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Insight and its relationship with internalized stigma among psychiatric patients

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Abstract: *Insight and internalized stigma are problems that afflict a large portion of people with psychiatric disorders. Therefore the* ***aims*** *of this study were to assess the levels of insight and internalized stigma and to determine the relationship between them among psychiatric patients. Descriptive correlational research design was utilized in this study. This study was conducted at the inpatient unit at Bani- Ahmed psychiatric hospital in Minia governorate.* ***Four tools*** *were utilized to measure the variables of the study: Personal and Medical data Questionnaires, Brief Psychiatric Rating Scale, Insight Scale and Internalized Stigma of mental illness Inventory.*

Results*: revealed that, the severity of symptoms increased in females, those who resided rural area, widowed and divorced patients, also, increased among schizophrenia, depression and mania respectively. 61.6% of the studied sample disagreed that, if someone said they have a nervous or mental illness they would be right. 45.6% of the studied sample agreed that they didn't need medication. 35.6% were agree that having a mental illness has spoiled their life and they feel inferior to others who don't have mental. People can tell that I have a mental illness by the way I look.*

Conclusion: *More than half of the studied sample has lack of insight and there was a considerable feeling of alienation, endorsement of negative stereotypes and experiences of discrimination and considerable social withdrawal*

Recommendations: *psycho-educational programs are recommended to improve patient's insight and decrease their internalized stigma.*

Key words*: Insight, internalized stigma, Psychiatric patients.*

I. Introduction

Insight is an important concept in clinical psychiatry as it is a complex multidimensional construct which is shaped by individual psychology (i.e. motivation and denial) and the constraints of biology (as cognitive impairment and anosognosia) and is influenced by social construction of illness and culturally specific explanatory models **(Amador & David, 2004).** It has been alternatively held that acknowledgment of one's mental illness is a detriment and a key to successful adaptation. From one perspective, acceptance of illness has been advanced as a key to making informed decisions about one's future, to free oneself from blame for difficulties linked with illness and to forming bonds with others who are aware of one's difficulties. From another view however, "awareness of illness" has been suggested to represent the acceptance of a system of social power in which one's individuality and dignity is at risk of being diminished. Indeed both awareness and lack of awareness have significant risks associated with them, **(Saostowo, 2011).**

The search for positive outcomes from insight has revealed negative outcomes, particularly in the areas of quality of life and self-esteem. The concept of insight is problematic because it merges several aspects of the mental illness experience that may not belong together. An examination of the theoretical and empirical literatures in the area reveals a mélange of ideas about awareness of illness, acceptance of illness, willingness to take medication or other treatment, and endorsement of other expectations that are applied to people with mental disorders , **(Kravetz et al., 2000).**

David concluded that, although insight is a separate phenomenon, is modestly influenced by symptom dimensions of psychosis. Specifically, insight is worse in the presence of positive, negative symptoms and psychotic disorganizations. Conversely, insight is better in the context of depression **(David, 2004).**

People with mental illness often face a double problem: symptoms of their mental illness and public stigma. Some people with mental illness accept the common prejudices and lose self-esteem, resulting in self-stigmatization (**Rusch et al., 2005).**

One of the especially painful and destructive effects of stigma is that people with mental illness are left feeling that they are not full members of society. Regardless of the objective level of discrimination that an individual is exposed to, it is the subjective perception of being devalued and marginalized that directly affects a person's sense of self-esteem and level of distress. Among families of patients with schizophrenia, internalized

stigma may not only hinder help seeking but also result in the families attempting to provide care themselves, without assistance from mental health services **(Oleanomarorea, 2011).**

Some authors believe patients with insight tend to have higher self-stigma (**Mak & Wu, 2006**) while other authors don't support this conclusion. Mental health professionals expected that acceptance of illness and rejection of self-stigma lead to greater levels of adherence to prescribed medication, higher self-esteem, better adaptation to illness and better social functioning. On the other hand, when stigma accepted and illness rejected lead to higher self-esteem, poorer adaptation to illness and poorer social functioning (**Lysaker et al., 2007**).

