

## Stigma and Quality Of Life among Caregivers of Mentally Ill Patients: Family and Nursing Staff

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**Abstract:**Mentally ill patients' family caregivers and nursing staff play an important role in treatment and recovery of patients,however, they may experience stigma and discrimination simply because of their family relationships and the nature of their work as a psychiatric nurse which may seriously affect their quality of life. Theaim of this study was to assess the stigma and quality of life among caregivers of mentally ill patients from both families and nursing staff .The present study was conducted at AlAbassia Mental Health Hospital. A convenient sample of (200) mentally ill patient family caregivers, who attended "Outpatient Clinics" of the Al Abassia Mental Health Hospital and 100 nurses who are working in "Outpatient Clinics" and" Inpatient Departments" at the Al Abassia Mental Health Hospital were recruited for this study. A descriptive correlational design was used in the current study. Five research tools were used including demographic data,modified consumer experiences of stigma questionnaire,nursing staff stigma scale, and quality of life scale. The current study results revealed that,most of family caregivers and nursing staff had high levels of stigma, and both of them had average level of quality of life. Also, it revealed that, there was a significant relationship between stigma and quality of life for both family caregivers and nursing staff. The conclusion of the current study was that mental illness can equally affect family caregivers and nursing staff causing them to suffer from high level of stigma and affect their quality of life. The study recommended that, intervention programs should be held to help family caregivers and nursing staff to cope with their caregiving role.

**Keywords:**stigma, caregivers, quality of life,mentally ill patient, nursing staff.

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### I. Introduction

In the past decades, most researchers and mental health professionals have concentrated much of their time and efforts on mentally ill patients with particular interest on causation and symptomatology (Kenneth,Victor, Kwaku&Seth,2015). Nowadays there is a great need to focus on caregivers of mentally ill patients as well, especially in developing countries where health systems for managing mentally ill patients and their caregivers are lacking (Cooper, Adibokah, Akpalu, Lund&Doku, 2011).

Caregivers, particularly family members, are considered the principal source of support and important partners in the rehabilitation of mentally ill patients; they spend most of their time providing care for mentally ill relatives with little knowledge on how to deal with patient's condition (Reddy,2014).Moreover, their lack of knowledge, support and guidance from mental health services to manage mentally ill relatives at home may result in increase in the families daily responsibilities, create source of stress and affects the physical, psychological and socioeconomic well-being of the caregivers (Magliano et al., 2011) .

In fact, mentally ill patients' family caregivers face different types of burden which have been discussed in several research studies, for instances,Al-Naggar, (2013) identified three types burdens faced by family caregivers; first: objective burdens in coping with the mental illness (financial burden, time and effort in caregiving, disruption of daily routine and social life); second: subjective burdens in facing the mental illness's shame , guilt, stigma ,worry , anger and hopelessness toward mentally ill patients and third :burdens in management of behaviors problems of mentally ill patient such as aggressiveness, mood swings, unpredictability, and negative symptoms.

Results of Salvatore, Ameil,Marcco and Carmelamanto,(2014) showed how family members are less satisfied with their overall quality of life and are significantly distressed as a result of having a family member with mental disorder, in addition, greater burden and lower quality of life were predicted by different fundamental factors: duration, severity of illness and decreased tangible social support with restriction of caregivers social life may lead to increase negative feelings of caregiver such as shame, embarrassment, guilt,

stigma and self-blame (Izibeloko,Jack-Ide, Leana&Lyn, 2012).Moreover, economic status can negatively affect the quality of life of caregivers in developing countries , in which there is a limited number of healthcare professionals and healthcare centers ,and the increased cost of treatment (Wen-Yi & Chung,2015).

The mental health sector and its nursing staff are exposed to a unique range of workforce pressures, which make mental health field is currently one of the least chosen career paths of nurses(Anneli et al .,2015).According toLorind ,(2013) Stigma contributes not only to problems in recruitment but also to the complexity of working within the mental health sector, as it impacts greatly on the social engagement, health, wellbeing and recovery of mental health clients and hence on the stress levels and burnout of the nursing staff.

