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Al-Quds University**



**Attitudes of Mental Health Professionals Toward  
Patients with Schizophrenia in Gaza Strip**

**Omar Yousif Sukar**

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**Attitudes of Mental Health Professionals Toward  
Patients with Schizophrenia in Gaza Strip**

Prepared By

**Omar Yousif Sukar**

Bachelor of Medicine and surgery LUMHS Pakistan

**Supervisor: Prof. Mohammed-wafaie Alawi Elhelou**

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School of Public Health



### Thesis Approval

## Attitudes of Mental Health Professionals Toward Patients with Schizophrenia in Gaza Strip

Prepared By: Omar Yousif Sukar  
Registration No.: 21311276

Supervisor: Prof Mohammed-wafaie Alawi Elhelou

Master thesis submitted and accepted. Date: / /

The names of signatures of the examining committee members are as follows:

1. Head of committee: Prof. Mohammed Elhelou
2. Internal examiner: Prof. Abdelaziz Thabet
3. External examiner: Dr. Ahmed M.AL-Hawajri

Signature. *E. Chelou Mhd. w.*  
Signature. *Dr. A. Thabet*  
Signature. *A. Hawajri*

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## **Dedication**

This thesis dedicated to my parents who introduced me to the joy of reading from birth, enabling such a study to take place today.

I also dedicate this work to my wife, brothers and sisters

Omar Yousif Sukar

## Declaration

I hereby declare that the work in this thesis is my own except for quotations and summaries, which have been duly acknowledged.

## Signed:

Omar Yousif Sukar

....../....../.....

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

إِنَّ فِي خَلْقِ السَّمَوَاتِ وَالْأَرْضِ وَاخْتِلَافِ اللَّيْلِ وَالنَّهَارِ لآيَاتٍ لِّأُولِي الْأَلْبَابِ الَّذِينَ يَذْكُرُونَ اللَّهَ قِيَامًا وَقَعُودًا وَعَلَىٰ جُنُوبِهِمْ وَيَتَفَكَّرُونَ فِي خَلْقِ السَّمَوَاتِ وَالْأَرْضِ رَبَّنَا مَا خَلَقْتَ هَذَا بَاطِلًا سُبْحَانَكَ فَقِنَا عَذَابَ النَّارِ

(١٩٠-١٩١) آل عمران

صدق الله العظيم

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## Abstract

This study was designed to examine the attitude of mental illness professionals toward individuals with schizophrenia within Gaza Strip. 13 Psychiatrist, 11 Clinical Psychologist, 16 Psychologist, 16 Clinical Social Worker, 35 Psychiatric Nurse and 13 Other (Directorates and Pharmacists ) Professionals were assessed using the General Attribution Questionnaire (G-AQ-23) with eight factors Fear, Dangerousness, Avoid, Anger, Pity, Responsible, Help and Improvable. Of the 104 participants working on General Directorate of Mental Health Ministry of Health MOH included in the convenient sample, 46 were female (44.2%) and 58 were male (55.8%), with ages ranging from 21 through 60 ( $M = 37.71$  years,  $SD = 8.67$  years). Although no statistically significant differences were found between male and female on 5 attitudinal factors, differences were found on 3 factors assessing the emotional responses of fear and help toward persons with schizophrenia, as well as avoid. The result showed that female attitude were more negative on two factors fear and avoid but the female were more positive on help factor. In addition, significant differences were found between the attitudes held by participants with Diploma degree and participants with Master or Doctoral degree on factor of Fear, the diploma were more negative, significant differences were also found between participants with Bachelor's degree and participants with Master or Doctoral degree on the measure of Anger the Bachelors were more negative on anger factor. One-way ANOVA's test was conducted to understand the differences on attitudes for participants with different position/occupation. the results showed there are significant differences between participants whom reported their positions as Psychiatrist and participants were identified as Psychologist on the factor of Fear. Significant differences were also found between participants whom reported their positions as Psychiatrist and participants were identified as Psychologist, Clinical Social Worker or other on the measure of Responsible. Pearson correlation coefficients were used to determine the strength of relationship between age of participants and their attitudes toward patients with schizophrenia the results showed there are a significant negative correlation between age and all attitudes, except responsible and improvable were insignificantly negatively correlated with age. These results indicate that older professional hold significantly more positive attitudes toward people with schizophrenia than younger participants. Results also indicate that older age, being female, higher education level, and more years of experience providing direct clinical services to persons with schizophrenia have a positive effect on attitude factor. The strength of relationship between years of experience of participants and their attitudes toward patients with schizophrenia were also investigated by Pearson correlation coefficients, correlation analysis showed significant negative correlation between years of experience and all attitudes, except responsible and improvable were insignificantly negatively correlated with years of experience. The findings are congruent with past research findings and support the position that increased knowledge of and more experience with mental illness person is associated with more favorable views.

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## **List of Abbreviations**

ANOVA	Analysis of variance
APA	American Psychiatric Association
CBT	Cognitive Behavioral Therapy
CDC	Center for Disease Control
CMHC	Community Mental Health Centers
COP	Coming out Proud
DSM-V	Diagnostic and Statistical Manual of Mental Disorders-V
G-AQ-23	General Attribution Questionnaire-23
ICD 10	International Classification of Diseases 10
MOH	Ministry of Health
NAMI	National Alliance on Mental Illness
NIH	National Institute of Health
NIMH	National Institute of Mental Health
OCD	Obsessive Compulsive Disorder
PTSD	Post Traumatic Stress Disorder
SMI	Sever Mental Illness
WHO	World Health Organization

## **Chapter One: Introduction**

### **1.1 Introduction**

A spectacular number of individuals worldwide are affected by schizophrenia. In Palestine and elsewhere in the world, negative attitudes toward persons with schizophrenia is a significant problem, with the public and mass media misrepresenting the mentally ill as dangerous and childlike. Psychotic patients need care for long period because these patients suffer from perception and behavior disorder the most recognized psychotic disorder is schizophrenia. The researcher believes that it is important to consider the attitude of mental health professionals because its impact on the process of treatment and recovery of patients with schizophrenia. In fact, it has been 24 million people suffer from schizophrenia (World Health Organization, 2015). In addition, one in four patients visiting a health service has at least one mental, neurological or behavioral disorder; however, most of these disorders are neither diagnosed nor treated. Also the World Health Organization (2001) has also reported that four of the 10 leading causes of disability in the United States and other developed countries are mental disorders. Due to the fact that the impact on individuals and families is potentially debilitating, and because so many are affected, mental illness is internationally as well as in middle east recognized as one of the largest and most devastating threats to health and positive adjustment. The schizophrenia patients estimated in Gaza about 1% in general public treated by General Directorate of Mental Health Ministry of Health (MOH 2015).

Schizophrenia tends to have a largely negative impact on productivity; however, many individuals with schizophrenia, particularly those with access to treatment, have extended periods when they are mentally ill. Schizophrenia is a psychiatric illness that is characterized by neurocognitive deficits in the perception or expression of reality, resulting in significant social or occupational dysfunction (American Psychiatric Association [APA], 2000). Combining the complexity of neurological, environmental, cognitive, and behavioral factors, this disorder has a prevalence rate of 0.7% in the United States. The overall annual cost associated with schizophrenia in the U.S. is approximately \$ 62.7 billion from direct treatment, societal and family expenses (National Institute of Mental Health [NIMH], 2011; Wu et al., 2005). In addition to the direct medical costs associated with schizophrenia, the impact on the lives of persons diagnosed with schizophrenia creates a human cost of psychological distress (Thornicroft et al., 2004).

In a very real sense, the mentally ill have replaced lepers as targets of public repulsion, abhorrence, and rejection. From the time of the Greeks through the Middle Ages, insanity was given as a label to those who behaved peculiarly, and was commonly considered a part of daily life; however, it was not until the seventeenth century that such people were deemed threatening and confined to specialized in the nineteenth and early twentieth centuries, disturbed behavior was assumed to be caused by either ignorance or incorrect understanding, and that it could be changed through the application of various social and psychological variables. In the mid-nineteenth century, both of these assumptions were discarded, and a belief that troubled behavior was the result of unidentified etiology prevailed. After the turn of the century, as the methods and underlying philosophy of moral (i.e., psychological) treatment were increasingly acknowledged by many professionals in the mental healthfield, schizophrenia was understood to be an exaggeration of particular behaviors caused by stressful life conditions that are too overwhelming to effectively manage.

Stigma against schizophrenia is a remarkable phenomenon because it has persisted despite the gradual growth of tolerance for other stigmatized groups. Indeed, individuals with schizophrenia comprise one of few groups in which derogation remains somewhat socially acceptable (Stier & Hinshaw, 2007).