II. Significance of the Study

According to the previous research, lack of insight and internalized stigma have a paramount important in psychotic patients' condition, both of them are contributed to poorer global functioning, severity of psychopathology, delayed treatment-seeking, treatment-refractory symptoms, prolonged course, avoidable hospitalizations, recurrence and poorer outcome. Therefore, this study will investigate the relationship between insight and internalized stigma among psychiatric patients for their close association with patients' willingness to seek or accept care for their mental illness. Data generated from this study could be helpful in identifying the way psychiatric patients perceive or understand their illness and the degree to which psychiatric patients accept or apply negative stereotypes to themselves.

III. Patients and Method

Aim of the study: This study aimed to assess the levels of insight and internalized stigma in psychiatric patients and to determine the relationship between insight and internalized stigma in psychiatric patients.

Research design: A descriptive correlational design was used in the study; such design fits the nature of the problem under investigation.

Setting of the study: This study was conducted at the inpatient unit at Bani- Ahmed psychiatric hospital in Minia governorate. This hospital is affiliated to Ministry of Health. It consists of two floors; the first floor for the outpatient clinics, pharmacy and administrations. The second floor includes psychiatric inpatients and nursing offices. The hospital capacity is 50 beds for both genders.

Sample: included all patients admitted to the psychiatric inpatient units during ten months started from the first of March to the end of December 2013, their number accounted to 250 psychiatric patients. Patients with any other neurological disorder or major physical illness were excluded.

Tools of data collection:

1- Socio-demographic and clinical data questionnaire:

This questionnaire was developed by the researcher to elicit data about patient's age, sex, educational level, marital status, occupation, diagnosis and duration of illness.

2- Brief Psychiatric Rating Scale (BPRS):

Brief Psychiatric rating scale was developed by Overall et al., 1963 and modified by Ventura et al., 1993. This scale includes 24 symptoms to assess the severity of psychiatric symptoms. It is rated on a 7-point scale of severity ranging from "not present" (1) to "extremely severe" (7), higher score indicates greater severity. Reading of this score is range from 168 high score to 24 low score. The higher positive score indicates greater severity of the symptoms. This scale possesses adequate internal consistency (cronbach alpha 0.79) for Arabic form. Validity of this scale was tested by five experts in the field of psychiatry and psychiatric nursing. Rate items 1-14 on the basis of individual's self-report. Items 15-24 are rated on the basis of observed behavior and speech. This scale translated into Arabic language and the content validity was tested by 3 bilingual experts in the field of psychiatry and psychology by **shehata (2008)**.

3- Insight scale (IS):

Developed by Birchwood and colleagues in 1994. It consist of 8 items divided into 3 subscales to assess awareness of illness (2 items number 2&7) maximum total 4, relabel of experiences (2 items number 1&8) maximum total 4 and need for treatment (4 items number 3,4,5&6) divide score by 2 to give total score. Scored on a 3- point likert scale (0= disagree, 1= unsure & 2= agree) with higher scores indicating higher level of insight. This scale possesses adequate internal consistency (cronbach alpha 0.75) for Arabic form. The tool was translated into Arabic by the researcher and back translation was done. Validity of this scale was tested by five experts in the field of psychiatry and psychiatric nursing and their modifications were collected and revised by the supervisors and certain modifications were done accordingly. Note: Items numbers (2, 3, 6 & 8) are

reversed scoring.

4- Internalized Stigma of mental illness (ISMI) inventory: developed by Ritsher and colleagues (2003) contains 29 items scored on a 4-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 psychiatry and psychiatric nursing. Minor discrepancies into the content were found and necessary modifications were done. Note: The stigma resistance items (25, 26, 27, 28& 29) are reversed coded.