Quality of life (QOL) has become a topic of growing interest in medical and nursing professions and the importance of QOL is increasing being recognized as an important outcome measure in different health populations, including workers in stressful working conditions such as mental health nursing staff (Shaher ,2015).Laurant, Hassard, and Alijandra,(2012) found that workplace stress contributes to poor psychological well-being which may lead to diminish their quality of life ,in addition, they found that support from friends and family, general work satisfaction, and years of experience in the nursing profession were significant predictors of nurses' psychological well-being while occupational stressors have been related to negative health outcomes, which could be the result of the combined effect of insomnia, tension, anxiety, stigma, and dissatisfaction that has strong effect on quality of life .

Besides the change of quality of life, some studies carried out in public services with health professionals, highlighted that nursing staff working in inpatient services had more negative and stigmatized attitudes than the staff working in outpatient services due to the nature of inpatient nursing staff work as inpatients have more severe, long term and recurrent mental illness (Hansson, 2013).In addition, nursing staff may suffering from psychosocial aspects such as anxiety, stress, depression, burnout, social stigma, and all those factors have an impact and can worsen the quality of life of nursing staff caring for mentally ill patients (Celalettin&Keziban, 2013).

Caregivers have no choice toward their responsibilities of mentally ill patient and they have to carry out their physical, emotional, spiritual, and financial needs solitarily (Johnson, 2015).Therefore there is a great need for better understanding of caregivers experiences in providing care for their mentally ill patients as this will help health service providers and social service network to better understand the requirements of caregivers when targeted caregiver interventions are planned (Jone , Patrick &Corrigan,2013).

## **II. Significance of the Study**

According to The General Secretarial for Mental Health,(2014) the prevalence of mental illness in Egypt has increased to be (16.4%) in Upper Egypt ,(18%) in Cairo and (16.9%) in Provinces face marine of the studied adult population. This increment means more psychosocial problems and burdens including both self and social stigma and lower QOL in mentally ill caregivers.

Previous research findings focused on patient's stigma that is the only pain of mentally ill persons, however, they did not acknowledge the caregivers distress, burden and social exclusion from society. Therefore, this study will focus on one of the weaknesses in the Egyptian community because those people are in contact most of their time with mentally ill patients and suppose to suffer from stigma, consequently, the current study will address whether caregivers are emotionally, physically, economically and societally affected. In addition, the current research study will help health professionals to incorporate families' problems to their intervention programs simultaneously with their mentally ill relatives.

Mental illness stigma mightnegatively affects all aspects of mentally ill patients caregivers quality of life, in addition to, they don't receive social support, which may lead to caregivers to gradually withdrawal from community ,accordingly, this study returns in benefit to the practice and increase body of knowledge of nursing staff as regarding the concepts included in the studythat might enhance their coping abilities , highlight the importance and potential benefits to family caregivers by reducing the stigma associated with mental illness and helping them developing effective intervention strategies that make mentally ill patients and their caregivers not to excessively expose to rejection and discrimination.

**Aim of the Study**This study aimed to assess the stigma and quality of life among caregivers of mentally ill patients: families and nursing staff.

### **Research Questions**

- Q1. What is the relation between stigma and family caregivers' quality of life?
- Q2. What is the relation between stigma and psychiatric nurses' quality of life?
- Q3. What is the difference between level of stigma in family caregivers and nursing staff?
- Q4. What is the difference between quality of life in family caregivers and nursing staff?

### **III. Research Design**

The research design of this study was descriptive correlational.

#### **Sample**

A convenient sample of (200) mentally ill patient family caregivers, who attended "Outpatient Clinics" of the Al Abassia Mental Health Hospital and (100) nurse who are working in "Outpatient Clinics" and "Inpatient Departments" at the Al Abassia Mental Health Hospital were recruited for this study. Using the following sample size formula:

$$n = Z^2 * P * (1 - P) / C^2$$

Z = Z value (e.g. 1.96 for 95% confidence level)

P = Percentage picking a choice, expressed as decimal (0.5 used for sample size needed)

C = Confidence interval, expressed as decimal

Accordingly, the total sample of the nursing staff who will participate in the current study will be (100) nurse, and as for the family caregivers (200) participants.