Schizophrenia is a severe, chronic mental illness that affects the brain and thinking processes of individuals affected. The Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 2000) defined schizophrenia as follows:

Schizophrenia is a mental disorder involving a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. The diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning: and no one symptom is pathognomonic of the disorder. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-V; American Psychiatric Association, 2013) has made significant adjustments to the definition of schizophrenia to assist in the improvement of detection at an early intervention stage. Individuals with schizophrenia will display symptoms of delusions, hallucinations, disorganized speech and behavior, and other symptoms that cause social and/or occupational dysfunction. In order

for a diagnosis, an individual must have symptoms present for six months and at least one month of active symptoms. The symptoms threshold has been made more extensive in the DSM–5 with the requirement changing from one symptom to two symptoms. In addition, there has been an elimination of the diagnostic criteria and the removal of the identification of subtypes due to their unhelpful nature to clinicians as symptoms can change and overlap. As with many other mental illnesses and disabilities, the condition continues to be seen as being present at varying levels of severity and with varying signs and symptoms unique to each individual person (Corrigan, 2004b; National Institute of Health [NIH], 2010).

The global prevalence of schizophrenia, a severe and chronic mental illness, is huge (Bhugra, 2005). The prevalence of schizophrenia rates is dependent on the data collection tools used to gather information, the definition of the prevalence construct used, and whether or not the dividing denominator is the whole population or a portion of the population (Saha, Chant, Welhman, & McGrath, 2005). Four of the main types of prevalence gathering methods for schizophrenia rates are point prevalence, period prevalence, lifetime prevalence, and lifetime morbid rates.

## **1.2 Research problem**

- Mental health professionals' attitudes toward patients with schizophrenia can create new barriers to receive treatment.
- Efforts to achieve rehabilitation and recovery from schizophrenia can be sabotage by prejudice and negative assumptions, particularly from the very people in the mental health field who are expect to offer help to persons with schizophrenia.
- Negative attitudes might harmfully affect the pursuit of mental health services, treatment adherence.
- Corrigan (2000), indicated that mental health professionals who endorse authoritarian attitudes toward their client believing that persons with schizophrenia

are irresponsible, and should leave life decisions to others are likely to rob them of their power over treatment.

- While clinicians play a crucial role in the provision of mental health services, their attitudes toward persons with schizophrenia have not been assessed to the same degree as the attitudes of other health professionals.

### **1.3 Study justification**

The attitude of mental health professional toward mentally ill never conducted in Gaza strip. Specifically there is no study regarding schizophrenia carried out in Palestine this vague area needs to investigate. Therefore it's important to perform a study to explore the verity of mental health professional attitude.

### **1.4 Research objectives**

#### **1.4.1 General objective**

The present study is being carried out in order to discover and clarify the difference among mental health professionals specifically, clinicians, psychiatrist, psychologist, social worker, counselors, nursing and others (Administrators and Pharmacist) view people with schizophrenia.

#### **1.4.2 Specific objectives**

1. To study the attitudes of mental health provider towards patient with schizophrenia.
2. To identify the most factors that influences the attitudes of mental health professionals.
3. To compare the attitudes among professionals in Gaza with other studies elsewhere.

### **1.5 Research questions**

In the end of this study, the researcher can answer the following research questions.

1. What attitudes do professionals have toward patients with schizophrenia?
2. What differences exist between the attitudes held by professionals based on demographic variables and professional background variables including age, gender, highest degree earned, and number of years providing direct services to patients with schizophrenia?
3. Is there deference in attitude of mental health professional in Gaza and other places in the world

The hypothesis is that professionals will demonstrate specific descriptive attitudes toward chronically mentally ill clients. It is also theorized that there will be differences in attitudes toward the patients with schizophrenia between professionals and professional background variables (i.e., age, gender, highest degree earned, and amount of direct service hours) will have an effect on the various mental health professionals' attitudes toward the patients with schizophrenia. Finally, it is hypothesized that negative attitudes will be most often expressed by those mental health professionals who work with individuals displaying severe and persistent conditions, and that such attitudes will exist the longer the professionals has worked with the patients with schizophrenia population.

## **1.6 Basic assumptions**

Within this study, it is assumed that mental health professionals who participated in this study meet the basic competency requirements to counsel in the setting in which they are employed or receive their training. It is also assumed that the mental health professionals have an awareness and understanding of schizophrenia. And finally, it is assumed that the mental health professionals who participate in this study will be truthful and accurate in their responses on the various attitude measures.

### **1.6.1 Definitions and terms**

**Attitude**: Attitudes are seen as comprised of three major components: belief, affect, and behavior. As such, an attitude is a positive or negative reaction to an object, accompanied

by specific beliefs that tend to impel the individual in a particular way toward an object in some evaluative way (Geskie & Salasek, 1988).

**Mental illness:** An a current definition of mental illness includes the spectrum of cognitions, emotions, and behaviors that interfere with interpersonal relationships, in addition to functions required for work, at home, and in school (Johnstone, 2001). WHO definition as they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others WHO, 2015.

**Schizophrenia:**is a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions. It can impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies (WHO, 2015).

**Mental health professional** is a health care practitioner or community services provider who offers services for the purpose of improving an individual's mental health or to treat mental illness. This broad category was developed as a name for community personnel who worked in the new community mental health agencies begun in the 1970s to assist individuals moving from state hospitals, to prevent admissions, and to provide support in homes, jobs, education and community (Raskin, N. 2004).

## **1.7 Thesis organization**

This thesis is organized into five chapters. It starts with Chapter one which provides an overview of schizophrenia, Chronic mental illness and Attitudes concept and background, and describes the problem statement, research questions and research objectives. In Chapter 2, there will be a literature review, leading to explore the current research on this thesis topic. It will then move on to design the research methodology in Chapter 3.the findings and analysis is presented in Chapter 4. Finally, Chapter 5 presents conclusions, limitations and recommendations for further research.

## Chapter: two

### 2.1 Conceptual framework

Figure 2.1 represents a conceptual framework that helps the researcher through the stages of preparing the study, as it shows how the study variables linked to each other and how the effect of each variable in the other variables, and consists of the conceptual framework for the study of the following

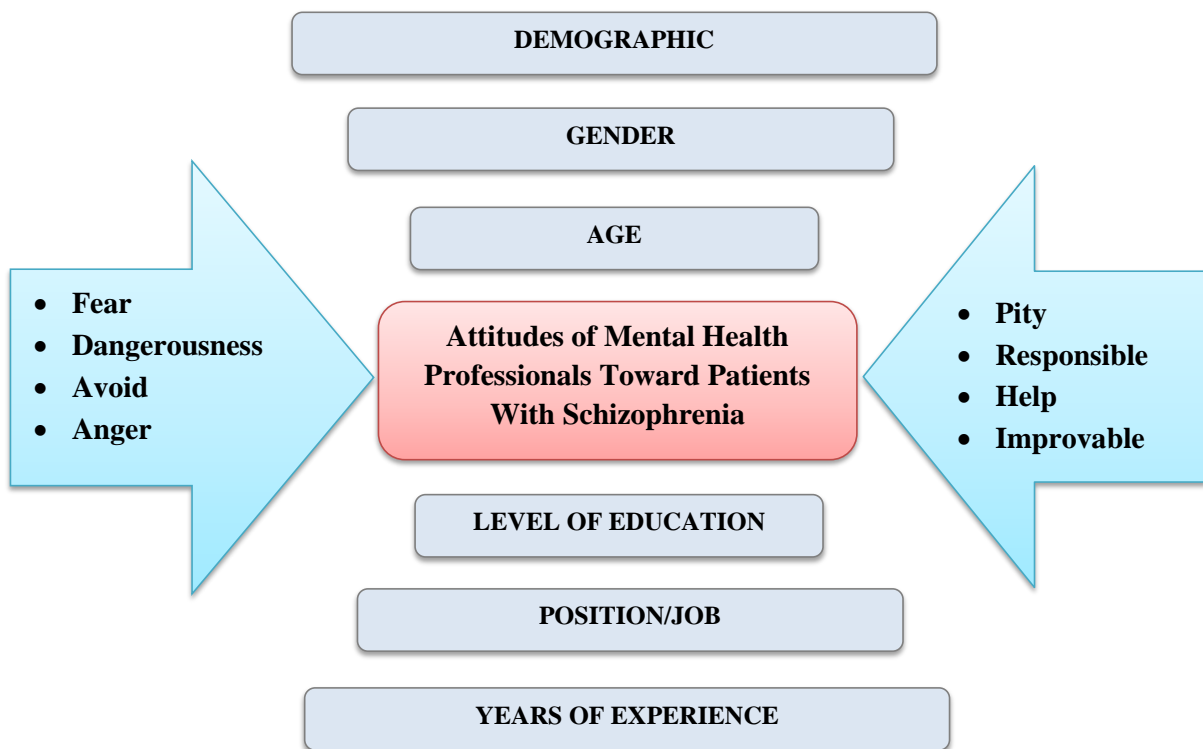


Figure 2.1 conceptual framework

***First:*** factors measures the attitudes of professionals the main variable in this study, consisting of eight factors as following

**Fear:** This factor measures how fears the mental health professional from the thoughts and behavior of patients with schizophrenia to people and society

**Dangerousness:** This factor measures the therapist believe and thinking for seriousness dangerousness of schizophrenia

**Avoid:** This factor measures the avoids ignored and neglecting of schizophrenia patients

**Anger:** This factor measures the degree of anger felt by the therapist through his dealings with these patients

**Pity:** This shows pity and empathy feeling toward schizophrenia patients

**Responsible:** it is view of the therapists opinion for schizophrenia patient is responsible for himself and decision-making

**Help:** This factor measures the reality intentions of the therapist to help the patient with schizophrenia

**Improvable:** This shows the therapist's belief toward schizophrenic patient for treatment and his recovery response

**Second:** Demographic variables which are divided into five variables represented in age, gender, level of education participant has completed, current job position and how many years of experience for mental health working. These changes may affect the mental health professional's attitudes toward psychiatry in terms of social and cultural factors play an important role in the formation trends.