Preparatory phase

An official letter was sent from the dean of the Faculty of Nursing, Minia University, to the director of Bani Ahmed psychiatric hospital in Minia to secure permission for data collection. The aim and process of study were briefly explained through direct personal communication with the patients, also oral or written informed consent was taken from patients' committee of the psychiatric patients' rights within the hospital.

Pilot Study

A pilot study was done to evaluate the tools clarity and applicability as well as the time needed to fulfill each sheet. It was carried out on a sample of 25 patients and they were excluded from the actual study sample.

Data collection

Data was collected during ten months started from the first of March to the end of December 2013. Data collection was carried out 2 days per week from 10 am to 2pm. patients were interviewed using the study tools after taking oral or written consent. The interview took about 30 minutes with every patient.

Ethical consideration

The following ethical considerations were considered throughout data collection:

- Permission to carry out the study was obtained from the director of Bani Ahmed psychiatric hospital in Minia governorate.
- Oral or written informed consent was obtained from the patients and the participation in the research was elective.
- The researcher ensured that confidentiality was maintained during and after the research process.
- The participant's dignity and privacy were maintained and respected throughout the research process.
- Risk-benefits assessment: There was no risk during the application of the research.

IV. Statistical Analysis

The content of each scale was analyzed, categorized and then coded by investigator. Patients' responses to each category were tabulated separately by using statistical package for social science (SPSS) version 17. Descriptive statistics were calculated as frequencies, percentage, mean and standard deviation. Chi square was also used. Probability (P-value) is considered significant at or less than 0.05 and considered highly significant at or less than 0.001.

V. Results

Table (1): Distribution of demographic and medical characteristics of the studied sample (N=250).

Demographic characteristics	**Range**	**Mean (SD)**
Age	17- 57	34. 39 + (9.73)
Demographic characteristics	**N**	**%**
Sex		
Male	184	73.6
Female	66	26.4
Residence		
Urban	125	50
Rural	125	50
Education		
Illiterate	57	22.8

Read& write	11	4.4
Primary	17	6.8
Preparatory	10	4.0
Secondary	118	47.2
University	37	14.8
Marital status		
Single	115	46
Married	91	36.4
Divorced	35	14
Widow	9	3.6
Occupation		
Employee	56	22.4
Not working	89	35.6
Farmer	52	20.8
House wife	53	21.2
Diagnosis		
Schizophrenia	136	54.4
Depression	49	19.6
Mania	44	17.6
Schizoaffective	6	2.4
Others (delusional dis., personality dis.,)	15	6.0

Table (2): Frequency distribution of Brief Psychiatric Rating Scale (BPRS) among studied sample (N=250).