#### **Setting**

**This study was carried out in Al Abassia Mental Health Hospital in Cairo.**

#### **Tools of Data Collection**

##### **1. Socio- demographic Sheet for Mental Health Nursing Staff**

This sheet was developed by the researcher, it consists of personal and social characteristics of nurses as gender, age, marital status, educational degree, duration of nursing work, and duration of experience in psychiatric wards.

##### **2. Socio- demographic Sheet for Mentally ill Patients Family Caregivers**

This sheet was developed by the researcher; it includes personal and social characteristics of patients' caregivers as gender, age, sex, education, residence, marital status, occupation, duration of illness, number of hospital admissions, and any other family history of psychiatric illnesses.

##### **3. Modified Consumer Experiences of Stigma Questionnaire (MCESQ) (Dickerson et al., 2002).**

This scale was developed by (Dickerson, Sommerville, Origoni, Ringel & Parente, 2002) to assess negative reactions experienced by relatives of mentally ill patients, the scale consists of twenty-six items and two subscales each statement is rated on four-point Likert scale: (1) =strongly disagree, (2) =disagree, (3) =agree, (4) =strongly agree, items were grouped thematically a priori into two subscales: stigma experience and discrimination experience that assessed the degree to which an individual had perceived negative social actions. The stigma" subscale measure the degree to which caregivers deal with negative attitudes from others because of their relatives' severe mental illness.

The "discrimination" subscale measure whether caregivers experience discrimination in working, housing, participation social activities. The tool's scoring system is non-stigmatized= (< 29), stigmatized= (29-<87), the reliability of the tool was measured by Cornbach's alpha test = (.887) indicating a high degree of internal consistency.

##### **4. Nursing Staff stigma scale (Ritsher and Jennifer, 2003 & Struening et al., 2001).**

This scale was adapted by the researcher after reviewing the Devaluation of Consumer Scale which was developed by (Struening, Perlick, Link, Hellman, Herman & Sirey, 2001) to assess the extent to which caregivers believe most people devalue consumers and their families and the Internalized Stigma of Mental Illness (ISMI) Inventory which developed by (Ritsher & Jennifer, 2003) to assess the internal feeling of self-stigma. The scale consisting of 26 items, each statement was rated on the following four-point anchored Likert scale: (1)=strongly disagree, (2)=disagree, (3)=agree, (4)=strongly agree, Items were grouped thematically a priori into two subscales stigma experience and discrimination experience that assessed the degree to which individual had perceived negative social actions. The stigma" subscale measured the degree to which nursing staff deal with negative attitudes from others because of their nature of work career in psychiatric hospitals with mentally ill patients.

The "discrimination" subscale measured whether nursing staff experience discrimination in working, housing, participation social activities, For example, " your family receive derision from others because of the nature of my work as a psychiatric nurse". The tool's scoring system is, non-stigmatized=(< 29), stigmatized=(29-<87), the reliability of the tool was measured by Cornbach's alpha test =(.887) indicating a high degree of internal consistency.

**5. Quality of life scale (WHO QOL scale, 2011).**

scale consists of 100 items could be grouped into seven dimensions , namely: physical, social, psychological, spiritual, positive feeling and satisfaction , work and general satisfaction for both mentally ill patients' family caregivers and nursing staff, the first subscale is positive feeling and satisfaction that consists of (39) items, the second subscale is physical health and activities that consists of (13) items.

The third subscale is social relationships that consists of (33), the fourth subscale is psychological state that consists of (3) items, the fifth subscale is ability to work that consists of (4) items, the sixth subscale is spiritual beliefs that consists of (4) items, the seventh subscale is general satisfaction that consists of (5) items. Responses will be measured on five-point Likert-type scale where:(1)=never, (2)=rarely, (3)=sometimes, (4)=usually, ( 5)= always, the higher the score the better the quality of life. The total quality of life score was scored as follows low QOL= (0-<24), moderate QQL= (24-<30), and high QQL= (30-<40).The reliability of the tool was measured by Cronbach`s alpha test = .864, indicating a high degree of internal consistency.

