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Relation between social support, stigma and empowerment on the quality of life among schizophrenic patients

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Abstract
Empowerment has come to play a central role in psychiatric nursing and is positively related to essential recovery outcomes as quality of life and level of functioning of schizophrenic patients generally experience not only but also symptoms of their mental illness and public stigma. The aim of the study: The study aimed to investigate and explore the relation between social support, stigma and empowerment on the quality of life among schizophrenic patients. The study sample: was comprised all patient's in inpatient's psychiatric unit and out patient's setting at Assiut university hospital diagnosed schizophrenia. Research Design: Descriptive correlation research design used in this study. Sitting: The study was conducted in inpatient psychiatric department and outpatient setting at Assiut university hospital. Tools: Five tools were used for data collection: Sociodemographic Data; Structured Interview schedules; Social Support scale; Internalized stigma of mental illness scale, Empowerment scale and Quality of life scale. Results: The main results yielded in this study are: There is a significant difference in the levels of social support, most of the inpatients have moderate level of social support, there is a significant difference among inpatient and outpatient alienation, discrimination and stigma resistance, there is a significant differences among inpatient and outpatient group as regard the quality of life levels. Conclusion: there is a negative correlation between the QOL with social support and empowerment among the inpatients and outpatients group and positive correlation between the QOL with all item of stigma for inpatients groups but in discrimination and social withdrawal only for the out patients group. Recommendations psychosocial intervention is recommended to improve patient's empowerment, social support and decrease their internalized stigma.

Keywords: Empowerment, quality of life, psychiatric patients, schizophrenia, social support, stigma

Introduction

Empowerment is an outcome pursued by advocacy groups, consumer organizations, mental health professionals and health care providers. Psychological empowerment as the connection between a sense of personal competence, a desire for and a willingness to take action in the public domain. McLean, (1995) [28] noted that empowerment is defined as the action of those who are disempowered and acting to become empowered. Furthermore, Segal *et al*., (1995) [35] and his colleagues described empowerment as a process of gaining central over one's life and influencing the organizational and societal structure in which one lives. Empowerment has been extensively discussed in several fields other than mental health including social work, community psychology, and also in case management. People with mental illness generally experience not only symptoms of their mental illness and public stigma, but are often also stereotyped by the general population as a result of internalize negative attitudes toward themselves and their peers, which eventually leads to self-stigmatization. Some of them accept the common prejudices and lose of self-esteem, resulting in self-stigmatization. Actuality some develop low self-esteem while others remain indifferent to stigma or react with empowerment and righteous anger has been called the "paradox of self-stigma and mental illness (Brohan, *et al*., 2010) [5]," (Rusch *et al*., 2005) [32].

The quality of life (QOL) of patients with schizophrenia is worse than that of the general population and that of many patients with physical and other mental disorders. (Bobes J, *et al*., 2006) [4] Beside the illness itself, the stigma of the mental illness and associated with discrimination cause a particularly harsh burden. Discrimination and rejection experiences are more prevalent among people with psychotic disorders than among people with other mental disorders (Lundberg B, *et al*. 2008) [25], and are associated with poor QOL (Depla MF, 2005) [12], (El-Badri S, 2007) [13] and (Switaj P, 2009) [38].

People with both a high internalization of stigma, i.e. the

inner subjective experience of stigma and its psychological effects resulting from applying negative stereotypes and stigmatizing attitudes to oneself, and a high extent of perceived stigma and anticipated discrimination, i.e. the perception that the public holds negative attitudes towards people with mental disorders and discriminate against them, may have difficulties to see their life as a meaningful and to enjoy it (Corrigan PW, *et al*., 2009) [11]. Another important aspect for a good QOL is an individual's empowerment, i.e. their strengths, the ability to sustain control over their life and the conviction that the own doing has an influence on one's life (Lundberg B, *et al*. 2008) [25], (Rogers ES, *et al*., 1997) [33] and (Yanos PT, *et al*. 2007) [40].