N	BSRS	**Not present**		**Very mild**		**Mild**		**Moderate**		**Moderately sever**		**severe**	
		N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
1	**Somatic concern**	78	31.2	36	14.4	88	35.2	44	17.5	2	.8	2	0.8
2	**Anxiety**	45	18.0	22	8.8	112	44.8	71	28.4	-	-	-	-
3	**Depression**	84	33.6	20	8.0	27	10.8	90	**36**	27	10.8	2	0.8
4	**Suicidality**	48	19.2	8	3.2	76	30.4	92	**36.8**	24	9.6	2	.8
5	**Guilt**	147	58.8	15	6.0	13	5.2	51	20.4	23	9.2	1	.4
6	**Hostility**	76	30.4	15	6.0	106	42.4	46	18.4	7	2.8	-	-
7	**Elated mood**	154	61.6	7	2.8	26	10.4	44	17.6	19	7.6	-	-
8	**Grandiosity**	134	53.6	-	-	29	11.6	58	23.2	27	10.8	2	.8
9	**Suspiciousness**	94	37.5	7	2.8	50	20.0	65	26.0	32	12.8	2	.8
10	**Hallucination**	53	21.2	5	2.0	49	19.6	98	**39.2**	41	16.4	4	1.6
11	**Unusual thought content**	17	6.8	46	18.4	87	34.8	82	**32.8**	18	7.2	-	-
12	**Bizarre behavior**	48	19.2	19	7.6	96	38.4	70	28.0	15	6.0	2	.8
13	**Self-neglect**	64	25.6	4	1.6	89	35.6	72	28.8	20	8.0	1	.4
14	**disorientation**	203	**80.9**	11	4.4	30	12.0	6	2.4	-	-	-	-
15	**Conceptual disorganization**	100	39.8	18	7.2	109	43.4	22	8.8	1	.4	-	-
16	**Blunted affect**	123	49.2	4	1.6	56	22.4	65	26.0	2	.8	-	-
17	**Emotional withdrawal**	69	27.6	6	2.4	66	26.4	91	**36.3**	18	7.2	-	-
18	**Motor retardation**	94	37.6	1	.4	59	23.6	57	22.8	32	12.8	7	2.8
19	**Tension**	34	13.6	38	15.2	154	**61.6**	24	9.6	-	-	-	-
20	**Uncooperativeness**	79	31.6	8	3.2	77	30.8	66	26.4	20	8.0	-	-
21	**Excitement**	120	48.0	16	6.4	58	23.2	44	17.6	12	4.8	-	-
22	**Distractibility**	43	17.2	14	5.6	82	32.8	80	32.0	26	10.4	5	2.0
23	**Motor hyperactivity**	168	67.2	4	1.6	14	5.6	39	15.6	23	9.2	2	.8
24	**Mannerism and posturing**	200	**80.0**	8	3.2	24	9.6	18	7.2	-	-	-	-

Table (3): Frequency distribution of Insight Scale (IS) among studied sample (N=250).

N	**Insight scale**	**Agree**		**Unsure**		**Disagree**	
		N	**%**	**N**	**%**	**N**	**%**
Awareness of illness							
1	I'm mentally well.	172	**68.8**	40	16.0	38	15.1
2	If someone said I have a nervous or mental illness they would be right.	72	28.8	24	9.6	154	**61.6**
Relabel of experiences							
3	Some of my symptoms are made by my mind.	88	35.2	35	14.0	127	**50.6**
4	None of the unusual things I experience are due to an illness.	98	39.2	42	16.8	110	44.0
Need for treatment							

5	I don't need medication.	114	**45.6**	26	10.4	110	44.0
6	My stay in hospital is necessary.	86	34.4	31	12.4	133	**53.2**
7	The doctor is right in prescribing medication for me.	126	**50.2**	24	9.6	100	40.0
8	I don't need to be seen by a doctor or psychiatrist.	93	37.2	35	14.0	122	**48.8**

Table (4a): Frequency distribution of alienation and Stereotype endorsement subscales of Internalized Stigma for Mental Illness (ISMI) scale among studied sample (N=250)

N	ISMI	Strongly disagree		disagree		agree		Strongly agree	
		N	%	N	%	N	%	N	%
Alienation									
1	I feel out of place in the world because I have mental illness	53	21.2	100	**40.0**	83	33.2	14	5.6
2	Having a mental illness has spoiled my life	53	21.2	86	34.4	89	**35.6**	22	8.8
3	People without mental illness could not possibly understand me	35	14.0	95	38.0	109	**43.6**	11	4.4
4	I am embarrassed or ashamed that I have a mental illness	54	21.6	91	36.4	87	34.8	18	7.2
5	I am disappointed in myself for having a mental illness	50	20.2	104	41.9	79	31.9	15	6.0
6	I feel inferior to others who don't have mental illness	64	25.6	89	35.6	89	**35.6**	8	3.2
Stereotype endorsement									
7	Stereotypes about the mentally ill apply to me	76	30.4	110	**44.0**	62	24.8	2	.8
8	People can tell that I have a mental illness by the way I look	48	19.2	98	39.2	94	**37.6**	10	4.0
9	Mentally ill people tend to be violent	46	18.4	77	30.8	109	**43.6**	18	7.2
10	Because I have a mental illness, I need others to make most decisions for me	55	22.2	113	**45.6**	75	30.2	5	2.0
11	People with mental illness cannot live a good, rewarding life	76	30.4	107	42.8	56	22.4	11	4.4
12	Mentally ill people shouldn't get married	79	31.6	126	**50.4**	41	16.4	4	1.6
13	I can't contribute anything to society because I have a mental illness	76	30.4	104	41.6	60	24.0	10	4.0