**IV. Results**

**Table (1): Demographic characteristics of the studied sample (family caregivers n=200 and nursing staff n=100)**

Variable	N		%	
	Family caregivers	Nursing staff	Family caregivers	Nursing staff
Age(Years)				
-20-30	28	40	14%	40%
-31-40	74	35	37%	35%
<40	98	25	49%	25%
Gender				
Male	97	35%	51.5%	35%
Female	103	65%	48.5%	65%
Marital Status				
Single	17	15	8.5%	15%
Married	164	65	82%	65%
Divorced	6	13	3%	13%
Widow	13	7	6.5%	7%
Educational level				
University degree	34	9	17%	9%
Secondary education	166	47	83%	47%
Technical institute	-	44	-	44%

Table (1) reveals that, almost more than one third (37%) of family caregivers their age ranged between 31-40 years old ,slightly more than half of them (51.5%) were females, the majority (82%) were married, and (83%) of them completed their secondary school education .Regarding nursing staff studied sample, more than one third (40%) of sample were between 20-30 years old, about two third(64.5%) were females and married,and less than half of them (47%) had diploma in nursing.

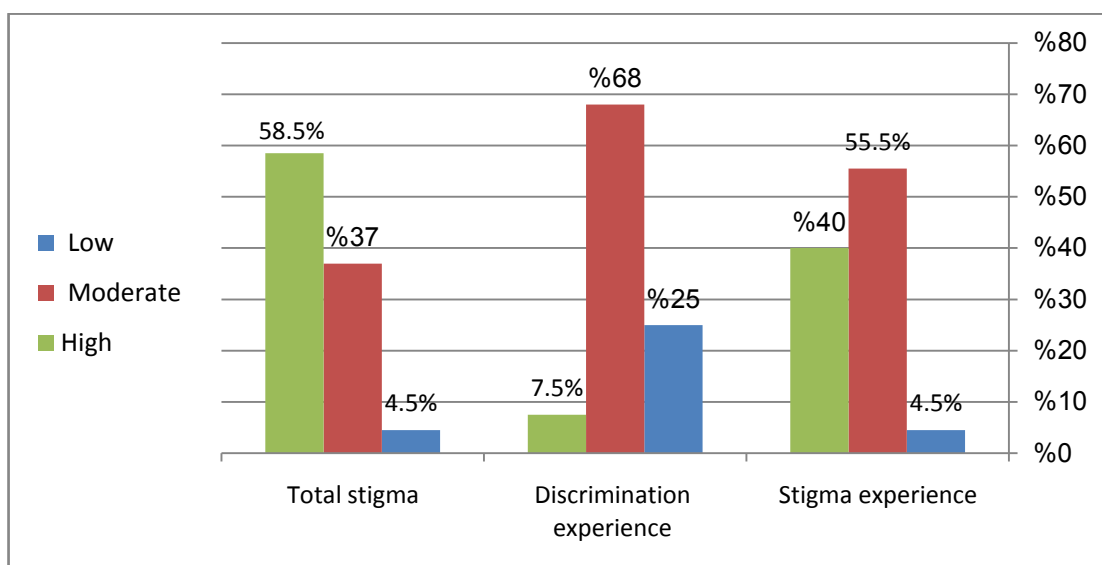


Figure (1): Distribution of family caregivers according to total level of stigma scale and its subscales.

Figure (1) shows that, less than three fifth (58.5%) of the sample had high level of total stigma. Slightly more than half of the family caregivers (55.5%) had moderate level of stigma experience and near to two thirds of the sample (68%) had moderate level of discrimination experience.

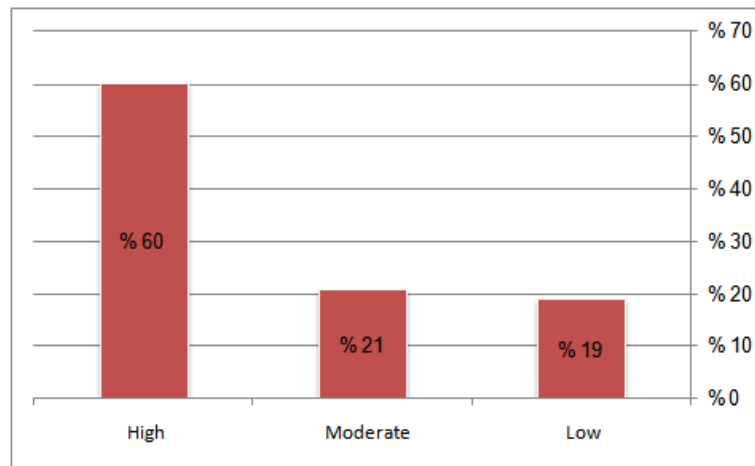


Figure (2) indicates that, near to two third (60%) of nursing staff had high stigma Figure (2): Distribution of nursing staff according to their total level of stigma.while, (21%) of the sample had moderate stigma, and only (19%) of the sample had low stigma

