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Patients' insight and felt stigma among psychiatric patients

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Abstract
Aim: *Was to explore the relationship between insight and felt stigma among psychiatric patients.*
Methods: *The research design was descriptive explorative study. The study was carried out in inpatients units and out patients' clinic of Port-Said Psychiatric health hospital, Egypt. A convenient sample of 130 patients from pervious mentioned setting. The tools that are used for data collection were: Birchwood Insight Scale, Felt Stigma Scale, socio-demographic questionnaire and clinical data interview schedule.*
Results: *The results revealed that, there was a statistically significant relation between patients' diagnosis and insight. The results showed statistically significant relation between patients' insight and its stigma. Psychotic illness contributes to poor insight and high stigma in most schizophrenic patients.*
Conclusion: *The study concluded that psychotic illness contributes to poor insight and high stigma in most schizophrenic patients. Single patients with previous admission to hospital, living in rural area, all contribute to poor insight in* Psychiatric *patients.*
Keywords: *Felt Stigma, Insight, Psychiatric patients.*

I. Introduction

Insight in mental illness refers to a patient's understanding and judgment of his disorder. It is an important marker of recovery from some mental disorders**.** A common view is that lack of insight is part and parcel of the psychotic state. Insight and psychosis are not synonymous phenomena, and indeed. Another piece of evidence that insight is not simply an aspect of psychosis is the observation that impairment of insight occurs in non-psychotic states **[1, 2].**

Poor insight associated with mental disorders is a vital sign of impaired psychosocial products**,** poorer clinical outcome, low treatment adherence**,** lower frontal and parietal gray matter volumes and suicidal behavior in patients with severe mental disorders **[3-5]**.

Insight into having a mental disorder represents a complex multidimensional phenomenon. Thus, dimensional rather than dichotomous measures have been widely used to address multiple aspects of insight into illness. These dimensions include awareness of illness, awareness of symptoms, and the perceived need for treatment **[6]**.

The stigmatization of mental illness is common among the general population, psychiatric patients, and their families. These negative attitudes are primarily based on the belief that psychiatric patients are prone to impulsive acts of violence and are incompetent because of their decreased capabilities **[7].** Such negative attitudes label psychiatric patients and isolate them from society. Because of the existence of stigma, patients often decrease their expectations about their potential achievements and regard themselves as losers **[8]**. Stigma delays care for psychological problems and increases the difficulties facing patients with mental illnesses when trying to re-integrate into society after an acute episode of illness. Some authors have described possible reasons for mental disorder-related stigma and possible counter measures **[9, 10].**

Health-related stigma is a common phenomenon worldwide. Many people suffering from a chronic health condition are stigmatized due to this condition **[11].** The stigma associated with mental illness is widespread **[12].** Stigma refers to social rejection and is therefore a social construct **[13]**. There are an increasing number of studies on the subjective experience of stigma amongst mentally ill persons but still few coming from low- and middle-income countries, and very few from Muslim countries **[12]**.

Significance of the study:

The concept of insight is problematic because it merges several aspects of the mental illness experience that may not related to each other **[14].** Stigmatizing attitudes toward people with mental illness are common and remain a burden for the stigmatized individuals as well as a major clinical and public health issue. Stigma surrounding psychiatric patients may result in delayed treatment, thereby increasing risks for health problems, abnormal behavior, and violence. The effects of mental illness stigma on the psychiatric patients include psychological stress, depression and other psychiatric morbidity, fear, marital and relationship problems, restrictions from social participation.

Aim of the study:
To explore the relationship between patient insight and felt stigma in psychiatric patients
Objectives:

- To assess clinical patients' insight.
- To determine level of stigma reported by psychiatric patients.
- To examine the relation between insights, level of stigma among psychiatric patients.

II. Subjects and Methods

Research Design: A descriptive explorative study.
Setting: The study was carried out in inpatients units and out patients' clinic in Port-Said Psychiatric hospital, Egypt. The hospital is affiliated to the Ministry of Health and provides inpatient service to the all catchment areas in Port-Said and two surrounding governorates (Ismailia and El Suez). The mental health hospital capacity is 150 beds. The hospital services are free and it composes six inpatients psychiatric units, three units for male patients and two units for female patients. The hospital has ward for drug dependents and psychiatric outpatient clinic.

Subjects: A convenient sample of **130** patients from the inpatients and out patients of Port - Said psychiatric hospital, selected from different diagnosis. Their age older than 20 years, from both sexes, able to share in the study and capable to fill all sheets. The researchers excluded mentally retarded patients and patients with major physical illness as Scabies Patients and Comatose patients.