Table (4b): Frequency distribution of discrimination experience and social withdrawal subscales of Internalized Stigma for Mental Illness (ISMI) scale among studied sample (N=250)

N	ISMI	Strongly disagree		disagree		agree		Strongly agree	
		N	%	N	%	N	%	N	%
Discrimination experience									
14	People discriminate against me because I have mental illness	52	20.8	86	34.4	110	**44.0**	2	.8
15	Others think that I can't achieve much in life because I have a mental illness	46	18.4	68	27.2	134	**53.6**	2	.8
16	People ignore me or take me less seriously just because I have a mental illness	52	20.8	72	28.8	116	**46.4**	10	4.0
17	People often patronize me, or treat me like a child, just because I have a mental illness	56	22.4	83	33.2	100	**40.0**	11	4.4
18	Nobody would be interested in getting close to me because I have a mental illness	63	25.2	90	36.0	84	33.6	13	5.2
Social withdrawal									
19	I don't talk about myself much because I don't want to burden others with my mental illness	38	15.2	83	33.2	114	**45.6**	15	6.0
20	I don't socialize as much as I used to because my mental illness might make me look or behave "weird"	47	18.8	101	**40.4**	91	36.4	11	4.4
21	Negative stereotypes about mental illness keep me isolated from the "normal" world	42	16.8	97	38.8	104	**41.6**	7	2.8
22	I stay away from social situations in order to protect my family or friends from embarrassment	51	20.4	96	38.4	94	37.6	9	3.6
23	Being around people who don't have a mental illness makes me feel out of place or inadequate	67	26.8	101	**40.4**	67	26.8	15	6.0
24	I avoid getting close to people who don't have a mental illness to avoid rejection	47	18.8	113	**45.2**	80	32.0	10	4.0

Table (4c): Frequency distribution of stigma resistance subscale of Internalized Stigma for Mental Illness (ISMI) scale among studied sample (N=250)

N	ISMI	Strongly disagree		disagree		agree		Strongly agree	
		N	%	N	%	N	%	N	%
Stigma resistance									
25	I feel comfortable being seen in public with an obviously mentally ill person	56	22.4	134	**53.6**	41	16.4	19	7.6
26	In general, I am able to live my life the way I want to	11	4.4	80	32.0	114	**45.6**	45	17.9
27	I can have a good, fulfilling life, despite my mental illness	16	6.4	65	26.0	127	**50.8**	42	16.8
28	People with mental illness make important contributions to society	29	11.6	114	**45.6**	89	35.6	18	7.2
29	Living with mental illness has made me a tough survivor	50	20.0	119	**47.6**	73	29.2	8	3.2

Figure (1): correlation between brief psychiatric rating score and insight score.