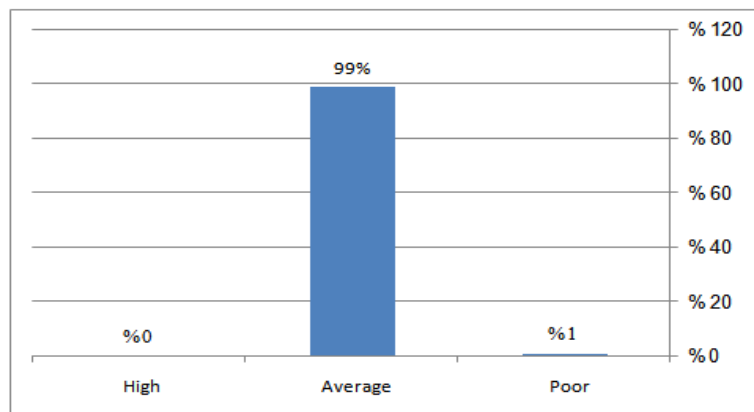


Figure (3): Distribution of caregivers according to their total level of QOL. Figure (3), illustrates that, (99%) of family caregivers studied sample had average level of OOL, and only (1%) of them had poor QOL level.

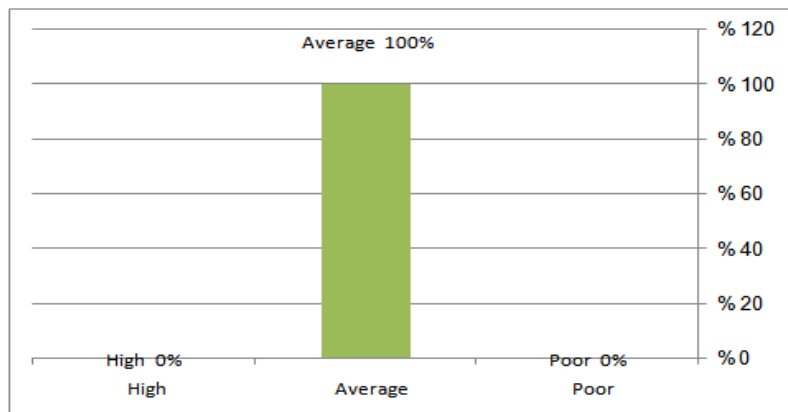


Figure (4): Distribution of nursing staff according to their total level of QOL. Figure (4) that, all nursing staff studied sample (100%) had average level of OOL.

Regarding the relationship between family caregivers' stigma and OOL subscales, the current study result revealed that, there were, negative statistical relationship between experience subscale and discrimination subscale, experience subscale and physical health and activities subscale, also, between discrimination subscale and positive feelings and satisfaction, total stigma scale and physical health and activities subscales, positive feelings and satisfaction subscale and physical health and activities subscale. On the other hand, there were positive statistical relationship among experience subscale and discrimination subscale, total stigma scale, discrimination subscale and physical health and activities subscales, finally, between total stigma scale and positive feelings and satisfaction subscale.

There were negative statistical relationship between experience and general satisfaction subscales, discrimination and negative experience and ability to work and spiritual beliefs subscales, total stigma scale and general satisfaction subscales, positive feelings and satisfaction. While, there were positive statistical relationship between experiences subscale and negative experience and ability to work, spiritual beliefs, and total stigma scale. Moreover, there were positive statistical relationship between discrimination subscale and general satisfaction subscale, and total OOL scale. As well as, there were positive statistical relationship among total stigma scale and negative experience and ability to work, spiritual beliefs, and total QOL subscales.