## **2.2 Theoretical framework**

The below figure 2.2 illustrate current literature and an overview of research on attitudes as it relates to mental health professionals and schizophrenia. The attributes that associated with schizophrenia were reviewed as well as the schizophrenia components this will give the researcher better understanding of other researcher finding. Moreover, the recant study of the factors influencing attitude, attitude formation and negative attitudes have been analyzed to view attitudes of mental health professional towards schizophrenia patient.

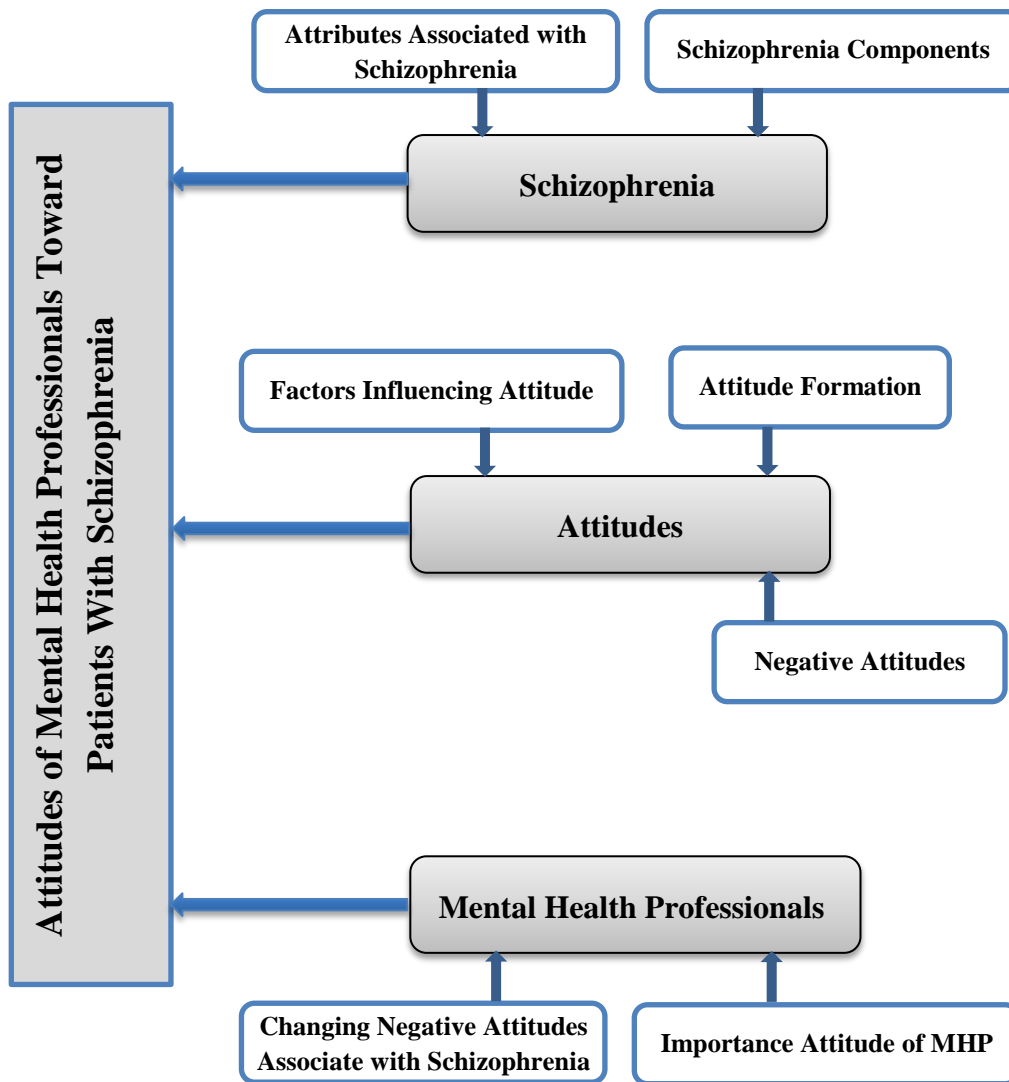


Figure 2.2 Theoretical framework of Selected Title

The researcher present a comprehensive definition regarding mental health professional, namely attitude, schizophrenia, stigma and mental health providers is carried out to understand the concept of this study. Surveys of the issues that are associated with mental health professional attitude measures in the literature are presented. The literature has been reviewed in order to identify the research gap. Based on the extent of literature relating to mental health professional attitude investigation has received less attention on the issue of “how the mental health professional treats schizophrenia patient”.

### **2.3 Schizophrenia and its components**

According to Corrigan (2008), severe mental illness "strikes with a double-edged sword. First, the symptoms, skill deficits, and cognitive dysfunction that accompany the psychiatric disease result in distress and lost opportunity (Corrigan, 2008). Second, societal reaction to severe mental illness results in stigma (Corrigan, 2000). That is to say, while the symptoms of severe mental illness, such as schizophrenia, the deficit syndrome, depression, and mania, are painful and disruptive, broad social disabilities related to the inability to live independently, secure a competitive job, make a satisfactory income, and develop long-term intimacies, as well as having a self-proclaimed poor quality of life, have an equally harmful impact on a person's ability to successfully achieve life goals (Corrigan, 1998). According to Link and Phelan (2001), stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination converge in a power situation that allows them. The Surgeon General of the United States has highlighted stigma as a significant obstacle to the treatment of mental disorders, and to the overall future progress made within the arena of mental illness and health (U.S. Department of Health and Human Services, 1999).

In reviewing the early literature on attitudes and beliefs towards schizophrenia, James (1993) ascertained that the earliest descriptions of madness, such as those found in the Bible, connote stigmatization. According to Jamison (2006), stigmas about schizophrenia continue to be deeply entrenched in ancient attitudes held by many citizens in the United States, and nearly every society on earth (Bhugra, 1989; Corrigan, River, Lundin, Wasowski, Campion, Mathisen, Goldstein, Bergman et al., 2001; & Rabkin, 1974). Explanations for stigma stem, in part, from the misguided split between mind and body first proposed by Descartes. Numerous studies have shown that persons with severe and persistent mental illness feel stigmatized by society (e.g., Johnstone, 2001), and the public's attitudes toward persons with severe mental illness are generally negative (e.g., Overton & Medina, 2008). Also, with respect to self-stigma, the very symptoms of schizophrenia often include internalization of blame and tendencies toward depression and self-derogation, which ultimately leads to interpersonal disruption, fractured identity, family discord, social rejection, low self-esteem, isolation, and hopelessness (Feldman & Crandall, 2007; Stier & Hinshaw, 2007; U.S. Department of Health

and Human Services,1999). First-person accounts in psychiatric journals (i.e., *Schizophrenia Bulletin*) continually report the pain of stigma and discrimination (Corrigan, 2008). For example, K. R. Jamison (2006) discusses her own perspective on stigma based not only on being a professional who studies mental illness, but on being someone who has suffered from bipolar disorder since she was 16 years old. Also, according to Stier and Hinshaw (2007), family members often feel shame, self-blame, and embarrassment due to the fact that they often must cope with the subjective burdens related to societal rejection over the relative's behavior patterns, and objective burdens related to care giving; the resultant impact is often negative and weighs heavily on their own mental and physical wellbeing.

In their attempts at differentiating labels from behaviors, (Martin, Pescosolido, and Tuch 2000) used vignette data describing people who had met DSM-IV criteria for schizophrenia, major depression, alcohol dependency, or drug dependency, and coupled it with a question that asked respondents to identify the case as demonstrative of a schizophrenia, a physical illness, or the "ups and downs" of life. Compatible with labeling theory, Martin et al. (2000) found that labels of "schizophrenia" had a negative impact on respondents' willingness to socially engage the individual described regardless of the vignette data presented.

Furthermore, rejection appeared to be linked to perceived dangerousness, indicating that labeling an individual's situation as "schizophrenia" as opposed to physical illness or the "ups and downs" of normal life will serve to increase stigmatizing beliefs and discriminatory potential. The study by Martin et al. (2000) also indicated that it appears that the public's assessment of the dangerousness of individuals with "schizophrenia" mediates the influence of the label on the endorsement of stigmatizing beliefs and discriminatory dispositions. The modern starting point for defining the stigma of mental illness is Goffman's "an attribute that is deeply discrediting" and that reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Several alternative or elaborated definitions were put forward following Goffman, though they varied considerably. Elliot and colleagues emphasize the social interaction in stigma (Elliot et al., 1982). In their definition, stigma is a form of deviance that leads others to judge an individual as not having legitimacy to participate in a social interaction. This occurs because of a perception that they lack the skills or abilities to

carry out such an interaction, and is also influenced by judgments about the dangerousness and unpredictability of the person. Once the person is considered as lacking legitimacy then they are beyond the rules of normal social behavior and may be ignored or excluded by the group.