Tools of Data Collection:
Tool I: Birchwood Insight Scale
The Birchwood Insight Scale (IS), developed by **Birchwood et al. [15],** used to evaluate clinical insight. This scale constitutes of eight statements divided into three levels of insight: awareness of illness (2 items), awareness of symptoms (2 items) and awareness of the need for treatment (4 items), rated on a 3-point Likert scale (agree - unsure - disagree). Each level is given equal weight when calculating the total score. Higher scores indicate better insight. The total score has a range of 0 to 12, with a score of 9 or more indicating insightful.

Tool II: Felt Stigma Scale
The Stigma Scale developed by **King et al., [16],** used to measure Self Stigma, It constitutes of 28 items, divided into 3 domains namely discrimination (13 items), disclosure (10 items) and positive aspects (5 items), rated on a 3-point Likert scale on which 3=‘strongly agree’ to 1=‘ disagree’, four negative statements reversed and eleven were positive statements). Thus, high scores reflected higher felt stigma and low scores reflected lower felt stigma (potential range: 15-45). Whereas 15-25 represents low level, 26-35 is medium; and 36-45 is high felt stigma.

Tool III: Socio-demographic questionnaire
Socio-demographic questionnaire and which included, age, sex, level of education, occupation, marital status, place of residence, religion, family size and monthly income as well as clinical data interview schedule included diagnosis, total duration of illness, number of hospital previous admission, time of hospitalization in the last time and history of family disease.

Pilot Study:
Thirteen psychiatric patients with different diagnosis were selected from inpatients units and out patients' clinic of Port-Said Psychiatric hospital and later, they were not involved in actual study. The pilot conducted to check and ensure the clarity and applicability of the Felt Stigma Scale and the Birchwood Insight Scale. Some changes in the wording of the Felt Stigma Scale and the Birchwood Insight Scale were done, and the scales were put into final form.

Field Work:
- The researchers visited inpatients units and out patients' clinic 2 days per week, from 8.30 to 11.30 a.m. after permission from the responsible authorities of Port Said Psychiatric Hospital. The duration of data collection started from 15th of October 2013 to 15th of January 2014.
- The patients' choose according to their previous diagnosis based on check their files.
- The aim of the study was explained to selected patient in the study.
- The verbal informed consent (assent) was obtained.

- Patients interviewed individually to collect necessary information using clinical data interview schedule, Felt Stigma Scale and the Birchwood Insight Scale respectively. Each patient interviewed from 30-60 minutes.
- Felt Stigma Scale and Birchwood Insight Scale were translated into Arabic Language by the researcher, and retranslated to English by English language expert.
- Felt Stigma Scale and the Birchwood Insight Scale were tested for face validity by five panel experts in the field of psychiatric nursing and medicine and the experts agreed on the two scales items after translation without correction.
- A Reliability test for "the Felt Stigma Scale" and "Birchwood Insight Scale" was done by Cronbach`s alpha of 0.783 for the Felt Stigma Scale which was highly acceptable, and for Birchwood Insight Scale which was also acceptable 0.672.

Ethical Consideration:
- Confidentiality and privacy were assured.
- The verbal informed consent was obtained
- All participants have the right to withdraw from study at any time.

Statistical Analysis:

Data were entered into the SPSS software program (version 20.0). Findings were presented in tables. Both descriptive and inferential statistics were used such as mean, percentage, standard deviation, Chi-Squire and t-test. Statistical significant difference was considered when P-Value ≤ 0.05.

III. Results

Table (1) reveals socio-demographic characteristics of the patient in relation to insight and its level of stigma. Patients' age ranges between 21-62 years with a mean age of 34.82 ± 11.998 years. More than half of the studied patients (54.0%) who has lack of insight is aged between 20 to less than 30 years, followed by patients aged 50 years and more (24.0%), 70% of them male compared to 30.0% of female patients, more than one third of them (38.0%) are in secondary level of education, only 18.0% of patients are not employed 78.0% of them are single. All patients who have lack of insight (100%) from rural area 68.0% of them have satisfactory monthly income. The results revealed that there is no statistically significant relation between socio-demographic characteristics of the patient and its insight, except in marital status and Place of residency, where of the single patient reported lack of insight (P-value= .042.). Patients who live in rural area reported lack of insight (P-value= ≤0.05).

