subscale is habits that consists of (3) items (e.g. Alcohol use causing harm to self or others; 5th subscale is thought and speech that consists of (12) items (e.g. Bizarrely illogical or disorganized behavior or speech (bizarre posturing, illogical speech), 6th subscale is memory and attention that consists of (2) items (e.g. Difficulty learning new things; forgetting to take medications; forgetting to keep appointments); 7th subscale is orientation and insight that consists of (2) items (e.g. Gets lost near home, doesn't know the year, or not awake enough to drive a car etc.); 8th subscale is mood that consists of (20) items (e.g. Panic Attacks Sudden, brief attacks of intense, unreasonable fear or panic not due to a specific situation). Each statement is rated on the following 3-point Likert scale: 2 = little difficulty, 1 = moderate difficulty, 0 = severe difficulty. The reliability of the tool was measured by Cronbach's alpha test = .864, indicating a high degree of internal consistency.

3. Internalized Stigma of Mental Illness (ISMI) Inventory (Ritsher & Jennifer, 2003).

This scale measures the subjective experience of stigma of Mental Illness and is consisting of 29 items (e.g., "Having a mental illness has spoiled my life" and "I feel out of place in the world because I have a mental illness"). Each statement is rated on the following 4-point Likert scale: 0 = strongly disagree, 1= disagree, 2 = agree, 3 = strongly agree. The scoring system of the scale was, (0-29) indicates low stigma, ≥30 indicates stigma. The reliability of the tool was measured by Cronbach's alpha test = (.887) indicating a high degree of internal consistency.

4. Ethical consideration

A written ethical approval was obtained from the Ethical Committee of Scientific Research at the Faculty of Nursing, Cairo University. In addition, an official permission to conduct the proposed study was obtained from the head of "Mental Health and Addiction Prevention Hospital at El Manial University Hospital. A complete description of the purpose and nature of the study was done to the subjects. All subjects were informed that participation in the current study is voluntary, anonymity and confidentiality of each subject was protected by the allocation of a code number for each subject who responded to the questionnaire. Subjects were informed that they could withdraw at any time from the study without giving any reason In addition, their oral consent was taken.

5. Procedure

The researchers made a comprehensive reading of the available literature to assure the significance of the study and to attain an idea about previous and current researches in this field; a written ethical approval was received from the Ethical Committee of Scientific Research at the Faculty of Nursing, Cairo University. In addition, an official permission was obtained from the Head of the Outpatient Clinics of the Mental Health and Addiction Prevention Hospital at El Manial University Hospital. Tools were constructed after reviewing related literature and researches. All the tools were revised by a panel of experts to assure their content validity. After explaining the purpose of the study and getting oral agreement, the investigator interviewed each participant individually to collect the required data included in the socio demographic and medical data sheet. It was filled in by the investigators, followed by quality of life interview scale, and internalized stigma of mental illness (ISMI) inventory. The interviews were conducted at the "Outpatient Clinics" of the "Mental Health and Addiction Prevention Hospital" in "El Manial University Hospital". The investigators collected data [over a period of 19 months beginning of October 2012 till end of April 2014.] The interview with each participant took between 30 minutes to one hour. Questions were asked and recorded by the investigators.

6. Results

Table (1) reveals that, the studied sample consists of 100 psychiatric patients with a mean age 34.53 and standard deviation 10.089, 39% were 20-30 years old, 33% were 30-40 years old, 17% were 40-50 years old, and 11% were aged 50 years old or more. As for sex, 60% of the studied samples were males while 40% were females. The table also reveals that, in relation to educational level, 19% were illiterates, 27% were read and write, 40% completed secondary education and 14% completed high education. As regards occupational state, less than three fifths (59%) of the studied sample were not working, more than one quarter of them (27.0%) had private work, and only 14% of them were employees. Considering marital status 41% of studied sample were married, more than two fifth (44.0%) of them were single, 13.0% were separated, and 2.0% were widowed.

Table 1: Frequency distribution of the studied sample according to their socio demographics (n=100).