## **2.4 Attitudes**

Overall, the majority of researchers worldwide have found that mental health professionals' attitudes toward people with SMI were more positive than the attitudes of the general public but that negative attitudes were present (Wahl & Aroesty-Cohen, 2010). Schulze (2007) reported two studies in which psychiatrists in the United Kingdom and Italy rejected the idea that people with schizophrenia were responsible for their condition, dangerous (Kingdon et al., 2004), or unpredictable (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004). However, other studies contained evidence that mental health professionals held negative stereotypes of people with SMI. Many mental health professionals indicated sharing the public's fear of and anger towards people with SMI, disbelief in possibility for recovery, and desire for social distance (Schulze, 2007). Lauber, Anthony, Ajdacic-Gross, and Rossler (2004) reported Swiss psychiatrists held more negative stereotypes than nurses, psychologists, and other unspecified therapists.

### **2.4.1 Attitude formation and the origins of negative attitudes**

In order to understand the negative attitudes and adverse reactions toward individuals with schizophrenia, it is important to define the fundamental negative bias, and elucidate the possible origins, determinants, roots, or sources of these negative attitudes. First, according to Wright (1988), the basic proposition of the fundamental negative bias asserts that, "(1) if something that is observed stands out sufficiently (saliency), and (2) if, for whatever reason, it is regarded as negative (value), and (3) if its context is vague or sparse (context). then the psychological events that follow will assume a negative course" (p. 19). In effect, the negative value that is assigned to the object under evaluation will be a significant factor in influencing perceptions, thoughts, and feelings, with the resulting attitude being negative.

In fact, as Servais and Saunders (2007) state, one of the primary duties of clinical psychologists is to provide diagnostic evaluations that are oftentimes negative in tone because, for instance, those with schizophrenia may act irrationally, demonstrate behaviors suggestive of impending danger to self or others, or exhibit limited life-skills. While such evaluations provide important information about treatment needs, being problem-oriented nevertheless leads to maintenance of the fundamental negative bias towards the mentally ill (Servais & Saunders, 2007; Wright, 1988).

#### **2.4.2 Factors influencing attitude formation**

A number of factors have been identified as having an impact on the formation and maintenance of attitudes. These include age, gender of both the mentally ill target and the Cognition, education, general knowledge regarding schizophrenia, level and nature of training, degree of contact, and years of experience working with individuals with mental disorders (Geskie & Salasek, 1988).

**Age.** First, age has been studied in relation to attitude formation, and has been shown to have a strong positive relationship with rejection of persons with mental disorders (Geskie & Salsek, 1988). For example, in a study conducted by Cohen and Struening (1962), as age increased so, too, did social restrictiveness amongst the various occupational groups under investigation. In a related study using a modified Opinions About Mental Illness Scale (OMI), the more authoritarian and socially restrictive attitudes increased with age, while the more favorable attitudes, such as benevolence and mental health ideology, decreased (Perry, 1974). Similarly, in an assessment of the factors deemed most relevant to prejudice toward individuals with schizophrenia, older participants tended to display higher rejection rates (Tanaka, Inadomi, Kikuchi, & Ohta, 2004).

**Gender.** Gender has also been shown to have an effect upon attitude development.

With regards to the gender of the mentally ill target, female patients are consistently more tolerated socially than are male patients (Phelan & Basow, 2007). Furthermore, gender significantly influences perceptions of dangerousness and desire for social distance, with male target characters perceived as less tolerated. A recent vignette study by Schnittker (2000)

proposed that the gender difference in tolerance may be due to differences in perceptions of dangerousness, as men tend to be viewed as more dangerous and, accordingly, less tolerated than women, regardless of the presence of schizophrenia. Differences in perceptions of dangerousness for male targets may also be attributed to typical size and strength differences between men and women, or to the idea that schizophrenia is considered to be more taboo for men, who are socialized to be autonomous and emotionless (Phelan & Basow, 2007). Because fear of people with schizophrenia is assumed to underlie much of the public's rejection of those with psychiatric disorders, the degree to which such articles influence public perceptions is of considerable interest. Anger meyer and Matschinger (1996) conducted a study assessing the impact of two assassination attempts against prominent politicians in Germany by persons who were mentally ill on attitudes held by the general public. Just as hypothesized, there appeared to be a marked increase in desired social distance from individuals labeled schizophrenic immediately following the violent attacks compared to a survey carried out prior to the attacks.

**Level of education.** Another factor that has a strong relationship with attitude formation includes the amount of education. Strongly related to socioeconomic status and intellectual functioning, level of education was found to be related to opinions regarding the etiology and prevention of mental disorders (Freeman & Kassenbaum, 1960). As shown by Cohen and Struening (1962), a sharp negative correlation was found between authoritarianism and education on the OMI.

**General knowledge.** General knowledge about a disability has been found to be an influential factor in the formation of attitudes, particularly because it replaces stigma with more accurate conceptions about schizophrenia (Corrigan et al., 2002). Specifically, Pryer and Distefano (1977) found that increased mental health knowledge has been associated with a decrease in authoritarianism and socially restrictive attitudes among aides following completion of basic training courses. Furthermore, in a study designed to examine the relationship between familiarity with schizophrenia and stigmatizing attitudes about schizophrenia, respondents who were familiar with schizophrenia were less likely to perceive people with schizophrenia or major depression as dangerous.

**Nature and level of training.** In addition to age, education, general knowledge, and gender considerations, a variable that has been cited as potentially relevant in the formation of attitudes toward the mentally ill is the level and nature of training. Auerbach and Johnson (1977), in a review of the literature on level of therapist experience, found that experienced therapists are more active, self-revealing, and variable in their behavior, make more interpretations, and are less optimistic about therapy outcomes.

**Years of experience.** Years of experience working with individuals with a mental disorder has also found to be a contributory factor in the development of attitudes. Using a modified OMI, Perry (1974) found that the negative attitudes, characterized by social restrictiveness and authoritarianism, held by psychiatric aides increased with years of experience, while positive attitudes, characterized by benevolence and mental health ideology, decreased.

## **2.5 Recovery beliefs and social distance**

In a review of studies, psychiatrists and psychiatric nurses indicated both positive and negative recovery beliefs. For example, psychiatrists in the United Kingdom reported greater optimism than the general public that schizophrenia would improve with treatment, but were uncertain as to the depth of recovery as only 26% reporting a belief that people with schizophrenia could recover fully (Kingdon, Sharma, & Hart., 2004). A large group of Italian mental health professionals, including psychiatrists, psychologists, nurses, sociologists, occupational therapists, social workers, and auxiliary personnel reported significantly more optimistic beliefs than family members regarding treatment outcome in schizophrenia, although 40% reported believing not much could be done for people with schizophrenia other than helping them live in a peaceful place (Magliano et al., 2004).

Researchers reported the most reliable measure of stigma seemed to be assessments by social distance scales (SDS). Social distance instruments ask participants to rate their willingness to interact with people with SMI or a specific mental illness, identified either by vignette or diagnosis, in a variety of social situations. Lauber et al. (2004) stated that Swiss psychiatrists, after reading a vignette describing a man with schizophrenia, did not differ from the general

public in reluctance to recommend the man for a job, rent him a room, or have him marry their child. Nordt et al. (2006) utilized an SDS and found that Swiss psychiatrists, nurses, and psychologists reported less willingness to interact with people with schizophrenia than other therapists and the Swiss public.

Grausgruber et al. (2007) wrote that barely half of Austrian psychiatric nurses, social workers, psychologists, physiotherapists, and occupational therapists participating in a study indicated a willingness to employ a person with schizophrenia. In the same study, participants indicated they were unwilling to accept a person with schizophrenia as a superior (70%) or in a position of caring for their children (81%). Even within Kingdon et al.'s (2004) study that reported predominantly positive attitudes, 20% of UK psychiatrists agreed or were undecided that they "would not want to live next door to someone who had been mentally ill."

Corrigan's (2004b) research of stigma towards schizophrenia has suggested that a common misconception of individuals with schizophrenia is they do not have the ability to care for themselves. Furthermore, schizophrenia research has suggested, without a caretaker of higher authority, individuals are unable to assist and make major decisions on their own behalf. The way society sees and stigmatizes schizophrenia is historically influenced to believe the person is responsible for their condition and attainment of their disability. Indeed, individuals with schizophrenia are found to often face alienation due to the misconception and blame for their condition. The attribution of responsibility was first discussed by Weiner, Perry, and Magnusson (1988) as a result of a broad study of college students' beliefs and attitudes towards various socially stigmatized groups.