Felt stigma among patients (53.3%) are highly, their age between 20 to less than 30 years, 80% of them male, while 46.7% of them has basic level of education. Regarding patients' occupation, notice that 73.3 % of them employed 60.0% of them single, while, 33.3% from rural area, 40.0% of them have satisfactory family monthly income. There is no statistically significant relation between the levels of stigma and patient's socio-demographic characteristics except in relation to place of residency (P-value=006).

Table (2) illustrates that clinical characteristic of the patient in relation to insight and its level of stigma; it indicates that, 46.0% of schizophrenic patients have lack of insight followed by 38.0% of patients with bipolar affective disorder, manic type. The results revealed that, 90.0% of patients has lack of insight admitted previously to hospital, more than half of them (51.3%) admitted from 1 to 2 times previously. Speaking about duration of illness**,** more than three quarters of studied patients has lack of insight has duration of illness from 1 to 4 years (78.0%), 86.2% of them not has any family history to psychiatric illness. In relation to levels of stigma, about half of patients has lack of insight has medium felt stigma level (48.0%).

The results clear that clinical characteristic of the patient in relation to its insight. There were statistically significant relations between patients diagnosis and insight, the schizophrenic patients were significant lack of insight than the bipolar affective disorder (p-value=0.000). Also, there are a statistically significant relation is found between patient's previous admission to hospital and lack of insight (p-value=.009) as well as duration of illness (p-value=.012). High felt stigma (46.7%) schizophrenic patients followed by 20.0% of patients with drug dependence. 60.0% of them admitted previously to hospital, 44.4% of them admitted from 3 to 4 times previously. Concerning duration of illness**,** about three quarters of studied patients (73.3%) has high felt stigma had duration of illness from 1 to 4 years, the majority of them not has any family history to psychiatric illness (93.3%). In relation to patients' insight, more than one quarter of patients (73.3%) felt stigma highly has lack of insight.

A statistically significant relation is found between patient's last time of hospitalization and the levels of stigma (T Test= -7.255 and P-value= 0.000) and patient insight and its relationship with the levels of stigma (P-value= 0.045**).**

Table (3) shows the relation between patients' insight and its stigma score. The table revels that the insightful patients' and patients' with lack of insight have significant level of felt stigma (P-value= 0.017). Also there is statistically significant relation between total patients' insight score and its stigma score (P-value= 0.000).

Table (4) shows the relation between patients' diagnosis and insight, stigma. As regard patients' insight, most of the drug dependent patients (53.3%), nearly half of schizophrenic (46.0%), bipolar affective disorder, depressant type 40.0%, aware of illness. While only 6.0% schizophrenic, 24.0% of depressant patients of bipolar affective disorder and 40.0% of obsessive compulsive disorder has awareness of the need to treatment. Concerning patient's level of stigma, 80.0% of the patients with drug dependence, obsessive compulsive disorders (OCD) and 56.0% of bipolar affective disorder, manic and depressive type and schizophrenic patients, shows positive aspects of stigma.

IV. Discussion

Stigma contributes to discrimination and human rights violations experienced by people with mental disorders **[17].** Stigma has been divided into public and self. Public stigma is the reaction that the general population expresses towards persons with mental disorders. Self-stigma is the prejudice which people with mental disorders turn against themselves. Both public and self-stigma may be understood in terms of three components: stereotypes, prejudice, and discrimination **[18].**

Regarding patient's insight in relation to the participants' socio-demographic characteristics, there was no significant differences between sub-categories of the most socio-demographic characteristics (age, sex, level of education, occupation and family income) in regard to patients' insight. This result was in the same line with **Mintz, Dobson, and Romney [19]** found insignificant relation between insight and age at illness onset. Concerning the patients' marital status, the findings of current study revealed significant relation between insight and marital status, single patients reported lack of insight. However, the presence of a partner can be a source of social, psychological as well as a physical support and awareness in married patients. The current study displayed that, patients' clinical characteristics in relation to its insight; there were significant relations between sub-categories of the most clinical characteristics as diagnosis, pervious admission and duration of illness. There were statistically significant relations between lack of insight and schizophrenic patients' than the bipolar affective disorder. This finding may be due to the fact that schizophrenia usually affects the cognitive, affective and behavioral status of the patients. Moreover, psychosis was a syndrome characterized by gross impairments in the ability to assess reality and behave coherently. This result was inconsistent with **Amador [20],** who reported that, nearly two thirds of the patients with schizophrenia and nearly half of the subjects with manic depression (with psychosis) were unaware of being ill. Similarly, **Baier [21]** supported the same findings, as they found that, about third to half of schizophrenic patients had poor insight, meaning they may not acknowledge their illness or the need for treatment. Moreover, **David, Buchanan, Reed, Almeida [22]** found correlation between insight and severity of illness in schizophrenics in a subsequent study.