Additionally, there were positive statistical relationship between positive feelings and satisfaction subscale and negative experience and ability to work, spiritual beliefs subscales, and total QOL scale, and between physical health and activities subscale and general satisfaction subscale, negative experience and ability to work, spiritual beliefs subscales and total QOL scale

Furthermore, there were positive statistical relationship between general satisfaction subscale and negative experience and ability to work, spiritual beliefs subscales, and total QOL scale, negative experience and ability to work subscale and spiritual beliefs subscale and total QOL scale, and finally there was positive statistical relationship between spiritual beliefs subscale and total QOL scale .

Considering the relationship between nursing staff' stigma and OOL subscales, the study findings indicates that, there were positive statistical relationship between experience subscale and discrimination subscale, total stigma scale, positive feelings and satisfaction, and between discrimination subscale with total stigma scale, positive feelings and satisfaction subscale ,and finally between total stigma scale, positive feelings and satisfaction. However, there was negative statistical relationship between physical health and activities with experience, discrimination subscales, total stigma scale and positive feelings and satisfaction subscale.

Moreover, there were positive statistical relationships between general satisfaction subscale with negative experience and ability to work subscale , experience, discrimination subscales, total stigma scale, positive feelings and satisfaction, physical health and activities subscales ,also, there were positive statistical relationship between spiritual beliefs subscale total QOL with positive feelings and satisfaction, physical health and activities, general satisfaction and negative experience subscales ,and finally there was positive statistical relationship among general satisfaction subscale with physical health and activities subscale

On the other hand, there were negative statistical relationship between general satisfaction subscale with experience, discrimination subscales, total stigma scale and positive feelings and satisfaction subscale, and this negative statistical relationship were also between spiritual beliefs subscale and total QOL scale with experience, discrimination subscales ,total stigma scale and positive feelings and satisfaction subscale .

*Table (2) Difference between family caregivers and nursing staff level of stigma scale and its subscales.*

Variable	Family caregivers	Nursing staff	t	p
	M±SD+	M±SD		
Experience subscale	23.28±6.57	28.14±7.63	-5.00	.000*
Discrimination subscale	9.10±2.86	24.17±9.46	-15.14	.000*
Total stigma scale	32.38±6.85	52.31±16.77	-11.13	.000*

Table(2) indicates that, there were statistically differences among family caregivers, nursing staff and experience subscale, discrimination subscale, and total stigma scale as (t=-5.00,p=.000;t=-15.14,p=.000;t=-11.13,p=.000 respectively).

*Table (3) Difference between family caregivers and nursing staff level of stigma scale and its subscales.*

Variable	Family caregivers	Nursing staff	t	p
	M±SD	M±SD		
Positive feeling and satisfaction subscale	112.94±10.43	125.13±9.55	-9.82	.000*
Physical health and activities subscale	34.46±5.66	34.56±5.75	-.115	.908
General satisfaction subscale	91.14±13.98	84.52±22.41	2.49	.014*
Negative experiences and ability to work	35.89±3.04	41.09±3.39	-9.89	.000*
Spiritual beliefs subscale	18.40±3.71	20.33±1.97	-4.52	.000*
Total QOL scale	292.83±20.13	305.63±25.88	-3.78	.000*

Table (3), reveals that, there were statistically differences among family caregivers, nursing staff and positive feeling and satisfaction subscale, general satisfaction subscale, negative experiences and ability to work, spiritual beliefs subscale, total QOL scale, while, there was no statistically significant difference only between family caregivers, nursing staff and physical health and activities subscale as(  $t=-.115, p=.908$ )

## V. Discussion

The distribution of family caregivers studied sample according to age, gender, level of education, and marital status. Concerning age, results of the current study revealed that, most of the family caregivers' age ranged between (30-40) years old, although there was no statistical significant relation between age and stigma total scores, it was observed that among family caregivers aged from (20-40) years old, the total discrimination experience and total stigma scores were highly recorded. This finding is in the same line with the study of Mak and Cheung, (2014) who reported that the majority of their participants almost had the same age and explained the reason for this as this young age group found to be high among young caregivers, especially those with less severe stage of disease patients, because caregiving role may be slightly less stressful where patients be more aware of their own impairments and associated stereotypes.