## **2.6 Schizophrenia**

The classification of psychological disorders is consistent across international psychodiagnostic systems. In the United States, mental disorders are identified according to the criteria established in the fourth revision of the Diagnostic and Statistical Manual (DSM-IV; American Psychological Association, 2000). In the United Kingdom, mental and behavioral disorders are classified according to in the tenth edition of the International

Classification of Diseases (ICD-10; World Health Organization, 1992, 1993). In general, the descriptions of the disorders in the DSM-IV and the ICD-10 can be used interchangeably (Peters, Slade & Andrews, 1999). In 1995 the DSM-IV was reprinted as an International Edition (APA, 1995). This edition lists DSM-IV criteria for disorders along with their corresponding ICD-10 codes. The DSM-IV and ICD-10 criteria for schizophrenia are almost identical. According to both systems, schizophrenia describes three broad types of symptoms, including psychotic symptoms, negative symptoms and cognitive impairments (Mueser & McGurk, 2004). The DSM-IV identifies schizophrenia as a psychotic disorder (DSM-IV; American Psychological Association, 2000). Psychosis is defined in this system as "delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behavior (p.297)." According to the ICD-10, schizophrenia is a disorder characterized by "fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect" (ICD-10; World Health Organization, 1992, 1993). Both classification systems describe the same basic subgroups of schizophrenia, including paranoid, hebephrenic, undifferentiated, catatonic and residual.

The ICD-10 also describes the "simple" subgroup (Turkington, 2002). According to Mueser and McGurk (2004), there are two major differences between the classification systems. First, in order for an individual to meet DSM-IV criteria for schizophrenia, the individual needs to experience social or occupational dysfunction. This criterion is not specified in the ICD-10. Secondly, according to the DSM-IV, an individual must experience symptoms for a minimum of 6-months in order to meet criteria for schizophrenia. The ICD-10 only requires an individual to be symptomatic for one month. In summary, while the definition of schizophrenia is somewhat narrower in the DSM-IV, the criteria are the largely same. With respect to treatment, differences between the diagnostic criteria established in the DSM-IV and the ICD-10 might prove to be irrelevant. Diagnostic criteria are meant to inform treatment, and treatment techniques are not yet sophisticated enough to vary according to DSM-IV or ICD-10 criteria (Peters et al, 1999). Patients who meet criteria for schizophrenia are an extremely heterogeneous group. Therefore, although there are minor differences between the two classification systems, the impact of these differences is probably not significant at this time.

Therapists working with patients with schizophrenia should have the same basic treatment plans whether basing their diagnoses on the DSM-IV or the ICD-10. Schizophrenia Widely recognized as one of the most stigmatized mental health conditions, schizophrenia has traditionally been viewed as non-recoverable. This chronic psychotic disorder is characterized by neurocognitive deficits in the perception or expression of reality and a deteriorating course of pre-morbid social or occupational dysfunction (APA, 2000, 2009; Vauth, 2007). Lifetime prevalence is often comorbid with clinical depression, anxiety disorders, social problems, substance abuse, and decrease in life expectancy of 10-12 years, as well as an increase in suicide rate (Pennington, 2002). Symptoms of schizophrenia are classified as positive or negative (APA, 2000). Positive symptoms are distortions of normal functioning manifested as hallucinations, delusions and disorganized speech and behavior. These positive symptoms although easier to notice are not always present (Beck & Rector, 2001; 2005). Negative symptoms are characterized by a reduction of normal functioning and manifested as perception of deficient cognitive resources, defeatist performance beliefs, social-aversion attitudes, and negative expectancies for pleasure and success (Beck et al, 2009). Although negative symptoms are more difficult to identify, they limit the client's ability to make and execute plans in his or her everyday life (APA, 2000; Yogev, Sirota, Gutman, & Hadar, 2004).

### **2.6.1 Schizophrenia and negative attitudes**

Schizophrenia becomes complex not only by the symptomology of the illness but also by long-standing societal views of the disorder. Historically, patients with schizophrenia were isolated from society and viewed as being 'crazy' and unable to recover. Through the years, prejudicial and discriminatory stereotypes began to form; such as, "They're dangerous", "I don't like those crazy people", and "They shouldn't be out in society". This stigma against people with schizophrenia elicited a separated view in society of the 'us and them' mentality (Beck et al., 2009; Vauth, 2007; Corrigan et al., 2009). As these views remained stagnant over time, mental health stereotypes developed. Patients were labeled as socially unacceptable and were treated as a separate sect of society.

Demoralization through social stigma elicited a persistent failure to cope with the illness, resulting in feelings of helplessness, diminished self-esteem, isolation, incompetence, hopelessness, and loss of meaning for life with a possible wish to die. In due course, social stigma serves as a major obstacle to recovery by weakening the patient's self-esteem and personal worth, producing low expectation for change (Calveti et al., 2011; Hendrichs, 2005; Onken, Craig, Ridgway, Ralph & Cook, 2007; Ritsher et al., 2003; Kleim et al., 2008). Lysaker, Davis, Warman, Strasburger, & Beattie (2007) found that patients diagnosed with schizophrenia showed an increase in depression and a decrease in self-esteem due to internalized stigmatization during 6-month follow-up studies. Low self-esteem in individuals with schizophrenia is common; however, self-esteem is also adversely affected by stigma (Beck et al., 2009). Therefore, although low self-esteem is expected among negative symptoms, the construct of stigma remains unaddressed and hidden within symptomology and poor treatment outcomes (Cavelti et al., 2011). Unfortunately, there has been little research to address this quagmire (Knight, 2006; Lysaker et al., 2007; Ritsher & Phelan, 2004; Sibitz, et al., 2011; Vauth, 2007).

The self-esteem of patients with schizophrenia can be diminished by self-stigma if they identify with negative stereotypes of incompetence (Corrigan, 1998; Corrigan & Watson, 2002; Angermeyer et al., 2004). Regardless of the level of discrimination that the patients encounter, their beliefs and perceptions of being devalued by stigma are the elements that greatly affect their self-esteem (Link, 1987; Link et al., 1991; Rogers, Chamberlin, Ellison & Crean, 1997; Corrigan & Penn, 1999; Corrigan, Faber, Rashid, & Leary, 1999; Wright et al., 2000; Link & Phelan, 2001; Camp, Finlay & Lyons, 2002). Negative self-views lead to self-isolation in order to protect themselves from their perceived stigma (Lencz, Smith, Auther, Correll & Cornblatt, 2004). Several studies have found that psychological harm caused by self-stigma impedes treatment by eroding the patient's self-esteem, self-efficacy and his or her belief in recovery (Rosenfield, 1997; Angermeyer & Matschinger, 1999; Sirey et al., 1999; Cooper et al., 2003; Phelan, Link, Stueve & Pescosolido, 2000; Link et al., 1991; Wright et al., 2000; Link & Phelan, 2001; Perlick et al., 2001; Struening et al., 2001; Sirey et al., 2001; Vauth 2007). Corrigan, Rafacz, & Rusch (2011) found that after patients become aware of associated stereotypes, agree with them, and internalize the stigma, their levels of

hopelessness and self-esteem were negatively impacted. Results of this study were consistent at the 6-month follow-up, indicating the stability of stigma and its negative impact on self-esteem and hope for recovery (Corrigan, Rafacz, Rusch, 2011).

Psychological distress tends to increase as self-stigmatization and diminished self-esteem becomes a part of the patient's schema (Masuda & Latzman, 2011). Cavelti, Kvrjic, Beck, Rusch, & Vauth (2011) examined the relationships between self-stigma beliefs and demoralization among individuals with schizophrenia. Evidence was found that patients with beliefs of self-stigma experienced higher levels of demoralization. This demoralization also showed an adverse effect on the patients' positive and negative symptoms of schizophrenia. This study highlights the importance of the way in which stigma increases demoralization through hopelessness, negative self-esteem and depression, thus collectively resulting in poor recovery for the patient (Cavelti et al., 2011; Staring, Van der Gaag, Ven den Berge, Duivenvoorden & Mulder, 2009). Further evidence supports the fact that the maintaining factor between self-stigma and demoralization is the patient's ability to change his or her belief or self-schema (Masuda & Latzman, 2011; Masuda, Price, Anderson, Schmertz, & Calamaras, 2009).

Therefore, taking an active role in treatment is essential in order to help clients change or alter their beliefs. Unfortunately, Tsang, Fung, & Chung (2010) found that patients with self-stigma often withdraw and limit their collaboration with others (Perlick et al., 2001; Corrigan, 2004; Vauth et al., 2007). Multiple studies have affirmed that the cycle of stigma produces low self-esteem and feelings of hopelessness, causes the patients to doubt the benefits of treatment, and frequently results in withdrawal (Corrigan & Watson, 2002; Corrigan, 2004; Fung, Tsang, Corrigan, Lam & Cheng, 2007; Fung et al., 2008; Rosenfield, 1997; Watson & Corrigan, 2001). To encourage active involvement in treatment, it is imperative to address feelings of stigma and instill hope for the patient's recovery (Barkhof et al., 2006; Chou et al., 2012; Miller & Rollnick, 2002; Ng & Tsang, 2002).