Significance of Study

Empowerment has a significant influence on schizophrenic patient outcomes, including helplessness, recovery and quality of life living with psychosis is a very traumatic experience. Patients do not know what to expect as psychosis is highly unpredictable and symptoms vary (Lodge, 2010) [21]; Lysaker, 2010) [22]. Up until now, the theirs no sufficient studies that have discussed relation between social support, stigma and empowerment on the quality of life among schizophrenic Patients. In psychiatry, stigma is a distinguishing demarcation between the people with and without psychiatric illnesses, attributing negative characteristics of schizophrenic (Eksteen & Becker, 2017) [14]. Stigma can lead to negative discrimination, low self-esteem, psychological burden, and ultimately interfere with psychiatric services (Sewilam & Watson, 2015) [36]. So the present study trying to investigate and explore the relation between social support, stigma and empowerment on the quality of life among schizophrenic patients.

The Aim of This Study

The study aimed to investigate and explore the relation between social support, stigma and empowerment on the quality of life among schizophrenic patients.

This Aim will be achieved through the Following Objectives

1. Assess levels of social support among schizophrenic patients.
2. Identify the presence of internalized stigmatization among schizophrenic patients.
3. Identify the sense of empowerment among schizophrenic patients.
4. Measure levels of quality of life among schizophrenic patients.
5. Finds out the correlation between social support, stigma and empowerment on the quality of life among schizophrenic patients.

Subjects and Method

Research Questions

Are there a relation between social support, stigma and empowerment on the quality of life among schizophrenic patients?

Research Design

Descriptive correlation research design used in this study, such design fits the nature of the problem under investigation.

Research Setting

The study was conducted in inpatient psychiatric department and outpatient setting at Assiut university hospital. The hospital is serving Assiut City and all Upper Egypt governorates.

Subjects

Convenience sample of all available male and female patients diagnosed schizophrenia according to DSM 1V included in the study during six months period from starting the data collection in the previous mentioned hospitals in the time of data collection with total number (100) patients.

Tools of the Study: Four tools were used for data collection:

Tool I: Social Support Scale

This scale was developed in English language and translated into Arabic language by Rana Merhi, shahe S (2012) [30]. The aim of this scale was to assess social support composed of twelve items measured on a seven points (1-7) Likert scale. The items tended to divided into factor groups relating to the source of the social support, namely family (Fam), friends (Fri) or significant others (SO). Patients will choose the most suitable of these statements that describe his social support. The total score is (84). This divided into three levels:

- Low social support level ranges from 1to 27
- Moderate social support level ranges from 28 to 55
- High social support level ranges from 56 to 84

Tool II: Internalized Stigma of Mental Illness Scale (ISMI) inventory

It was developed by Ritsher and colleagues (2003) [31] the aim of this scale was to measure the subjective experience of stigma with subscales measuring Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal and Stigma Resistance. It contains 29 items scored on a four point Likert scales (1='strongly disagree' to 4='strongly agree') high scores indicate that internalized stigmatization is more sever in the individual. The scale is divided into five subscales: Alienation (six items reflecting the respondent's feeling of participation in the society), stereotype endorsement (seven items reflecting the respondent's tendency to endorse stereotyped impressions of psychiatric patients), discrimination experience (five items reflecting the respondent's experiences of unfair treatment due to other people's discrimination), social withdrawal (six items reflecting the respondent's experience of frequent refusal by others due to his mental disorder), and stigma resistance (five items reflecting respondent's perceived ability to deflect stigma) the internal consistency for Arabic form of the scale (Cronbach's alpha) was 0.91. The scale was translated into Arabic and back translated was done by the researcher and validity of the scale was estimated by five experts in the field of psychiatric medicine and psychiatric nursing. Minor discrepancies into the content were found and necessary modifications were done. Note: Five items are reversed coded.

Tool III: Empowerment Scale

It was developed by Rogers, Chamberlin, Ellison and Crean (1997) [33] in English language the aim of this scale was to measure of personal empowerment, 31 item self-report empowerment scale assessed a sense of empowerment, including five subscales: self-esteem/self-efficacy, power/powerlessness, community activation and autonomy, optimism and control over the future, and righteous anger. Along a four-point likert type scale ranging from strongly disagree (1) to strongly agree (4). Total scores ranged from 28 to 112, where higher scores indicated a stronger sense of empowerment. Cronbach alpha in the original study was .86, indicating high internal consistency not Translated to Arabic and use English form.