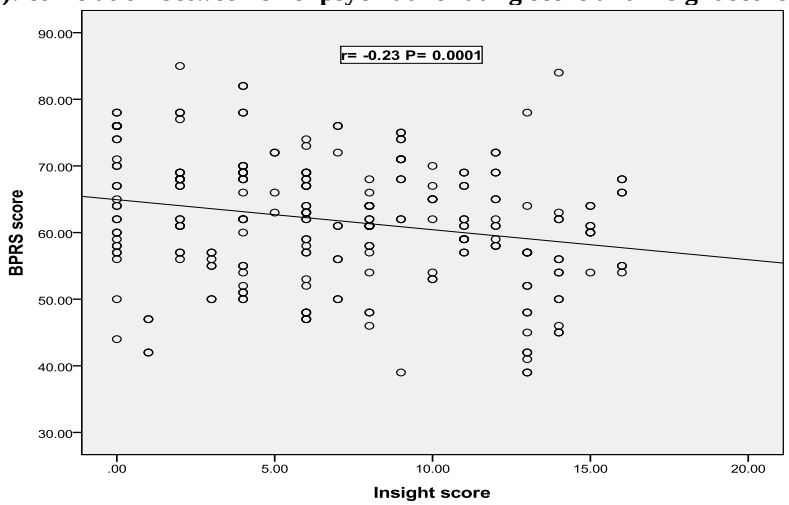

Figure (2): correlation between brief psychiatric rating score and internalized stigma score.

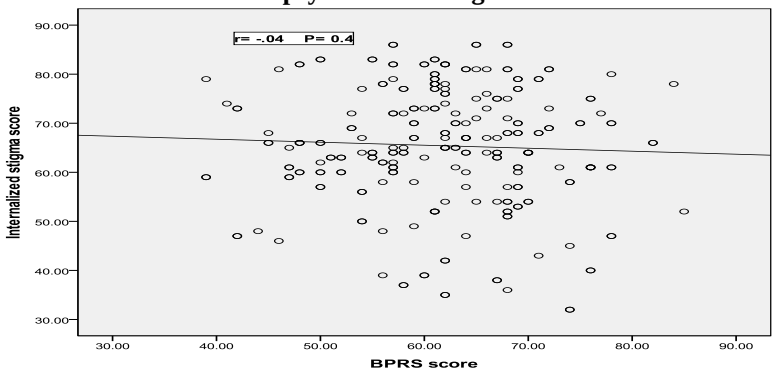

Figure (3): correlation between insight and internalized stigma scores.

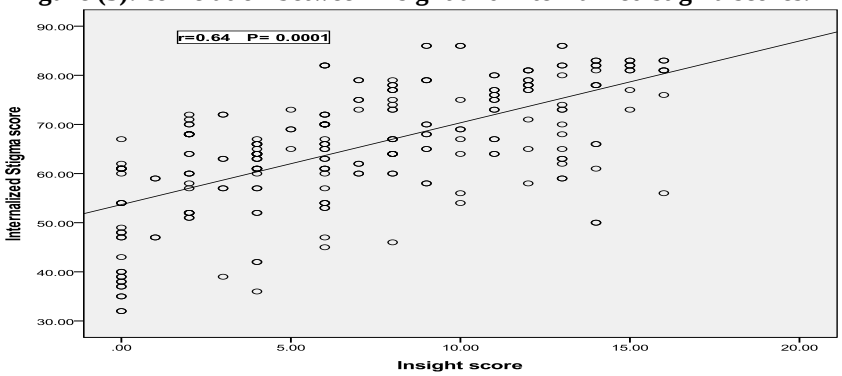

Table (1) shows distribution of demographic characteristics of the studied sample. The studied sample consisted of 250 psychiatric patients. The mean age of the studied patients was 34.39+ (9.73). Male patients represent (73.6%) while females were (26.4%) patients. 50 % of the sample resided in rural area. 47.2 % of the studied sample were graduated from secondary school. 46% of the sample were single and 36 % of them were married. More than one third of the studied sample (35.6 %) did not work. More than one half of the studied sample (54.4%) was schizophrenics.

Table (2) shows frequency distribution of brief psychiatric rating scale among studied sample. the majority of the studied sample (80.9 & 80 %) respectively were oriented and didn't have mannerism or abnormal posturing. 61.6% of them have mild tension. about one third of patients (36%, 36.8%, 39.2, 32.8%& 36.3%) respectively have moderate depression, suicidility, hallucination, unusual thought content and emotional withdrawal.