Items	*No*	*%*	*Items*		*%*
Age (years)			Marital Status		
20-	39	39	Married	41	41
30-	33	33	Single	44	44
40-	17	17	Separate	13	13
50-	11	11	Widowed	2	2
Mean ± SD	34.53 ± 10.089				
Sex			Educational Level		
Male	60	60	Illiterate	19	19
Female	40	40	Read & write	27	27
Occupation			Secondary education	40	40
Employee	14	14			
Private work	27	27	High education	14	14
Not working	59	59			

Table (2) reveals that, half of the studied sample (50%) of studied sample had no previous admissions to psychiatric hospitals, 18% were admitted once, 14% were admitted twice and 18% of them were admitted thrice or more.

Table 2: Frequency distribution of the studied sample according to their number of previous admissions to psychiatric hospitals (n=100).

Previous admission	*No.*	*%*
None	50	50.0
Once.	18	18.0
Twice.	14	14.0
Thrice or more	18	18.0

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Figure (1) shows that 39% of studied sample had bipolar disorder, 40% were schizophrenics, 16% had major depressive disorder and 5% had schizoaffective disorder.

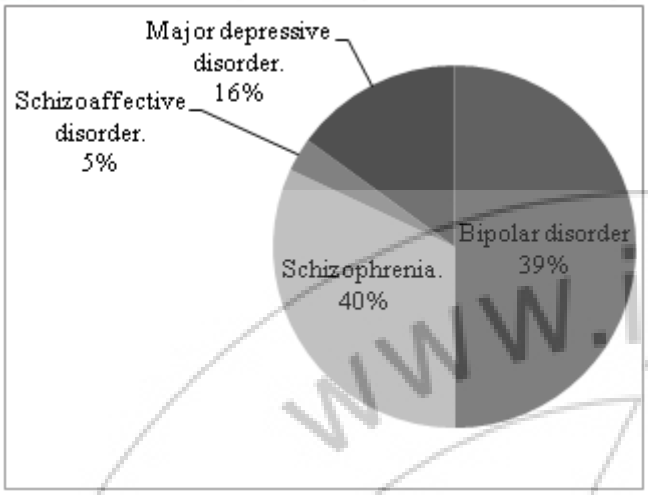

Figure 1: Distribution of the studied sample as regards their diagnosis (n=100).

Table (3) shows duration of psychiatric illness among the studied sample with a mean duration of 9.63 and standard deviation 6.752. Moreover, more than two thirds of them (70%) had illness for 3-< 10 years, less than one fifth (19%) suffered from mental illness for 10 -< 20 years, and only 11% had experienced mental illness for 20 years or more.

Table 3: Frequency distribution of the studied sample regarding their duration of the psychiatric illness (n=100).

Duration of Illness (In years)	No.	%
3 -	70	70
10 -	19	19
20 +	11	11
Mean ± SD 9.63 ± 6.752		

Figure (2) indicates that most of the studied sample (91%) had experienced stigma from their mental illness, and only 9% didn't experience any stigma with a mean 46.97 and standard deviation 12.102.

Figure 2

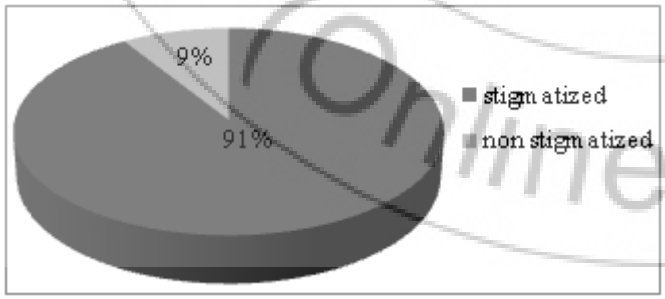

Figure 2: Distribution of the studied sample as regards their degree of stigma (n=100).

Table (4) indicates that less than half (45%) of the studied sample showed moderate total QOL, slightly more than one third (35%) showed high total Q.O.L and 20% had low total QOL with a mean 107.67 and standard deviation 20.806.

Table 4: Frequency distribution of the studied sample as regards their stigma degrees & total quality of life (n=100

Total Quality of Life	*No.*	*%*
Low (0-<24)	20	20.0
Moderate (24-<30)	45	45.0
High (30-<40)	35	35.0
Mean ± SD	107.67 ±	20.806

Table (5) shows the degrees of quality of life subscales, social relationships and economic status domain, habits domain, memory and attention domain, orientation and insight domain, thought and speech domain, physical health and activities' domain, showed the highest frequencies in low QOL (100%, 100%, 100%, 100%, 97% & 94% respectively). Meanwhile, 41% of the studied sample had moderate QOL regarding their general behavior and attitude

Table 5: Distribution of the studied sample according to their levels of quality of life domains (n=100).