On the contrary, **McEvoy, Apperson, Appelbaum, Ortilip, Brecosky, et al., [23]** found no any relation between the insight levels and etiology of illness. Moreover, the changes in insight scores during hospitalization did inconsistently with changes in acute psychopathology. The only significant finding was between overall insight and clinical outcome in schizophrenia. The authors concluded that the lack of insight could not be explained on the basis of psychopathology.

Insightful patients who stigma seems to be more depressed than those who don't. Furthermore the associations of insight with depression, low quality of life, and negative self-esteem are moderated by stigma. Those with lack of insight had problems with service engagement and medication compliance. Insightful patients accompanied by stigmatizing beliefs had the highest risk of experiencing low quality of life, negative self-esteem, and depressed mood. The present study depicted that the men with lower educational level were found to more subjected to stigma than those with higher educational level .While in both genders subjects not living with a spouse in rural area and employed subjects were also more subjected to felt stigma highly, they were more likely than the others to report common mental problems in presence of stigma. This result was supported by **McLean, Paxton, Massey, Hay, Mond, et al [24]** stated that the men compared with women and lower compared with higher education and income groups held significantly higher stigmatizing attitudes and beliefs. As a result of, **Stewart, Jameson, and Curtin [25]** stated that older adults living in isolated rural counties demonstrated higher levels of public and self-stigma and lower levels of psychological openness than older adults in urban areas even after accounting for education, employment, and income. **Sarkin, Lale, Sklar, Center, Gilmer, et al, [26]** contradicted this study and mentioned that, females facing stigma more than males, but males were fewer liable to approve the potentially positive aspects of facing mental health challenges than females.

Concerning patient's socio-demographic characteristics in relation to the level of stigma. There were no significant differences between sub-categories of the most demographic variables (age, sex, level of education, occupation, marital status, and family income). The study by **Sarkin et al. [26]** found that patients in young age suffering from stigma due problems related to mental health. Poor people with mental illness were more prone to stigma and other unfavorable consequences of mental illness than their counterparts with higher socio-economic status **[27].**

As a result of, the impact of patients' clinical characteristics, it was evident that schizophrenic patients tended to be felt stigma highest than other disorders. This latter finding may be due to the fact that mental illness usually affects the cognitive, affective and behavioral status of the patients and also suggesting a significant impact of culture which was presumed to more heavily stigmatize mental illness and especially psychosis. However, there is a general belief that 'people with schizophrenia are not able to do things very well,' that 'they will fail. This finding was supported by, **Reitan [28]**, who emphasized that the people with schizophrenia have experienced some form of discrimination, which has hampered their motivates to work. This result was congruent with **Murri, Respino, Innamorati, Cervetti, Calcagno, et al [29]** who found that the patients with schizophrenia are in long-term contact with specialized services and they perceive stigma arising from such institutions and from health professionals**.** The current study showed that there were statistically significant relation between the levels of stigma and patients' insight. This is probably due to Self-stigmatization undermines treatment compliance. Its indirect effects can be mediated via stages of change and insight. **Mishra, Alreja, Sengar, and Singh [30]**, **Hasson-Ohayon, Tuval-Mashiach [31], Morag-Yaffe, Gaziel, et al [32]** were congruent with the currents study**.** It was found that insightful patient feel stigma highly significant than patients with lack of insight**.** As well as, **Marialuisa, Nicolas, and Roland [33]** found that more insight at baseline and an increase in self-stigma**.** This in contrast with **Caputo, Melillo, Elce, Mazza, Colletti, et al (34)** who stated that lower levels of insight are related to higher stigma resistance and higher stigma leads to poorer functioning in social contexts. Moreover, **Anton [35]** who reported that patients with good insight who do not perceive much stigmatization seem to be best off across various outcome parameters. In addition**, Bouvet and Bouchoux [36], Anton [35]** stated that the relationship between insight and depression is mediated by stigma.

Also literature indicated although the presence of depressive symptoms in schizophrenic patients they report better insight. Consequently, **Sarkin, Lale, Sklar, Center, Gilmer, et al [26]** reported that, although patients with affective disorders reported more embarrassment with disclosing mental illness than people with schizophrenic disorders. At the same time, they did not report more discrimination than patients with schizophrenic disorders.