This approach addresses concern for patients who frequently keep their mental illnesses a secret to avoid further stigmatization (Kleim et al., 2008). Yet, challenges persist even after a

patient is in treatment because negative effects of self-stigma serve as a barrier to treatment, inhibiting a patient's readiness for change and the belief in his or her ability to recover (Beck et al., 2009; Cavelti et al., 2012; Miller & Rollnick, 2002). Prior studies demonstrate that devaluation through stigma and dysfunctional coping strategies, such as avoidance and ambivalence, results in reduced self-efficacy (Cavelti et al., 2012; Cooper et al., 2003; Sirey et al., 2001). Low self-efficacy slips into the patient's symptomology and remains a hidden construct within his or her treatment, which further complicates the ability to recover.

In the resolution for recovery, APA endorses therapeutic interventions that address constructs such as self-efficacy and self-esteem because of their interference with the patient's recovery process. An approach to promote recovery aptitude while providing treatment for these cognitively based symptoms has prompted treatment using cognitive behavioral therapy (CBT). This study particularly focuses on the Beck model because of his inclusion of the therapist and client barriers that will be addressed.

### **2.6.2 Schizophrenia stigma**

There is no group more stigmatized in society than that of individuals with mental illness (Stuart, 2008). Stigma is defined as "a mark of shame or discredit; an identifying mark or characteristic (Merriam-Webster's online dictionary). Stigma is demonstrated when an individual avoids particular individuals, groups, and/or activities in an effort to minimize feelings of discomfort and is often caused by avoidance and misconceptions. Stigma of mental illness has been identified as one of the most challenging components of mental health treatment and outcomes (Hinshaw & Cicchetti, 2000). Society's views of stigma towards individuals with mental illness continues to cause additional barriers that have negative impacts on the usage of mental health services thus further hampering their ability to be productive members of society. Stigma towards individuals with mental illness causes two distinct forms of harm to societies which are direct effects and social rejection (Feldman & Crandall, 2007). The first form of harm to society is as a direct effect of the mental illness such as the cognitive, affective, and behavioral difficulties that limit one's ability to function effectively. The second harm is the more encompassing and impacts the people living with mental illness as well as all of society. The social rejection that individuals with mental illness

experience is destructive and the focus of research due to the negative compounding effects social rejection, interpersonal disruption, and fractured identity that comes from the stigma of mental illness.

### **2.6.3 Importance attitude of mental health professionals**

To facilitate progress on addressing the attitudes toward the mentally ill, an adequate understanding of the role that attitudes of nondisabled persons play in the lives of people with disabilities is essential. Attitudes toward people with schizophrenia are relevant to social, psychological, physical, and economic wellbeing of those affected by schizophrenia. As such, the negative attitudes toward persons with schizophrenia can be physically, socially, and vocationally isolating. That is, these attitudes contribute to wide spread stigmatization of schizophrenia and subsequent stereotyping, prejudice, and discrimination, which result in the reduction of important life opportunities that are essential for achieving life goals. The negative impact of public stigma is also observed in the criminal justice system, as persons displaying symptoms of severe mental illness are more liable than others to be arrested by the police, and spend more time incarcerated than those without mental illness.

Negative attitude also influences the quality and amount of available health care services, with those people without mental illnesses receiving more medical services and an increased range of insurance benefits than those people labeled mentally ill. Taken together, the aforementioned evidence indicates that the stigma of schizophrenia can be as detrimental as the mental illness itself. Negative public attitudes also play a large role in the self-stigma and shame experienced by persons with schizophrenia, serve as a significant obstacle to successful treatment and overall life satisfaction, and damage one's sense of self. The most common consequences of self-stigma of the schizophrenia include diminished self-esteem, low self-efficacy, and fear of pursuing one's goals. Such self-prejudice often leads to negative emotional reactions, such as demoralization, social distancing, and significantly interferes with a person's quality of life and full participation in society.

According to Corrigan (2004), public attitudes toward the mentally ill are generally deduced from four cues: psychiatric symptoms, social-skills deficits, physical appearance, and labels.

Many of the symptoms of severe mental illness, such as incongruent affect and eccentric behavior, generate stigmatizing reactions, as do limited social skills and poor personal hygiene (Corrigan, 2000). In addition, the labels imposed on persons from others, such as psychiatrists or psychologists, and by association lead to stigma (Corrigan, 2004). The influence of the attitudes held by clinicians is an area that has received considerable attention in the research literature (i.e., Baker & Schulberg, 1967; Cohen & Struening, 1962; Hugo, 2001; Jorm, Korten, Jacomb, Christensen, & Henderson, 1998; Nordt, Rossler, & Lauber, 2006; Servais & Saunders, 2007; Wicas & Caluccio, 1971). The mental health professionals who hold stigmatizing attitudes toward the mentally ill can unintentionally impede effective treatment, particularly when they are required to assess their patients' social and intellectual potential (Sadow & Ryder, 2008).

## **2.7 Attributes associated with schizophrenia**

In general, severe mental illness elicits attitudes and beliefs associated with discomfort which, in turn, influences stigma; this leads to the social exclusion of the individuals with mental illness, in particular schizophrenia. In the past decade, there has been an increase of research in the area of attitudes toward individuals with schizophrenia and stigma (Corrigan, Larson, Sells, Niessen, & Watson, 2007; Corrigan, Watson, & Barr, 2006; Larson & Corrigan, 2008; Marie & Miles, 2008; Thornicroft, Rose, Kassam, & Sartorius, 2007). The increase of information such as assumptions and the misconceptions of schizophrenia are necessary for the dissolution of stigma. A study focused on the internalizing stigma by individuals with schizophrenia by Ritsher and Phelan (2004) suggested that depression from alienation increases barriers and prevents help-seeking behaviors.

According to Corrigan, Lurie, Goldman, Slopen, Medasani, and Phelan (2005) contact, or familiarity, decreases mental illness stigma. Attributes of stigma were identified by Corrigan, Markowitz, et al. (2003) as responsibility for illness, pity, anger, danger, fear, help, coercion, segregation, and avoidance. Attributes have been measured using Corrigan's Attribution Questionnaire (AQ-27) scale to assess a person's rating of stereotypes commonly associated with schizophrenia. A great deal of research has been focused on attributions towards mental

illness and has found that the greater amount of exposure to members of a stigmatized group, the more favorable the attitudes will be towards them (Penn, et al., 1994; de Sousa, Marques, Curren, & Queirós, 2012). Hayward and Bright (1997) found attributes that are most commonly associated with stigma towards individuals with schizophrenia including individual responsibility, social interaction, and dangerousness. Subsequently, Brown (2008) incorporated the Attribution Questionnaire (AQ) and assessed participants' attributes towards individuals with schizophrenia. The attribution factors of fear, dangerousness, help, interaction, and negative emotions provided the most reliable attributes that contribute to the continued stigma of individuals with schizophrenia. Such accurate measurements of attitudes, beliefs and attributes towards individuals with schizophrenia provide a complex understanding of stigma in society. The increased knowledge can contribute to the development of programs and interventions aimed at reducing stigma.

### **2.7.1 Individual responsibility**

Corrigan's (2004b) research of stigma towards schizophrenia has suggested that a common misconception of individuals with schizophrenia is they do not have the ability to care for themselves. Furthermore, schizophrenia research has suggested, without a caretaker of higher authority, individuals are unable to assist and make major decisions on their own behalf. The way society sees and stigmatizes schizophrenia is historically influenced to believe the person is responsible for their condition and attainment of their disability. Indeed, individuals with schizophrenia are found to often face alienation due to the misconception and blame for their condition.

The attribution of responsibility was first discussed by Weiner, Perry, and Magnusson (1988) as a result of a broad study of college students' beliefs and attitudes towards various socially stigmatized groups. The research established that particular group's illicit more stigmas depending on the cause of the disability and/or stigmatized condition. Empathetic behavior was not found for individuals that experience mental health issues. Rather, the individual was seen as being responsible for their condition. Rather than feeling pity towards the individuals with mental illness, the respondents felt anger towards the people for not preventing their

condition. The level of personal responsibility was seen as being greater towards individuals with a severe mental illness such as schizophrenia.

Corrigan, River, et al. (1999) continued to determine that controllability continues to be a factor in schizophrenia stigma. Based on results from the Psychiatric Disability Attribution Questionnaire (PDAQ), a 36 item measure of attribution, a sample of 152 community college students ranked the factor of controllability the highest. An additional study by Corrigan et al., (2000) measured the stigma towards the attribution of responsibility as a result of personal responsibility or environmental issues. The study found that the participants rated mental disabilities more negatively in comparison to the physical disabilities. The results demonstrated a preconceived notion that individuals with mental illness are in control of their behavior, thus not requiring professional mental health intervention and/or services. Furthermore, Corrigan et al., (2002) explained the stigmatizing attitudes and belief that individuals with schizophrenia were not only able to control their illness but they were also responsible for their condition. An anti-stigma program with 213 community college students measured the willingness to assist individuals with mental illness. The Attribution Questionnaire (AQ) and the Social Distance Scale were administered and perceived dangerousness was found to be the main cause of stigma. However, education through the anti-stigma program did not provide long-term results for participants. A recent study by Obonsawin, McLindsay and Hunter (2013) found factors related to responsibility included emotions such as pity and anger in addition to controllability of mental illness. A between groups design was used with three vignettes with varying degrees of controllability. An ANOVA analysis determined as the factors of controllability, pity and anger increased the willingness to assist an individual with a mental illness decreased.