Degrees / **Domains of QOL**	**Low**		**Moderate**		**High**	
	No.	%	No.	%	No	%
Physical health & activities	94	94.0	5	5.0	1	1.0
Social Relationships & economic status	100	100.0	0	0.0	0	0.0
General behavior & Attitude	59	59.0	41	41.0	0	0.0
Habits	100	100.0	0	0.0	0	0.0
Thought & speech	97	97.0	3	3.0	0	0.0
Memory & Attention	100	100.0	0	0.0	0	0.0
Orientation& insight	100	100.0	0	0.0	0	0.0
Mood	47	47.0	30	30.0	23	23.0

Table (6) shows that there's inverse highly statistically significant correlation between QOL and stigma, when r = -.587** at p=.000.

Table 6: Correlation among study variables of the studied sample

Study Variables	QOL		Stigma	
	r	p	r	P
Q.O.L	-	-	-.587**	.000
Stigma	-.587**	.000	-	-

7. Discussion

The current study was conducted to examine the effect of stigma on quality of life for people with mental illnesses, In relation to level of stigma among the studied sample, The study finding revealed that most of the studied sample were non stigmatized. This result may be returned to the concomitant personal and public perception regarding mental illness and its symptoms that may make the patients either disturbed in their relations with other people, at work, friends and even at home or totally far from reality. This view is congruent with that of [33], who reported that the perceived effect of stigma was greater if the patient had more prominent positive symptoms, adding to this the great subjective feeling that they are not full members of society that may produced from the objective level of discrimination that an individual is exposed to [35].

This finding also was supported by [27] who revealed that a larger proportion of their study sample reported seeking relief from traditional alternative treatments and contributed

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to having anxiety about disclosing the illness to others or continuing treatment. Additionally this current study result was congruent with that of [29], which reported that most of patients (85.72%) classified their disease as mood disorder or confusion, nervousness, anxiety, stress, and problems in the head, and only 17.14% denominated themselves as mentally ill or mad and reported to have hallucinations, and this might indicate that they were not accepting having mental illness or psychiatric symptoms.

In this context, [17] studied "Insight enhancement program" on "Improving The perception of internalized stigma, and locus of control among schizophrenic patients", and reported that the patients lacking insight were not stigmatized may be as a result of denying having mental illness that protects patients from receiving the negative cultural aspect, that the society usually encompasses toward psychiatric patients such as dealing with them as dangerous, non-responsible, and retarded persons. As well [28], who studied "Insight into insight: A study on understanding schizophrenia", stated that lack of insight is thought to be a psychological defense, and denial is a mechanism of preserving the individual's self-esteem, minimizing the social and cultural context of each individual. From another perspective, [14] and [10] suggested that mental illness is not stigmatized, or at least does not elicit as much stigma in the Arab world compared to other societies, often explaining this with reference to religion in non-western societies.

Considering the relationship between socio demographic characteristics, medical data and stigma, there was a positive significant correlation between job and stigma, and there was no significant relation between the rest of socio demographic characteristics, medical data and stigma. As regards the job, there was evidence suggests that unemployment is a risk factor for the development or exacerbation of mental health conditions [11]. Unemployment also results in decreased social networks and loss of structure, purpose and identity [5], [9]. However, [8] concluded that judgments of social distance were virtually independent of any socio-demographic characteristics of the study sample.

Regarding the relationship between stigma and study sample's age, the result showed no significant relation between both, this finding was also supported by [43] who didn't find an association between stigma and age. Additionally, [15] added that, there was no statistical significance between stigma & age, but it was found that subjects aged 40-50 years reported a slight but not significantly higher level of knowledge and higher positive attitude toward mental illness, this might be because as middle aged adult have a deeper and focused vision to different issues, also they are generally more positive, accepting understanding and experienced.

Moreover, on the time that mental health problems are among the most important contributors to the global burden of disease and disability, mental and behavioral disorders are estimated to account for 12% of disability-adjusted life-years lost globally, and 31% of all years lived with disability at all ages and in both sexes. Yet, more than 40% of countries have no mental health policy, over 90% have no mental health policy that include adolescents and children, and over 30% have no mental health programmes [41].