Tool IV: Quality of Life Scale

The original scale was constructed in English Language and translated into Arabic language by Halabi JO (2006) [19]. This scale used to measure and assess the quality of life of chronic illness. It consists of 57 items divided into six domains or subscales; the first domain comprising 13 items covering the physical health, the second domain comprises 8 items reflecting self–care, the third domain includes 14 items respecting patient's emotional status, the fourth domain consisted of 13 items related to personal and social relationship, the fifth domain includes 5 items which assess patient's ability to making decision, to work, to carry out the work duties and the patient's ability to taking responsibilities and the last domain consists of 5 items used to collect data about spiritual concerns and personal beliefs. Responses were measured on a three point likert scale, ranging from 0 to 2. In which the higher scores, the better quality of life. The total score was 114 points was obtained a score less than 57 points were considered to have a low quality of life. While those who 4 scored between 57-< 85 points were considered to have a moderate quality of life.

In addition, the personal and clinical data questionnaire was added: Which was developed by the researcher in Arabic language after a review of the literature. It included personal data such as the patient's age, gender, marital status, educational level, and occupation. As regarding clinical characteristics, these included the age at onset of illness, duration of illness, and number of previous hospitalizations.

Study Procedure

1. An official permission was obtained from the dean of Faculty of Nursing-Assiut University and from the hospital director to the head of Psychiatric Department at Assiut University
2. The aim of the study was explained to patients before starting data collection and will be informed about what will be done for them.
3. Tool two translated into Arabic language. Both the Arabic and English items were submitted to five experts from the English section, Faculty of Art, Assiut University to be reviewed for its translation. A jury of five experts in the psychiatric field examined the content validity. Reliability done by using Crombach alpha coefficient, it was 0.90.
4. Tool four translated into Arabic language. Both the Arabic and English items were submitted to five experts from the English section, Faculty of Art, Assiut University to be reviewed for its translation. A jury of five experts in the psychiatric field examined the content validity. Reliability done by using Crombach alpha coefficient, it was 0.98.
5. Explanation the purpose of the study for patients before starting data collection.
6. Before entering the actual study, a pilot study was carried out on 10% of schizophrenic patients (10 patients). Pilot study done to test the content clarity and applicability and estimate the length of the time needed to fill the study tools and modification will be done for the tools if needed. The pilot study sample excluded from the total study sample.
7. Each patient has been interviewed once on an individual basis at outpatient and inpatient psychiatric clinic (the outpatient clinic worked three times /week)
8. The patient was oral informed consent about the aim of the study and ensured about the confidentiality and privacy for them.
9. Risk benefits assessment: There is no risk at all during application of the research.
10. Confidentiality: This research was carried out by using of codes of names and information used only for the research work.
11. The patient was interviewed for about 30 – 45 minutes at one time.
12. The data were collected by the researchers during the period of six months from the first of December 2017 to May 2018.

Statistical Analysis

The data were computerized and verified using the SPSS (statistical package for social science) version 20 to perform tabulation and statistical analysis. Qualitative variables were described in frequency and percentages, while quantitative variables were described by mean and standard deviation. Mann-Whitney test, Chi-square test and Spearman correlation were also used. Mann-Whitney test is the non-parametric alternative test to the independent sample t-test. It is a non-parametric test that is used to compare two sample means that come from the same population, and used to test whether two sample means are equal or not. Spearman's rank correlation coefficient or Spearman's rho, is a nonparametric measure of rank correlation (statistical dependence between the rankings of two variables). It assesses how well the relationship between two variables can be described using a monotonic function.