Oposing to this result, Kelly and Kropf, (2015) found that, caregivers' age was positively associated with caregivers' experiences of stigma and patients' age was negatively related to stigma experiences. They explained that result as may the elder group encountered more discrimination because elder caregivers might provide a long period of care for their adult children or other relatives; they are also more sensitive to stigma from others, which may lead to poor quality of life for long-time caregiving. The researcher point of view toward the age of family caregivers that this finding may be due to the predetermined inclusion criteria of the studied sample and may be this age is reflects the age that are taking the caring responsibility in the Egyptian society.

Considering level of education, the majority of caregivers were secondary school graduates. Additionally the result of current study revealed that, the educational level has no significant relationship with stigma. However, it was observed that the less educational level the more stigma experience. In agreement with the current study finding Eshtey et al., (2014) studied "public stigma against family members of people with mental illness" and concluded that, high income but low educational level showed high stigmatized families, this may be in disadvantages to get more information about mental illness from other sources like print and visual media. In addition, they may also have limited opportunity to get awareness and knowledge about mental illness from the school environment.

In contradiction with the current study finding, Nakash et al., (2014) revealed that, the level of education has interesting relation with experiencing stigma and discrimination which is found to increase with the level of education as it might be returned to the probability of the fact that people might attribute psychiatric illness to lower level of mental capabilities, therefore, they think that by disclosing their patients' illness, their credibility and influence may be lost in the society. Moreover, Muhammad and Jude, (2014) contradicted the current study finding and revealed that, persons with low level of education showed high level of stigma and believed that mental illness is always attributed to punishment from God and magic.

In relation to marital status, the majority of family caregivers studied sample were married. The current study was congruent with Kahsay, (2015) who studied "the psychological distress, subjective burden and affiliate stigma among caregivers of people with mental illness" and revealed that more than half of the studied sample was married. Unlike current study result, the study of Benjamin et al., (2016) who concluded that more than half of the sample were single as they were unmarried or divorced due to the effect of internalized stigma, having low self-esteem, burden of caregiving role and predicting failure later on in their marital life. The result of the current study could be attributing to the mean age of caregivers sample was from 30-40 years which is the suitable age for marriage.

In the current study, most of single, widow, divorced and married caregivers were suffering from stigma, with statistical significant relation between discrimination and marital status, and these discrimination may be related to that marital life is one of the important areas in which discrimination occurs as partners of caregiver of mentally ill patient may negatively evaluate the patient since the behavior of mentally ill patient is burden and they may feel distressed from patients' symptoms and their partner caregiving role, consequently, they feel more stigma and discrimination.

Regarding nursing staff studied sample, the studied sample consist of one hundred nurse, more than one third of the sample were aged between 18-30 years, about two third them were females, and less than half of the them had diploma in nursing. According to relation between those variables and stigma, it was observed that, the stigma level was highly recorded in young age nurses. This may be due to older nurses more experienced, acceptance, and adjusted tonature of their work.

Similar to this finding, the study of Karamlou and Mottaghypour, (2013) reported that, older nurses have been found to have more positive attitudes towards patients than younger ones. They explained their result

as psychiatric nurses have an optimistic view of the community living of mentally ill patients. These psychiatric nurses' beliefs were related to their deeply understanding of mental illness and the right of mentally ill patient to receive treatment similar to other patients.

According to socio-demographic data of nursing staff and QOL, there were significance relation among QOL and gender, educational level, age and years of work. It is necessary to point out that nurses often have to care patients with severe health problems or with emotional specific requirements all this add up with the excessive workload which may affect their QOL .It was observed that grow older and experience years in nursing specially psychiatric field, QOL of nursing staff' was decreased.

This result is congruent with this result the results of Fradelos et al., (2014) whostudied "burnout syndrome impacts on quality of life in nursing professionals" found that, specific demographic factors such age and years of work are increasing the levels of burnout in nursing personnel ,moreover, the excessive administrative duties was an important factor in decreasing nursing staff QOL.They also hypothesized that, more working years in psychiatric fields can create feelings of anger, discomfort, fear and hopelessness in nurses, especially when the solutions of problems of patients are not always visible, predictable and easy, so that the situation becomes more complicated and frustrating.

Concerning experiencing stigma among family caregivers, the current results indicated that, most of them had experienced stigma especially in discrimination subscale. This finding was supported by Masunga ,Lusajo and Wahl,(2016) who concluded that, caregivers stigma in their study was high, and they explained this as, caregiving role was distributed among several family members, the presence of disease positive symptoms, so that, the burden of care and self-stigma were high.