In addition, the current study results revealed that there was no significant relation between stigma and sex. This result was concomitant with that of [43], on the contrary when referring to gender as a factor that may affect feeling of stigma, [3] reported that females were more stigmatized than males for identical behavior.

The individual's level of education is another concern that was considered to have effect on the individual's experience of stigma in literature, although the current study didn't approve significant relation between both, [4] revealed that the level of education has interesting relation with the feeling of stigma, which is found to increase with level of education and this was returned to the Probability of the fact that people might attribute psychiatric illness with lower level of mental capabilities; and therefore think that by disclosing their illness, their credibility and influence may be lost in the society.

Adding to the previous factors that may affect experience of stigma, the number of admissions to psychiatric hospitals, although half of the sample were not admitted previously to psychiatric hospitals and the number of admissions did not reach a significant level, This may indicate a relation to stigma, as interpreted by [29], who revealed that their study participants told that they did their best to avoid hospitalization in order to keep their social integration at work, school, family, etc.

Concerning patient's total quality of life degrees, the highest percentage of the studied sample demonstrated moderate degree of QOL, followed by high degree of QOL, and the least percentage had experienced low quality of life. This result could be attributed to the long duration of illness that patients had experienced, as it was specified in the inclusion criteria (more than 3 years) and reported by patients. This duration may be enough to make the patients adapt to their illness and modulate their life to the new circumstances. From another view, [2], who examined "schizophrenic patients' families psycho-education: outcomes on patient quality of life and disease relapse rate", they stated that the major improvements in the pharmacological as well as psychosocial treatments of patients have increased their hope and the psychiatrists' ambition not only to reduce symptoms, but also to improve quality of life and increase patients' reintegration.

Furthermore, the onset of a first episode of psychosis is frequently associated with a pronounced decline in education and employment [16] and by the time young people present to mental health services, close to half are already unemployed [24], [34], [40]. On the other hand the [26] argued that, people living with chronic illnesses, who anticipate greater stigma and living with concealable stigmatized identities are more likely to socially isolate themselves, experience lower quality of life; and this relationship is explained, in part, by higher stress, lower social support and lower patient satisfaction.

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As regards the correlation between stigma and total quality of life, quality of life is affected by stigma as revealed by the current study result, because of the burden put on the mentally ill people ranging from the negative attitude of public that they are faced by and social discrimination, ending by their fate in mental health treatment programs that are low funded and needs more and more enhancement, all of these barriers have their negative impact on the patient's quality of life. This result was congruent with [37], who reported that stigma is negatively associated with quality of life, additionally the impairment in social and leisure functioning associated with concerns about stigma has implications for the health and well-being of persons diagnosed as having bipolar illness. First, the extent and quality of social interactions have an important bearing on quality of life [20]. Second, research on social support has consistently shown that the absence of close or confiding relationships is associated with greater risk of relapse or non-remission among individuals with depression [39].

8. Conclusion

The results of the current study revealed that, the studied sample had apparent high feeling of stigma regarding mental illness associated with moderate quality of life; this finding indicates that caring mentally ill people's quality of life and conveying no discriminatory attitude from health care system and all of the surrounding society will decrease their sense of stigma and affect positively their quality of life.

9. Recommendations and future scope of this study

Based on the current findings, the following recommendations are suggested

a) Practice Recommendations

- Psychiatric institutions should play more roles not only in medical management of patients but also in promotion of their social life. Their life satisfaction, as well as all social activities that could improve the relationship and link between the patients and the institution.
- Planning and implementation of public health awareness programs to raise the orientation toward the nature of psychiatric disorders, this programs should reach all social classes and cultures in: schools, universities social clubs, religious institutions and mass media.
- Increase patient's awareness to certain issues could protect against more feelings of stigma like their role in relapse prevention, adequate social skills, and assumption of responsibility in life. This could be achieved through rehabilitative activities in psychiatric institutions.
- Mass media should exert role in de-stigmatization of psychiatric patients and psychiatric illness as well.

b) Research Recommendations

- Stigma and its sequelae should achieve a prominent place on the curriculum of all health service professionals and their student, and researchers.
- The coming researches should initially assess if the origin of the individual's stigma is public or self stigma to act on it accordingly in management.
- Health staff, administrative organizations of health, media should be included as a target of research as causative factors of stigma.
- Research in this area should include availability and the effectiveness of the applied management strategies, also the adherence of mentally ill people to it.

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