V. Conclusion

Based on the findings of the present study, it can be concluded that psychotic illness contributes to poor insight and high stigma in most schizophrenic patients. Single patients with previous admission to hospital, living in rural area, all contribute to poor insight in psychotic patients.

Also, there is relation between patient insight and the levels of stigma and between total patients' insight score and its stigma score.

The results from this study indicated that the increased patients awareness of mental illness has reduced the level of stigma surrounding psychiatric patients may result in delayed treatment, thereby increasing risks for health problems, abnormal behavior, and violence.

VI. Recommendations

1) There is a great need to establish a system of community mental health services that can cover all aspects of psychotic patient's insight as well as their stigma felt.
2) Increase awareness of the mental health team about the importance of dealing holistically with psychotic patients
3) Insight and stigma assessment can be integrated as important part of psychotic patients nursing assessment.
4) Psycho education of psychotic patients should be an important part of their nursing management. This may cover the followings:-

- Improving insight level should be completed by a specific attention to the level and evolution evaluation of internalized stigma**.**
- Special attention should be given to the possible negative implications that insight possesses**.**

5) The nurse should be available to the clients and their caregivers during difficult times to provide the psychosocial support needed.
6) It is recommended to study the insight and stigma in a large group of patients with schizophrenia and mood disorders separately
7) Mental health promotion programmers' should aim at educating the public, and particularly men and the lower educated public, on the impact of stigma and their significance.

Further research recommendations:

- The nurse should be available to the clients and their caregivers during difficult times to provide the psychosocial support needed.
- It is recommended to study the insight and stigma in a large group of patients with schizophrenia and mood disorders separately

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Table (1): Socio-demographic characteristics of the patient in relation to insight and its level of stigma.

Socio-demographic Characteristics	Levels of Stigma						Test χ^2	p-value	Insight				Total 130		Test χ^2	p-value
	Low felt stigma 50		Medium Felt Stigma 65		High felt Stigma 15				Lack of Insight 50		Insightful 80					
	N	%	N	%	N	%			N	%	N	%	N	%		
Age																
20-	29	58.0	37	59.0	8	53.3			47	58.7	27	54.0	74	56.9		
30-	4	8.0	4	6.2	2	13.3	2.23	.973	5	6.2	5	10.0	10	7.7	2.72	**.606**
40-	7	14.0	12	18.5	2	13.3			15	18.8	6	12.0	21	16.2		
50+	10	20.0	12	18.5	3	20.0			13	16.3	12	24.0	25	19.2		
M±SD	34.82 ± 11.998						Minimum and Maximum						21- 62			
Sex																
Male	40	80.0	49	75.4	12	80.0	.399	.819	66	82.5	35	70.0	101	77.7	2.77	**.075**
Female	10	20.0	16	24.6	3	20.0			14	17.5	15	30.0	29	22.3		
Level of education																
Illiterate	7	14.0	12	18.5	2	13.3			10	12.5	11	22.0	21	16.1		
Basic	23	46.0	30	46.2	7	46.7	1.76	.940	42	52.5	18	36.0	60	46.1		
Secondary	16	32.0	21	32.3	5	33.3			23	28.8	19	38.0	42	32.4	4.64	**. 200**
University or above	4	8.0	2	3.1	1	6.7			5	6.2	2	4.0	7	5.4		
Occupation																
Employed	43	86.0	52	80.0	11	73.3	1.49	.827	81.2	41	82.0	106	106	81.5	.070	**.966**
Not Employed	7	14.0	13	20.0	4	26.7			18.8	9	18.0	24	24	18.5		
Marital Status																
Single	37	74.0	47	72.3	9	60.0			39	78.0	93	71.5	93	71.5		
Married	3	6.0	7	10.8	3	20.0	4.08	.665	5	10.0	13	10.0	13	10.0	8.18	**.042***
Divorced	7	14.0	8	12.3	3	20.0			2	4.0	18	13.8	18	13.8		
Widow(ed)	3	6.0	3	4.6	0	0			4	8.0	6	4.6	6	4.7		
Place of Residency	*															
Urban	3	6.0	5	7.7	5	33.3	10.3	.006*	16.2	0	0	13	13	10.0	9.03	**.001***
Rural	47	94.0	60	92.3	10	66.7			83.8	50	100	117	117	90.0		
Family income/month																
Satisfactory	38	76.0	43	66.2	6	40.0			53	66.2	34	68.0	87	66.9	.765	**.682**
Intermediate	5	10.0	8	12.3	4	26.7	7.06	.132	12	15.0	5	10.0	17	13.12		
Unsatisfactory	7	14.0	14	21.5	5	33.3			15	18.8	11	22.0	26	0.0		

***significant at P≤0.05 M + SD: Mean and standard deviation χ^2 : Qui Square Test**

Table (2): Clinical characteristics of the patient in relation to insight and its level of stigma.