Table (3) reveals frequency distribution of insight scale among studied sample. More than half of the studied sample (68.8%) agreed that they are mentally well, and 61.6% of them disagreed that, if someone said they have a nervous or mental illness they would be right. 50.6 % of the studied sample disagreed that some of their symptoms are made by their minds. 45.6% of the studied sample agreed that they didn't need medication and 53.2% of them disagreed that their stay in hospital is necessary. More than half of the studied sample (50.2%) agreed that, the doctor is right in prescribing medication for them, while about half of them disagreed that they didn't need to be seen by a doctor or psychiatrist.

Table (4a) demonstrates frequency distribution of alienation and Stereotypes endorsement subscales of internalized stigma for mental illness scale among studied sample. Regarding alienation subscale one third of the studied sample (35.6%) agreed that having a mental illness has spoiled their life and they feel inferior to others who didn't have mental illness. According to stereotypes endorsement subscale 43.6 % of them agreed that people without mental illness could not possibly understand them. 43.6% and 37.6% of the studied sample agreed that mentally ill people tend to be violent and people can tell that they have a mental illness by the way they look respectively.

Table (4b) illustrates frequency distribution of discrimination experience and social withdrawal subscales of Internalized Stigma for Mental Illness (ISMI) scale among studied sample. In relation to discrimination experience, More than half (53.6%) of the studied sample agreed that others think that they can't achieve much in life because they have a mental illness. 44% of the studied sample agreed that people discriminate against them because they have mental illness. Also, on social withdrawal subscale 45.6% of the studied sample agreed that, they didn't talk about themselves much because they didn't want to burden others with their mental illness, Also, 41.6% agreed that negative stereotypes about mental illness keep them isolated from the" normal" world.

Table (4c) shows Frequency distribution of stigma resistance subscale of Internalized Stigma for Mental Illness (ISMI) scale among studied sample. More than half of the studied sample (53.6%) and (50.8%) respectively disagreed that they feel comfortable being seen in public with an obviously mentally ill person and they can have a good, fulfilling life, despite their mental illness.

Figure (1) demonstrates correlation between brief psychiatric rating score and insight score. There is negative and weak significant correlation between insight score and brief psychiatric rating score (r= - 0.23 & P= 0.000)

Figure (2) shows correlation between brief psychiatric rating score and internalized stigma score. a negative weak correlation between brief psychiatric rating score and internalized stigma score (r=-.04 & P=0 .4).

Figure (3) illustrates correlation between insight and internalized stigma scores. There is positive strong significant correlation between insight and internalized stigma scores (r=0.64 & P=0.0001).

VI. Discussion

The result of this study revealed that, more than half of the studied sample has mild tension. In addition, more than one third of the studied sample had moderate depression, suicidility, hallucination, unusual thought content and emotional withdrawal (table 2). This result could be explained by several possible factors. First factor was related to the nature of psychiatric disorders, where more than half of the studied sample has schizophrenia and about one quarter of them have depression and mania.

Hospitalization could be another factor for depressed feeling and emotional withdrawal in which the patients away from their families, friends, and familiar persons. Moreover, psychiatric patients who possess a considerable amount of their insight tend to realize their restrictions and their need for treatment. They become

depressed especially with the regain of their emotions and internalization of the stigma of their illness. Finally, people tend to respond negatively to psychiatric patient. Thus, it is speculated depressive symptoms, isolation and suicidal ideation that have a negative impact on well-being and mental health.

These assumptions are partially consistent with **Eagles et al., (2003)** study; as they reported that, anticipated and actual discrimination and internalized stigma decreased life satisfaction and self-esteem, as well as increased alcohol use ,depression and suicidility. In addition, these findings consistent with **Mishra et al., (2009)** who reported that, subjects participated in the study have mild to moderate level of severity on brief psychiatric rating scale

Concerning insight, the present study revealed that, more than half of the studied sample have a lack of insight (more than half agreed that they are mentally well, while more than half disagreed that, if someone said I have a nervous or mental illness they would be right and their stay in hospital is necessary. In addition, about half of studied sample agreed that they don't need medication) (table 3). These findings can be explained by; the recognition of illness seems to be strongly influenced by disease and sociocultural factors. These findings are consistent with the results of, **(Brown, 2010)** who found that, less insight in both the need for treatment and insight into having a mental disorder were associated with hospitalized patients.