Results

Table 1: Distribution of personal characteristics of schizophrenic patient (100 patients)

Personal characteristics	Inpatient n= 50		Outpatients n= 50		P-value
	No.	%	No.	%	
Gender					
Male	30	60.0	26	52.0	0.420
Female	20	40.0	24	48.0	
Age: (years)					
< 25	13	26.0	18	36.0	0.552
25-30	11	22.0	9	18.0	
> 30	26	52.0	23	46.0	
Mean ±SD	32.36 ± 8.98		30.48 ± 10.76		0.191
Marital status					
Married	17	34.0	13	26.0	0.781
Single	24	48.0	29	58.0	
Divorced/ separated	7	14.0	6	12.0	
Widow	2	4.0	2	4.0	
Level of Education					
Illiterate	8	16.0	10	20.0	0.026*
Read & write	3	6.0	10	20.0	
Basic education	7	14.0	13	26.0	
Secondary	26	52.0	12	24.0	
University	6	12.0	5	10.0	
Occupation					
Not work	18	36.0	11	22.0	0.085
Worker	15	30.0	18	36.0	
Housewife	12	24.0	20	40.0	
Professional	5	10.0	1	2.0	

Mann-Whitney test Chi-square test

Table 2: Distribution of clinical characteristics among schizophrenic patients (100 patients)

Clinical characteristics	Inpatients n= 50		Outpatients n= 50		P-value
	No.	%	No.	%	
Age at onset of illness					
Mean ± SD	26.90 ± 7.82		20.26 ± 6.94		0.000*
Range	10 - 44		10 – 40		
Duration of illness					
< 5	27	54.0	14	28.0	0.024*
5-< 10	11	22.0	14	28.0	
≥ 10	12	24.0	22	44.0	
Mean ± SD	5.46 ± 4.85		10.22 ± 7.67		0.000*
Number of previous hospitalization					
< 2	15	30.0	19	38.0	0.154
2-3	20	40.0	24	48.0	
>3	15	30.0	7	14.0	
Mean ± SD	2.86 ± 2.10		2.32 ± 1.66		0.171

Mann-Whitney test Chi-square test

Table 3: Total mean score and levels of social support among schizophrenic patients

Items	Inpatients n= 50		Outpatients n= 50		P-value
	No.	%	No.	%	
Social support score					
Mean ± SD	46.94 ± 20.03		44.20 ± 22.83		0.392
Range	7-89		2-84		
Level of social support					
Low	7	14.0	16	32.0	0.029*
Moderate	28	56.0	16	32.0	
High	15	30.0	18	36.0	

Chi-square test

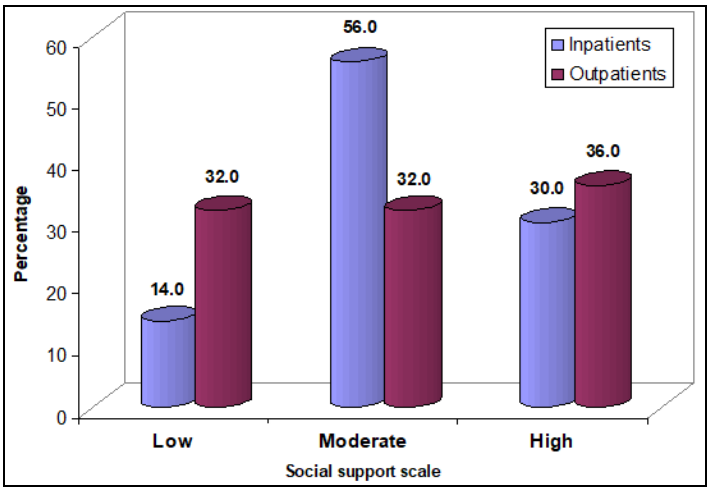

Fig 1: Level of social support among schizophrenic patients

Table 4: Total mean score of internalized stigma dimensions among schizophrenic patients

Internalized stigma dimensions	Inpatients n= 50	Outpatients n= 50	P-value
Alienation			
Mean ± SD	17.42 ± 5.02	15.52 ± 5.89	0.090
Range	6-24	3-24	
Stereotype			
Mean ± SD	16.626 ± 4.95	15.24 ± 5.82	0.233
Range	7-25	4-28	
Discrimination			
Mean ± SD	12.48 ± 3.95	14.08 ± 4.49	**0.034***
Range	5-20	5-20	
Social withdrawal			
Mean ± SD	15.90 ± 5.28	15.58 ± 4.48	0.628
Range	6-24	6-24	
Stigma resistance			
Mean ± SD	11.16 ± 3.66	13.92 ± 4.52	**0.001***
Range	5-20	5-20	