Clinical characteristics	Levels of Stigma						Test χ^2	p-value	Insight				Total		Test χ^2	p-value
	Low felt stigma 50		Medium Felt stigma 65		High felt stigma 15				Insightful 80		Lack of Insight 50					
	N	%	N	%	N	%			N	%	N	%	N	%		
Diagnosis																
-Schizophrenia	18	36.0	25	38.5	7	46.7			27	33.8	23	46.0	50	38.5		
-Bipolar Affective Disorder (Depressant type)	11	22.0	12	18.5	2	13.3	3.67	.885	6	7.5	19	38.0	25	19.2	35.28	.000*
-Bipolar Affective Disorder (manic type)	10	20.0	14	21.5	1	6.7			17	21.2	8	16.0	25	19.2		
-Obsessive Compulsive Disorder OCD	5	10.0	8	12.3	2	13.3			15	18.8	0	0.0	15	11.5		
-Drug Dependence	6	12.0	6	9.2	3	20.0			15	18.8	0	0.0	15	11.5		
Previous Admission																
No	10	20.0	12	18.5	6	40	3.46	.177	23	28.2	5	10.0	28	21.5	6.40	.009*
Yes	40	80.0	53	81.5	9	60			57	71.2	45	90.0	102	78.5		
If Yes: Number of Pervious Admission																
1-2 times	17	42.5	27	50.9	3	33.3	7.70	.655	24	42.1	23	51.2	47	46.0	9.94	.077
3-4 times	10	25.0	9	17.0	4	44.4			18	31.5	5	11.1	23	22.6		
5+ times	13	32.5	17	32.1	2	22.2			15	26.4	17	37.7	32	31.4		
Time of hospitalization in the last Time	**M±SD**								**14.607 ± 18.020**							
Duration of illness																
1-4	29	58.0	44	67.7	11	73.3	1.73	.422	45	56.2	39	78.0	84	64.6	6.37	.012*
4-8	21	42.0	21	32.3	4	26.7			35	43.8	11	22.0	46	35.4		
M- SD	3.661 ± 1.978															
History of family Disease																
Yes	7	14.0	13	20.0	1	6.7	1.88	.390	11	13.8	10	20.0	21	16.2	.89	.241
No	43	86.0	52	80.0	14	93.3			69	86.2	40	80.0	109	83.8		
Insight																
Insightful	28	56.0	41	63.1	11	73.3	1.60	.045*								
Lack of Insight	22	44.0	24	36.9	4	27.6										
Stigma																
Low felt stigma									28	35.0	22	44.0	50	38.5	1.595	.451
Medium felt stigma									41	51.2	24	48.0	65	50.0		
High felt Stigma									11	13.8	4	8.0	15	11.5		

***significant at P≤0.05 M + SD: Mean and standard deviation χ^2 : Qui Squar**

Table (3): Relation between patients' insight and its stigma score.

	N 130	**%**	**Stigma Score M + SD**	**T**	**p- value**
Insight					
Insightful	80	61.5	28.237 ± 7.626	2.429	.017*
Lack of Insight	50	38.5	24.880 ± 7.731		
Total insight			18.69 ± 7.832	27.214	.000*

***Significant at P≤0.05 T: T test M + SD: Mean and standard deviation**

Table (4): Relation between patients' diagnosis and insight, stigma.

	Diagnosis									
			Bipolar Affective Disorder							
	Schizophrenia 50		Depressant type 25		Manic type 25		OCD 15		Drug Dependence 15	
	N	%	N	%	N	%	N	%	N	%
Insight										
Awareness of: -										
-illness	23	46.0	10	40.0	4	16.o	5	33.3	8	53.3
-symptoms	12	24.0	0	0	6	24.o	0	0	0	0
-the need for treatment	3	6.0	6	24.0	0	0	6	40.0	0	0
Stigma										
-Disclosure	7	14.0	5	20.0	5	20.0	3	20.0	2	13.3
-Discrimination	25	50.0	12	48.0	15	60.0	9	60.0	8	53.3
-Positive Aspects	28	56.0	14	56.0	14	56.0	12	80.0	12	80.0