However, these results are contradicted with the findings of other studies which found that, better insight among inpatients and that's due to the fact that patients under psychological treatment had a better insight into the illness could be due to the psycho education provided by psychotherapy. Another explanation could be the reduction in the denial of the illness that would play a role in insight impairment. There may also be a bias, because patients with better insight would be more amenable to psychotherapy **(Gigante& Castel, 2008).**

Regarding to internalized stigma, this study found that, 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 (table 4a). 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 (table 4a).

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;)** 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)** 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 (table 4b).

These findings are supported by **Brohan et al., (2010)** , 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)**

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 (table 4b).

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)** 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)** 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 (table 4c). In this respect, **Botha et al., (2009)** who 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)** 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 (table 4c). In this respect, **Mishra et al., (2009)** 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)** 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.

In this study, it was found that there was negative weak significant correlation among symptoms severity and insight (figure 1). These results, that link between insight and severity of symptoms offering hope that treating the symptoms will improve insight. This finding is supported by **De Hert et al., (2009)** who reported that, unawareness of symptoms is related to severity of illness in schizophrenic patients. While contradicted with these findings of **Saravanan et al., (2007)** who stated that, no significant correlation was found between brief psychiatric total score and schedule assessment of insight.

Moreover there was a weak negative correlation between the severity of symptoms and internalized stigma (figure 2) while **Livingston & Boyd (2010)** found that, internalized stigma had statistically significant, positive associations with symptoms severity and significant negative correlation with treatment adherence. Therefore, a higher level of internalized stigma was associated with greater psychiatric symptoms severity and poorer treatment adherence.

However in this study, there was a positive strong significant correlation between insight and internalized stigma of mental illness scale (figure 3). Therefore; those with poorer insight tend to be less stigmatized by their illness. Accordingly, insight produced lower self-esteem, emotional withdrawal and depression due to its association with self-stigma.

This finding was supported by **Lincoln et al., (2007),** who reported that, insight is positively related to treatment adherence and to self- and social stigmatization. As well as, **Liu et al., (2008)** studies found, increase experience of internalized stigma among patients who have better insight. Similarly, **Mishra et al., (2009)** found that, the level of stigma felt by patients with insight was significantly higher than that felt by patients without insight.

In addition, **Ehab &Wesam (2010)** found that, patients with poorer insight exhibit significantly less internalized stigma. Moreover, patients with poorer insight exhibit significantly less depression scores than those who retain a considerable portion of their insight. Also, **Hasson et al., (2006)** actually found insight to be related positively to such indicators of poor psychosocial adjustment as depression and low emotional well-being.

While **LU& Wang (2012)** stated that, only the alienation subscale score of internalized stigma of mental illness scale was significantly different; patients with insight reported a greater feeling of alienation than those without insight. On the other hand, these results contradicted with **Livingston & Boyd (2010)** who reported that, there was no significant relation between insight and internalized stigma.

VII. Conclusion

Based in the results of the present study, it is concluded that, more than half of the studied sample had lack of insight. More over The studied sample had a considerable feeling of alienation, endorsement of negative stereotypes and experiences, as well as, considerable social withdrawal although; they possessed considerable strength regarding resistance of stigma. On the other hand, insight was significant and positively correlated with internalized stigma of mental illness scale; therefore; those with poorer insight tend to be less stigmatized by their illness.

Recommendations Based On Results

Psycho educational programs for patients to improve patient's insight and decrease internalized stigma, and for health care workers regarding how insight 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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