Mann-Whitney test P> 0.05 (significant)

Table 5: Total mean score of quality of life levels among schizophrenic patients

Quality of life score	Inpatients n= 50		Outpatients n= 50		P-value
	No.	%	No.	%	
Mean ± SD	110.86 ± 14.29		83.90 ± 26.37		
Range	68 - 145		57 – 170		
Level of quality of life					
Low	0	0	0	0	0.000*
Moderate	4	8.0	34	68.0	
High	46	92.0	16	32.0	

Mann-Whitney test Chi-square test *P> 0.05 (significant)

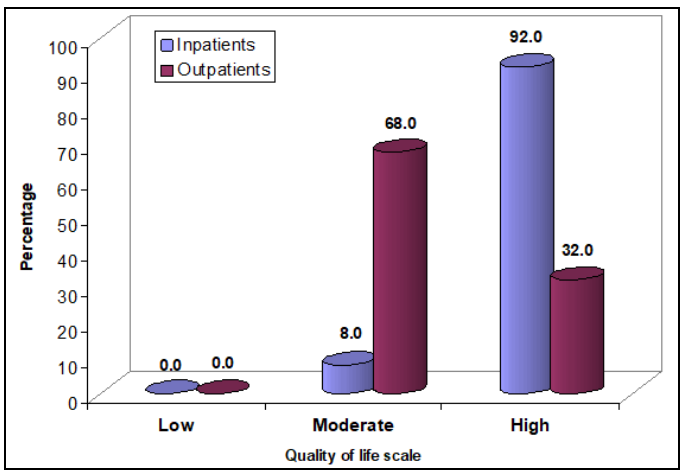

Fig 2: Levels of Quality of life among schizophrenic patients

Table 6: Total mean score of empowerment subscale among schizophrenic patients

Empowerment subscale	Inpatients (n= 50)	Outpatients (n= 50)	P-value
Self-esteem			0.493
Mean ± SD	19.28 ± 4.86	20.90 ± 6.69	
Range	9-29	9-36	
Optimistic			0.000*
Mean ± SD	8.50 ± 2.07	10.78 ± 2.76	
Range	4-13	5-16	
Community activism			0.128
Mean ± SD	15.52 ± 3.94	14.30 ± 4.46	
Range	6-23	6-23	
Power- powerlessness			0.038*
Mean ± SD	20.98 ± 4.95	19.18 ± 5.30	
Range	8-31	8-32	
Rightness of anger			0.065
Mean ± SD	10.40 ± 2.82	11.66 ± 2.45	
Range	4 - 16	6-16	

Mann-Whitney test P> 0.05 (significant)

Table 7: Correlation between QOL and social support, internalized stigma and empowerment among inpatients group with schizophrenia

Variables	Quality of Life Scale	
	r-value	P-value
Total social support	-0.138	0.339
Stigma dimension		
Alienation	-0.335	0.017*
Stereotype	-0.329	0.020*
Discrimination	-0.328	0.020*
Social withdrawal	-0.395	0.005*
Stigma resistance	-0.301	0.033*
Empowerment subscale		
Self-esteem	0.217	0.131
Optimistic	0.157	0.275
Community activism	-0.025	0.864
Power /powerlessness	-0.042	0.771
Rightness anger	0.038	0.792

Spearman correlation

Table 8: Correlation between QOL and social support, internalized stigma and empowerment among outpatients group with schizophrenia

Items	Quality of life scale	
	r-value	P-value
Total social support	0.232	0.104
internalized stigma		
Alienation	-0.121	0.402
Stereotype	0.111	0.445
Discrimination	**0.370**	**0.008***
Social withdrawal	**0.448**	**0.001***
Stigma resistance	0.252	0.078
Empowerment		
Self-esteem	-0.063	0.662
Optimistic	0.188	0.191
Community activism	0.028	0.848
Power/ powerlessness	0.148	0.305
Rightness anger	0.270	0.058

Table 9: Relation between Levels of quality of life &Level of social support among schizophrenic patients