In the opposite to the current study result, Wong et al., (2012) who studied"stigma in families of individuals in early stages of psychotic illness" observed that, low levels of stigma among family members of patients with severe mental illness, and added thatwhen comparing the attitudes of their participants with those of other studies conducted with the general population, attitudes of fear, dangerousness, responsibility for the condition, and avoidance seem to have been less frequent in their study. In the current study and from the researcher's clinical observation, the highly recorded experiences of stigma might be related to the associated personal and public perception regarding mental illness and its symptoms and how to deal with mentally ill patients that may obligate patients and their families to disturb their relations with others or make them totally withdraw from the community.

Regarding family caregivers' QOL, the current study findings revealed that, the highest percentage of them demonstrated moderate degree of quality of life .The lower percentage had experienced low quality of life .This result may be attributed to the long duration of patient's illness that family caregivers who had more experience in caregiving role as it was specified in the inclusion criteria (two years and more).This long duration might be enough to make caregivers adapt to their role and adjust their life to the new circumstances.

Additionally, the current study showed that, there was a statistical significant relation between stigma and quality of life among family caregivers .This may be caused by the negative role of stigma on stigmatized person in disturbing social relation, social role, and enjoying life. In this context, Sucharita and Narasipuram, (2012) studied "quality of life and perception of burden among caregivers of persons with mental illness" supported the current study result and reported that, caregivers with high burden reported significantly reduced quality of life, they also stated that, in the quality of life, the domains of physical health, social relationships, and environment were significantly affected.

Similarly Kahsay, (2015) who showed that, subjective burden and affiliate stigma among caregivers were negatively associated with QOL .They reported that more positive symptoms ,severity of those symptoms and lower independence performance, together with lower self-control attributed to the patient, decrease in social interests, and less affective support, predict burden in caregivers.

There was no difference between level of stigma in family caregivers and nursing staff as their result almost the same. The current study result revealed that, near to two third (the largest percentage) of both family caregivers and nursing staff had high stigma. This findings was in the same line with the study of Bin- Sun,Ni et al.,(2014) who studied "Attitudes towards people with mental illness among psychiatrists ,psychiatric nurses, involved family members and general population in large city in china" and reported that ,the stigmatized attitudes and discrimination against mentally ill patients among studied sample were found to be the same. They explained that result as the bio psychosocial view of the causation of mental illness which was suggested that this view of the etiology of mental illness a part of professional and family caregivers' culture.

In contrast to this findings the result of Wei, Shiyand Xiaoqian, (2014) who found that, the stigmatized attitude in family caregivers was higher than nursing staff and they explained that finding as the knowledge of nursing staff, duration of experience of working in mental health settings and the experience in dealing with mentally ill patients were important factors to decrease stigma in nursing staff and decrease social distance from mentally ill patients. The current study result may be clarified as, the same level of stigma in



family caregivers and nursing staff returned to the culture background of family caregivers and nursing staff about mental illness and lack of knowledge, experience in nursing staff.

There was no difference between level of QOL in family caregivers and nursing staff as, almost all family caregivers and nursing staff studied sample had average level of QOL. The possible explanation for this findings was that, family caregivers and nursing staff QOL was adapted to their caregiving role and responsibility, moreover, in Egyptian society, QOL and economic state are considered very sensitive and private objects, so family caregivers and nursing staff may be not say all information about their QOL state to keep their image.

## VI. Conclusion

The current study concluded that, mental illness can equally affect family caregivers and nursing staff causing them to suffer from high level of stigma, and affect their quality of life.

## Recommendations

- Assessment and frequent surveys should be carried out to identify family caregivers and nursing staff stigma.
- Designing educational programs for both family caregivers and nursing staff to enhance their quality of life and decrease their sense of inferiority.
- Mass media should exert role in the de-stigmatization of psychiatric patients, psychiatric illness and their caregivers as well
- Basic education and training of nursing staff should emphasize the area of communication, nursing staff-patients relationship
- Future researchers should continue using qualitative methods of research to explore the stigma among mentally ill patients and their caregivers

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