.	*21-59 years*	
Mean ± SD	*36.91 ± 10.11 years*	
Marital Status		
Single	41	27.3
Married	98	65.3
Divorced	7	4.7
Widowed	4	2.7
Educational level		
Illiterate	15	10.0
Read and write	21	14.0
Basic education	63	42.0
Secondary education	35	23.3
University education	16	10.7
Working status		
Housewife	70	46.7
Working	53	35.3
Unemployed	23	15.3
Retired	4	2.7
Place of residence		
Urban	140	93.3
Rural	10	6.7
Cohabitation		
Family	143	95.3
Alone	7	4.7
Income sufficiency		
Sufficient	111	74.0
Insufficient	39	26.0

Table (2): Distribution of the studied patients according to their clinical characteristics (n=150)

Patients' clinical characteristics	(n=150)	
	No.	%
Duration of illness (in years)		
≤5	118	78.7
10 –	12	8.0
15 ≥ 20	20	13.3
Min. – Max.	*1-20 years*	
Mean ± SD.	*5.78 ± 5.124 years*	
Number of patient's visits to the outpatient clinic		
<5	13	8.7
5-	18	12.0
10-	28	18.7
15-	11	7.3
20+	80	53.3
Min. – Max.	*1-150 visit*	
Mean ± SD.	*3. 89 ±1.684 visit*	
Previous psychiatric hospitalization		
Yes	31	20.7
No	119	79.3
Number of previous psychiatric hospitalization	(n = 31)	
Once	26	15.1
Twice	5	32.8
Type of currently prescribed treatments#		
Antidepressant medications	150	100.0
Other psychotropic medications (antipsychotics and anxiolytics)	86	57.3
ECT	26	17.3
Psychotherapy	14	9.3
Medication compliance		
Compliant	122	81.3
Noncompliant	28	18.7
Main cause of noncompliance	(n = 28)	
Medication side-effects	21	75.0
Forgetfulness	7	25.0
Family history of mental illness		
No	113	75.3
Yes	37	24.7
Presence of support during illness		
Yes	112	74.7
No	38	25.3
Type of support#	(n = 113)	
Financial	95	84.1
Emotional	18	15.9

More than one response can be given by the same patient.

Table (3): Distribution of the studied patients according to their levels and total mean score of depression (n= 150)

Levels of depression	No.	%
- Mild (Range = 8–13)	36	24.0
- Moderate (Range =14 – 8)	55	36.7
- Severe (Range =19–22)	41	27.3
- Very Severe (Range ≥ 23)	18	12.0
Range of total scale score = 0-52		
Min. – Max.	7–29	
Mean ± SD	16.50 ± 5.569	
Mean Percent Score	31.73%	

Table (4): Distribution of the studied patients according to their levels, total and subscales mean scores of recovery (n= 150)

Recovery	Levels of Recovery						Mean Scores		Mean Percentage Score
	Low		Moderate		High		Min- Max	Mean ± SD	
	NO.	%	NO.	%	NO.	%			
- Personal confidence (Range =9-45)	24	16	83	55.3	43	28.7	21-37	31.57 ± 4.746	70.16%
- Willing to ask for help (Range= 3-15)	90	60.0	22	14.7	38	25.5	4-12	8.45 ± 2.574	56.33%
-Goal and success orientation (Range= 5-25)	23	15.3	45	30.0	82	54.7	6-23	18.28 ± 4.257	73.12%
- Reliance on others (Range = 4 -20)	38	25.3	99	66.0	13	8.7	5-18	12.66 ± 3.045	63.30%
- Not dominated by symptoms (Range = 3-15)	54	36.0	66	44.0	30	20.0	3-13	9.030 ± 2.38	60.20%
Total recovery (Range = 24 -120)	28	18.7	114	76.0	8	5.3	54-99	82.23±12.57	68.52%

Table (5): Distribution of the studied patients according to their levels and total mean score of hopelessness (n= 150)

Levels of hopelessness	No.	%
- No hopelessness (Hopefulness) (Range = 0 – 3)	50	33.3
- Mild hopelessness (Range = 4 – 8)	49	32.7
- Moderate hopelessness (Range = 9–14)	27	18.0
- Severe hopelessness (Range = 15–20)	24	16.0
Range of total scale score = 0-20		
Min. – Max.	2–19	
Mean ± SD	7.38±5.30	
Mean Percent Score	36.9%	

Table (6): Distribution of the studied patients according to their levels and total mean score of stigma resistance (n= 150)

Levels of stigma resistance	No.	%
- Mild (Range = 5 - 12)	39	26.0
- Moderate (Range = 13 - 16)	101	67.3
- Severe (Range = 17 - 20)	10	6.7
Range of total scale score = 5-20		
Min. – Max.	6–19	
Mean ± SD	14.05 ± 2.905	
Mean Percent Score	70.25%	

Table (7): Correlation matrix between the studied patients' total mean scores of depression, recovery, hopelessness and internalized stigma resistance (n = 150)

Variables		Depression	Recovery	Hopelessness	Stigma resistance
Depression	r				
	P				
Recovery	r	-0.191*			
	P	0.019			
Hopelessness	r	0.298*	-0.741*		
	P	0.000	0.000		
Stigma Resistance	r	-0.009	0.653*	-0.685*	
	P	0.912	0.000	0.000	

r = Pearson Correlation Coefficient   **: Statistically significant at p ≤ 0.05*

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