Groups	Levels of quality of life	Levels of social support						P-value
		Low		Moderate		High		
		No.	%	No.	%	No.	%	
Inpatients	Moderate	0	0.0	3	10.7	1	6.7	0.630
	High	7	100.0	25	89.3	14	93.3	
Outpatients	Moderate	12	75.0	11	68.8	11	61.1	0.685
	High	4	25.0	5	31.3	7	38.9	

Chi-square test

Results of the Present Study Showed that

Table (1) shows, the demographic characteristics of schizophrenic patients in which the majority of inpatients and outpatients are males, aged >30 year and single but most of the inpatients group are not work and have secondary level of education. Most of the outpatients group are worker and have basic level of education.

Table (2) shows the clinical characteristics of the studied group which indicates that most of the inpatient and the outpatient have nearly the same number of hospitalization from 2-3 times but the majority of the inpatient group at aged onset ranges from 10-44 years old and the years of illness<5year. Most of the outpatient group, the age at onset ranges from 10-40 years and the years of illness≥ 10 year.

Table (3) shows, total mean score of levels of social support scale among schizophrenic patients indicates that there is no significance difference among the inpatients and outpatients group in the mean score of social support but there is a significant difference in the levels of social support, most of the inpatients have moderate level of social support, but most of the outpatient have high level of social support.

Figure (1) reveals that, most of the inpatients have moderate level of social support, but most of the outpatients have high level of social support

Table (4) reveals that total mean score of internalizes stigma dimension among schizophrenic patients in which there is a significant difference among inpatient and outpatient alienation, discrimination and stigma resistance.

Table (5) shows total mean score levels of Quality of life scale among schizophrenic patients in which there is a significant differences among inpatient and outpatient group as regard the quality of life levels.

Figure (2) shows that, most of the inpatient group in the high level of quality of life, but most of the outpatient in the moderate level.

Table (6) shows total mean score of empowerment scale among schizophrenic patients in which there is a significant differences among the inpatient and the outpatient group in Optimistic, power- powerlessness and rightness of anger.

Table (7) shows that there is a negative correlation between the QOL with social support scale and empowerment scale among the inpatient group and positive correlation between the QOL with stigma scale.

Table (9) shows that there is no significance differences among the inpatients and outpatients group as regard the levels of social support and the Levels of quality of life.

Discussion

Psychotic disorders are often chronic, lifelong illnesses that have a major impact on the individual, family, and community resources. Capleton R, (2000) [9]. People with mental illness struggle with poor QOL and social support, they often cannot develop or sustain supportive relationships within their lives Mordoch E, (2005) [27].

Social support is widely recognized as a crucial factor for mental health and wellbeing. It is one of the most effective means by which people can cope with and adjust to difficult and stressful events and has a positive effect on the process and outcome of psychotherapy and psychiatric treatment. Therefore, the present study aimed to explore the impact of social support on the quality of life in schizophrenic patients.

In the present study the majority of inpatients and outpatients are males, aged >30 year and single but most of the inpatients group are not work and have secondary level of education. Most of the outpatients group are worker and have basic level of education. the present study findings when demonstrated the similar demographic characteristics of the group studied.

Regarding the number of hospitalization most of the inpatient and the outpatient have nearly the same number of hospitalization from 2-3 times but the majority of the inpatient group at aged onset ranges from 10-44 years old and the years of illness<5year. Most of the outpatient group, the age at onset ranges from 10-40 years and the years of illness≥ 10 year.

In relation to total social support level, the present study revealed that, more than half of patients had a low social support level. This is probably may be related to the stigma and discrimination, which have a direct effect on the social opportunities of people with mental illness. Also, the public does not understand the impact of mental illness and frequently fears persons with these disorders. who studied social networks of persons with severe mental illness in in-patient settings and supported community settings in Sweden and found that, a greater proportion of them in comparison to the general population, have smaller social networks and a low network density.

The finding of the present study denoted that, there is a significant differences among inpatient and outpatient group as regard the quality of life levels. Most of the inpatient group in the high quality of life, but most of the outpatient in the moderate level. Almost on all dimensions as well as on the total score. This may be because of the impact of psychiatric disorder is understandable considering the many dimensions of QOL that these disorders influence. This result was contrasted by Langeland *et al*., (2007) [20] who studied QOL among Norwegians with chronic mental health problems versus the general population and found that, they scored substantially lower than the general population in QOL total score and its sub- dimensions.