Stereotypes and stigma also affect family members, caregivers, and other people with close relationships with individuals with schizophrenia. The responsibility and role of care of individuals with schizophrenia was the focus of a survey research project by Lachaux, Caroli, and Masse (in press). The results showed common aspects between patients' families, care providers, and patients which lent to the stereotype that an individual with schizophrenia cannot be responsible for caring for themselves. If individuals with schizophrenia do not have

support from those surrounding them they may be more prone to symptoms of schizophrenia and thus additional stigma and alienation. Thus, the attributions that surround stigma towards schizophrenia are an important area of research to improve rates of acquiring mental health issues and positive outcomes.

### **2.7.2 Perceived dangerousness and violence**

One of the most common attribution and misconceptions of individuals with mental illness is that they are dangerous and should be avoided (Corrigan, 2004b). In the literature this misconception of fear is a particular area of interest amongst mental illness research. The element of fear is attributable to the stereotype the public has towards people with mental illness which expects a level of violence (Hayward & Bright, 1997). The constructs of peril and dangerousness are two of the dimensions that are used in the literature when discussing mental illness (Feldman & Crandall, 2007). Phelan and Link (1998) found that from the 1950's to the 1990's there has been an increase of the perception in people with mental illness as being dangerous and violent in American society. The construct of dangerousness describes the common fear people feel as a result of the increase of perceived threats (Feldman & Crandall, 2007). Dangerousness is associated with a need for greater social distance from an individual with mental illness because it elicits fear (Corrigan et al., 2003). The fear that the public has is adverse to reducing stigma due to an increase in social distance to the mentally ill; it serves as a way to protect themselves from a group of people society deems dangerous and violent (Link, Cullen, Frank, & Wozniak, 1987). Past research has framed the utilization of social distance scales and attribution questionnaires to determine the level of stigma based on perceived dangerousness. Penn, et al. (1994) studied the attribute of dangerousness amongst 329 undergraduates with the use of vignettes describing a person with a mental illness. A lack of previous contact and higher knowledge of symptomology alone were related to the belief that individuals with schizophrenia are dangerous. An additional study by Boisvert and Faust (1999) determined there was a relationship between social distance and the attribution of violence and schizophrenia for undergraduate students and mental health professionals.

Penn, Kommana, Mansfield, and Link (1999) used the Dangerousness Scale and surveyed 182 undergraduates for perceived dangerousness of individuals with mental illness based on level of contact. Once again, previous contact and knowledge of actual rates of violent behavior resulted in lower perceptions of danger for individuals with schizophrenia. These findings suggest that the level of the contact and discrediting stereotypes is vital for the process of reducing stigma towards individuals with schizophrenia.

The sense of fear is due to the misconception that individuals with schizophrenia are prone to exhibiting violence towards others; the truth is they are more prone to hurting themselves or withdrawing from social interaction (Walsh, Buchanan, & Fahy, 2002). The Center for Disease Control (CDC) has linked schizophrenia to a high risk of suicide attempts with 1 out of 10 committing suicide (Andreasen & Black, 2006). This rate of suicide is much higher when compared with the national statistics of 12 out of 100,000 people per year in 2009 (Kochanek, Xu, Murphy, Minino, & Kung, 2011). With such high prevalence and risk for selfharming behavior, individuals with schizophrenia are still commonly thought to be socially unacceptable, aggressive, a group of people with a lack of knowledge and information rather than a group of people in need of services, and a cause needing an array of awareness promotions (Corrigan, 2004b; Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Corrigan, River, et al., 2001; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Penn & Nowlin-Drummond, 2001). Society is discriminatory towards people with mental illness due to this fear of their dangerous and aggressive behavior (Corrigan, Edwards, et al., 2001; Crandall & Reser, 2005). Despite evidence that shows violence by individuals with schizophrenia is low, there continues to be discrepancies in reports. Douglas, Guy, and Hart (2009) explained inconsistencies of violence and schizophrenia as being dependent on confounding factors such as gender, age, low social economic status, and comorbidity of substance use and/or antisocial personality. Angermeyer (2000) reinforced evidence that violent crimes committed by individuals with schizophrenia or other severe mental disorder are inaccurately portrayed as being high. There is no clear evidence that there is an increase of violence committed by individuals with schizophrenia. Risk for being violently attacked by a stranger is lower for individuals with severe mental illness than that of people that are mentally healthy. Researchers are continuously looking for

factors that can assist to identify interventions to decrease the stigma of violence amongst individuals with severe mental illness such as schizophrenia.

## **2.8 Changing negative attitudes towards individuals with schizophrenia**

According to a report on mental health by the U.S. Surgeon General, the single factor that has the most impact on mental health is stigma (USDHHS, 1999). In an effort to understand stigma, research has identified effective modes of changing the misconceptions and stereotypes associated with negative beliefs towards individuals with mental illness. Related to the problem of stigma, it is important to consider diverse concepts used to define causes and possible influences to decrease stigma. Due to the detrimental effects of stigma on individuals with severe mental illness, there has been an increase in research related to promote stigma reduction programs (Corrigan, Kosyluk, & Rüsich, 2013; Corrigan, 2004a; Corrigan, River, et al., 2001; Pinfold, Thornicroft, Huxley, & Farmer, 2005). At its core such research has demonstrated that some techniques are more successful at providing positive and effective results in reducing stigma. Such activities have included positive media campaigns that facilitate the promotion of positive characteristics (Vaughan & Hansen, 2004), psycho-educational opportunities for mental health professionals (Pinfold et al., 2005), and computer-assisted education (O’Kearney, Gibson, Christensen, & Griffiths, 2006). These different concepts reflect several types of interventions based on various motivations of individuals. While numerous and creative interventions have been implemented to combat stigma, most programs fall into three categories. Rüsich et al. (2005) completed a review of relevant literature on reduction programs aimed at reducing public mental illness stigma and identified the main approaches to change as: education, contact, and protest.

### **2.8.1 Education**

In an attempt to reduce stigmatization of individuals with schizophrenia, education programs often incorporate cognitive aspects and provide information to contradict negative stereotypes. The approach attempts to replace negative attitudes and replace them with factual information (Corrigan, Morris, Michaels, Rafacz & Rüsich, 2012). Overtime, research has shown that some

educational programs are successful at bringing about significant changes in stigma levels (Corrigan, River, et al., 2001; Keane, 1991; Morrison, 1980; Penn et al., 1994). The positive aspects of educational programs include the ability for them to be used in various environments, with large groups of people, and their broad reach (Corrigan et al., 2012). Additionally, education strategies allow the usage of a variety of media sources such as public service announcements, books, flyers, documentaries, and blogs, to name a few (Finkelstein, Lapshin, & Wasserman, 2008; SAMHSA, 2014.).

Success has been found with the use of educational programs for the reduction of stigma towards individuals with mental illness (Keane 1990; Penn et al., 1994, 1999). One study by Corrigan, et al., (2001) demonstrated the effectiveness of education through the use of a three minute video featuring an individual with mental illness. Community college students were assigned to a treatment group to watch the video or the control group with no intervention being employed. The Psychiatric Disability Attribution Questionnaire and the Life Story Memory Test were administered to the participants. The videos were successful in reducing stigmatizing attitudes amongst the participants. A related study by Boysen and Vogel (2008) found similar results from the use of an educational intervention on college students. However, this study incorporated the impact of pre-existing attitudes in relation to the controllability of the mental illness. Results indicated an educational approach can be effective when the complex nature of attitudes and information on causes of the mental illness are incorporated in an intervention program. Positive outcomes were also found by Holmes et al. (1999) in the measurement of level of contact and stigma of 83 students using a pre and post study research design. Short-term education programs aimed at reducing stigma towards mental illness were found to be effective in promoting positive attitudes.

Educational programs have also been found to be effective in assisting individuals with mental illness to disclose their condition. A study by Rüscher et al. (2014) examined the process that many people with mental illness experience when disclosing their diagnosis to family and friends. Most individuals with a mental illness fear the stigma and discrimination associated with their condition. The researchers employed a randomized, controlled trial and used a

program called Coming out Proud (COP) with 100 participants with a diagnosed mental illness.

The program was successful and encouraged positive coping skills, reduction of self-stigma, empowerment, and benefits of disclosure. Numerous research studies have noted personal accounts of self-stigmatization where shame is more impairing than the actual symptoms of the mental illness regardless of severity level (Pinfold, Huxley, et al., 2003); making programs such as Coming out Proud a positive intervention to decrease stigma-related stress associated with disclosure and acquisition of mental health services. Organizations have also been created with the aim of reducing stigma through education. One such organization is the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) which was established in 1992 by Congress; it is a part of the U.S. Department of Health and Human Services. SAMHSA reported the budget for 2014 as \$3.6 billion, an increase of \$4 million above the 2012 budget. The organization is aimed at the improvement of the prevention, treatment and rehabilitative services in order to reduce illness, death, disability, and cost to society due to substance abuse and mental illnesses (SAMHSA, 2014). SAMHSA focuses primarily on family education as a primary forum for promoting social change towards stigma (Corrigan, 2004b). Research shows empirical evidence that the use of public education programs, advocacy groups, and psycho-educational programs aimed to reduce stigma are helpful and effective; however, there are limitations on the amount of lasting effect on attitudes over time (Corrigan, 2004b). Despite the success that is found with educational interventions, researchers have also indicated that such interventions need to be examined based on content of the programs (Rüsch, Angermeyer, & Corrigan, 2005). Yet, this examination does not discredit the ability for change to occur; educational means should not be the sole intervention for changing stigma. Corrigan (2004b) has argued that studies do show change of stigmatizing attitudes due to educational interventions.