The present study revealed that, most of patients had a low score in many areas especially the social domain and environmental domain as well as psychological domain of QOL scale. This might be interpreted by that, mentally ill patients have fewer social and cognitive skills, and fewer environmental assets, especially money. Similar findings were reported from China, as Young K,(2012) [41] studied QOL of people with severe mental illness and found that, respondents were least satisfied with their social, environmental, and psychological domains **.**

The results of the present study also indicated that, the physical domain was the highest domain that psychiatric patients had; this may be related to that, mental illness affects cognitive, affective, and behavioral status of patients rather than their physical status. This result was supported by an England study, as Blenkirson P & Hammille C, (2003) [7] studied patients' satisfaction with their mental health care and QOL and stated that the highest domain that psychiatric patients had was the physical domain. In contrast to Nyboe *et al*., (2012) [29] who examined the physical activity in people with mental health conditions in Denmark and demonstrated that, patients with severe mental illness had very low physical activity level.

Regarding to internalized stigma, this study with respect to alienation subscale, there was a considerable feeling of alienation among studied sample. Less than half of the studied sample agreed that people without mental illness couldn't possibly understand them while, more than one third agreed that having a mental illness has spoiled their life and they became inferior to others who don't have mental illness. This finding is consistent with the results of Ghanean *et al*., (2011) who found that, with respect to alienation factor, more than half of the respondents agreed or strongly agreed with three of the six statements: People without mental illness could not possible understand me; having a mental illness has spoiled my life, and I am disappointed in myself for having a mental illness.

In stereotypes endorsement subscales, less than half of the studied sample disagreed that, stereotypes about the mentally ill are applied to them and because they have a mental illness, they need others to make most of decisions for them. Also, slightly more than half of the studied sample disagreed that, mentally ill people shouldn't get married. While there was a high endorsement for two statements; less than half of the studied sample agreed that, mentally ill people tend to be violent and more than one third of them agreed that, people can tell that they have a mental illness by the way they look. These results are partially supported by previous studies using the ISMI, participants who had the lowest scores for the stereotype endorsement subscale (Brohan *et al*., 2010; Lysaker *et al*., 2009; Sibitz, *et al* **,.** 2009; Ritsher *et al*., 2003;) [5, 23, 39, 31] were e.g. "have mental illness, need others to make most of decisions for them", was not particularly frequently reported; with the majority of participants reporting minimal to low levels.

These results are contradicted with some results of Ghanean *et al*., (2011) in Iran, in the stereotype endorsement factor, less than half agreed with two of the seven statements: Because I have a mental illness, I need others to make most decisions for me and people with mental illness cannot live a good, rewarding life **.**While this study is partially supported with the same author who added that, there was a high endorsement for three additional statements: more than one third of studied sample agreed that, stereotypes about the mentally ill apply to me, mentally ill people tend to be violent and people can tell that I have a mental illness by the way I look**.**

Also, Botha *et al*., (2009) [6] reported that, 60% of the respondents in the South African sample agreed that mentally ill people tend to be violent, compared to 43.6% in our study. In the South African sample 24 ***%***agreed that mentally ill people shouldn't get married, while in our sample 50.4% were disagreed **.**

Regarding items belonging to discrimination experience subscales, there is a prevalence of negative experiences, more than half of the studied sample agreed that, others think that they can't achieve much in life because they have a mental illness. While less than half of them were agreed that, people ignore them or take them less seriously just because they have a mental illness, in addition, less than half of them agreed that, people discriminate against them because they have mental illness and people often patronize them, or treat them like a child, just because they have a mental illness. This suggests a strong association between perceptions of the outside world and representations within

the internal world by study sample.

These findings are supported by Brohan *et al*., (2010) [5], who stated that, the large majority of participants felt that the public hold negative attitudes towards people with a mental illness (about three quarters of them experience moderate to high levels of perceived discrimination). Similar to, Ghanean *et al*., (2011) Insight and its relationship with internalized stigma among psychiatric patients found that, a high prevalence of negative experiences; about three quarters of participants agreed or strongly agreed that people discriminate against them because they have a mental illness, and half of them agreed or strongly agreed that people often patronize them, or treat me like a child just because they have a mental illness.

Needless to say that people are sociable by their nature and desire interaction with others. In this study it was found that, patients reported considerable social withdrawal. About half of the studied sample were agreed that, they don't talk about themselves much because they don't want to burden others with their mental illness, while less than half of them were disagreed that, they don't socialize as much as they used to because their mental illness might make them look or behave "weird" and being around people who don't have a mental illness makes them feel out of place or inadequate. Also less than half were agreed that, negative stereotypes about mental illness keep them isolated from the" normal" world. This could be explained by that, patient found themselves hospitalized in a strange society and after discharge; people refuse to deal with them as a psychiatric patients especially in manual occupation related to stigma of mental illness or may be due to the nature of mental illness as a large number of mentally ill patients are isolated or withdrawn because of psychotic symptoms like delusions, mistrust and hallucinations **.**

These results are supported by lysaker *et al*., (2007) [24] who stated that, both the acceptance of stigma or unawareness of illness may lead to social isolation. However, it is also possible that an underlying risk factor for both poor insight and social isolation, such as neurocognitive impairment may explain these relationships. In this respect, Ghanean *et al*., (2011) [16] found that, more than half agreed or strongly agreed with the statements: they don't talk about themselves much because don't want to burden others with their mental illness, and negative stereotypes about mental illness keep them isolated from the normal world. More than one third agreed or strongly agreed on that they avoid getting close to people who don't have a mental illness to avoid rejection.

However, the stigma resistance subscale showed that, the studied sample possessed considerable strength. For example more than half agreed upon they can have a good fulfilling life, despite their mental illness and about half also agreed that in general, they are able to live their life the way they want to. In this respect, Botha *et al*., (2009) [6] reported that, in the South African study more than three quarters agreed that; I can have a good and fulfilling life despite my mental illness. Similar to, Brohan *et al*., (2010) [8]. found that, more than half of the sample reported moderate to high levels of stigma resistance

On the other hand, this study found that, more than half of the studied sample disagreed that, they feel comfortable being seen in public with an obviously mentally ill person, about half of them were disagreed that **,**people with mental illness make important contributions to society and living with mental illness has made them tough survivor. In this respect, Mishra *et al*., (2009) [26] added that, period of illness and recovery that may produce fluctuations in cognitive function, social skills, expression of paranoia, depression and other symptoms can alter ability of group identification and withstanding stigma **.**These results are contradicted with Ghanean *et al*., (2011) [16] findings; who reported that, over half of the respondents agreed or strongly agreed that people with mental illness make important contributions to society or Living with mental illness has made me a tough survivor.

These findings are consistent with other recent evidence supporting that the mean score of empowerment scale among schizophrenic is affected in which there is a significant differences among the inpatient and the outpatient group in Optimistic, power- powerlessness and rightness of anger. There is a negative correlation between the QOL with social support scale and empowerment among the inpatient group and positive correlation between the QOL with stigma scale. There are positive correlations between the QOL with stigma scale items.

Conclusion

Based in the results of the present study, it is concluded that, more than half of the studied sample had lack of social support, sense of empowerment. More over the studied sample had a considerable feeling of alienation, endorsement of negative stereotypes and experiences, as well as, great social withdrawal although; they possessed considerable strength regarding resistance of stigma. On the other hand, there is a negative correlation between the QOL with social support scale and empowerment scale among the inpatients and outpatients groups and positive correlation between the QOL with stigma scale for inpatients group in all items of the scale but in discrimination and social withdrawal only for the out patients group

Recommendations based on results

This study recommended that: Further study need about Psychosocial intervention for patients to improve patient's empowerment, social support and decrease internalized stigma and for health care workers regarding how social support and internalized stigma affect the treatment of psychiatric disorders and their relationship to variables such as medication compliance, treatment compliance **,** hospitalization, and psychosocial functioning, in order to plan and provide effective therapeutic interventions and services to their clients.

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