### **2.8.2 Contact**

Allport's seminal research on the concept of contact is defined as, close and pleasant interpersonal contact with people from different groups as being probably the best way to

achieve social harmony (Hogg & Abrams, 2007, p. 348). In line with Allport's concept, Corrigan, et. al. (2001) used meta-analyses and concluded that contact programs exceed the effectiveness of programs that use educational means. The ability for contact to have an increased level of promoting change of stigmatizing attitudes has been found effective with individuals with mental illness. Contact has been found to have an increased impact when participants interact with a person or group of persons that belong to a stigmatized group such as schizophrenia (Chinsky & Rappaport, 1970; Corrigan et al., 2002; Thornicroft et al., 2008).

In contact intervention, experience is used to change the attitudes from negative to more positive through interpersonal experiences. Similarly, Pinfold, Toulmin, et al. (2003) used an intervention program focused on increasing mental health literacy while dispelling negative stereotypes through the use of contact. The researchers surveyed 472 secondary school students and evaluated the participants' knowledge, attitudes, and behavioral interactions towards individuals with mental illness. The results indicated the highest level of change was amongst individuals who indicated higher levels of personal contact with people with mental illness. In a meta-analysis review of over 700 studies, contact interventions were found to be successful in reducing a variety of stigmas (Tropp & Pettigrew, 2009). Recently, Corrigan et al. (2014) completed an analysis of contact-based anti-stigma programs to determine if psycho-educational training would decrease the level of stigma towards individuals with schizophrenia. This particular study used previous results from qualitative research that found 32 items suggested for contact-based programs. Utilizing an online survey format, 100 participants were selected to participate. The results ranked the most important components of an anti-stigma program to be: face-to-face presentations, discussion, assessment based on goals; experienced staff; message of background stories; and evaluation and future follow-up. Continued research assists in tailoring programs to be as effective as possible.

### **2.8.3 Protest**

Protest is an additional strategy used reduce stigma in the field of mental illness. Corrigan and Penn (1999) define protest as a stigma reduction strategy aimed to suppress stigmatizing attitudes towards individuals with mental illness. Protest strategies include advocacy activities,

support groups and patient empowerment groups. Corrigan (2004a) defined the process of protest strategies as the use of focus being placed on the injustices of stigma toward individuals with mental illness. In recent years, there has been an increase in the number of public interest and advocacy groups that are invested in reducing the level of stigma and discrimination of individuals with mental illness. There are many organizations whose primary aim is to use protest as a major means to aid in the reduction of stigma towards individuals with mental illness in society.

The National Alliance on Mental Illness (NAMI) is a nation-wide group that has been active since 1979 and works to assist families and people impacted by mental illness. NAMI is active at the national and local levels promoting support and research such as public education and awareness activities such as conventions, charity races, and public announcements (The National Alliance on Mental Illness, n.d.). Other groups that promote the positive views of individuals with schizophrenia include the National Stigma Clearinghouse and the Resource Center to Address Discrimination and Stigma Associated with Mental Illness (Corrigan, 2004b). There are key entities in society that can assist in the reduction of stigma towards individuals with schizophrenia; however, until there are changes in key sectors such as employers and the media, there is little possibility of lasting change (Corrigan, 2004b). Antistigma campaigns have used protest to curtail the damaging effects of the portrayal of individuals with schizophrenia in the media. One form of protest is target-specific which is aimed at altering the negative connotations of not only media portrayal but also healthcare policies. Studies such as Penn and Nowlin-Drummond (2001) reinforce the injustice and degree of political incorrectness that terms and labels promote.

A vignette study by Socall and Holgraves (1992) found different reactions towards individuals depending on the type of label associated with their behavior were psychiatric or medial. It was found that psychiatric labels tended to have a less favorable association and induced negative stereotypes. Negative labels further reinforce the stigmatizing and misconceptions towards individuals with schizophrenia. Penn et al. (1994) similarly used vignette research where participants were given three different stories that gave information about lives of individuals with schizophrenia. Participants were asked to describe their

emotions and feelings towards the people in the vignettes. The use of psychological terms was associated with less positive views related to individuals with schizophrenia. Participants expressed less fear with vignettes that described the individual with schizophrenia in more relatable and human terms and resulted in less stigmatizing views.

While educational, contact, and protest interventions have been shown to provide meaningful effects, they all have one limitation. Intervention programs which can be time consuming and expensive cannot be done with large populations of people at a time. In order for the programs to run effectively, there needs to be individuals with schizophrenia that can serve as guides and be the focus of change. Thus, additional research into other factors that impact stigma is important.

## **2.9 Level of familiarity and social distance**

According to Corrigan, Edwards, et al. (2001), the level of familiarity or how intimate of a relationship a person has involving individuals with schizophrenia is determined as a result of contact and social proximity. In terms of contact, a low level of familiarity includes having watched a documentary about mental illness while a higher level of familiarity includes working or living with someone with a mental illness. Corrigan and Watson (2006) found more positive attitudes and fewer stigmas in studies where people have a higher level of familiarity with a person with a mental illness. According to Alexander and Link (2003) people with firsthand experience with people with mental illness have a more accepting attitude towards individuals with mental illness. Huxley (1993) also found that people who had limited encounters with individuals with mental illness would highly stigmatize this population. Those with an increased amount of exposure to people with mental illness through experiences such as mental health facilities and treatment programs have lower levels of stigmatizing attitudes. In a similar study, Angermeyer and Matschinger (1996) confirmed the relationship between personal experiences and lower levels of stigma. Structured interviews and vignettes were completed first in 1990 with 2,045 participants and again in 1993 with 4,237 participants. The participants rated their emotional responses and social distance in relation to the individual with schizophrenia from the vignette. Respondents with stronger

personal experiences to mental illness reported an increased level of positive social responses, less desire for social distance, and lower levels of anxiety towards schizophrenia.

Hudes (2006) also found a relationship between level of familiarity with mental illness and attitudes towards an individual with schizophrenia. After the informational sessions, participants were administered the Knowledge Test (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999), the Attribution Questionnaire (Corrigan, Green, et al., 2001), the Level of Contact (LOC) Report (Holmes, et al, 1999), and a demographic questionnaire. Findings once again concluded that preexisting knowledge was correlated with less stigmatizing attitudes. de Sousa, Marques, Curral, and Queirós (2012) used the AQ-27 in an exploratory study of 40 family members of individuals with schizophrenia. The level of stigma amongst family members and inner support systems of the individual with schizophrenia can lead to additional stigma and be harmful to the recovery and treatment process. Attributes with the highest scores included help, pity, and coercion. Contact with individuals with severe mental illness resulted in both positive and low levels of stigmatization amongst the sample. However, despite the increased level of familiarity, the participants reported high scores in coercion, pity and segregation. The results call into question the influence of negative experiences on stigmatizing views when there is a high level of familiarity to mental illness.

## **2.10 General comments**

The researcher can conclude that, the existing researches regarding the attitude of mental health professional toward patient with schizophrenia abrasive less attention. Also some other work relevant to this study does not consider all the factors affecting the attitude of mental health provider. In addition, some previous studies addressed the attitudes of medical student and quality of life for schizophrenia, this type of study did not take place in Gaza strip before. Basically it is important that a person is convinced of his duty being done to these patients, and this reflects the real attitude and motivation to work in mental health. Add to the above may be affected by trends in the mental health workers vary toward schizophrenia patients different depending on the work place such as community mental health CMH and psychiatric hospital.

The emergence of mental illness, the patients behavior, dangerous thoughts or perceptions, response to treatment improvement are possible to play a role in acceptance and affecting attitudes, from my experience I think that the interest in social care schizophrenia patient and the patients personal hygiene with commitment to treatment are a great significance and leads to a positive attitudes.

I believe that verity of conceptions and mental health knowledge about schizophrenia can be an influential factor in the formation of attitudes and familiarity with schizophrenia.

## **Chapter Three: Method and Design**

### **3.1 Study design**

Descriptive analytic research design used for this study. An important aspect of using surveys is the ability to describe the attitudes and beliefs of a specific population, and to predict behavior (Bordens & Abbot, 2002). The independent variables in this study are age, gender, highest degree earned, and number of years working directly with persons with schizophrenia. The dependent variables for this research are the mean scores for each of the scales were used. The researcher administered Likert-type rating scale instruments in order to ascertain attitudes toward the persons with schizophrenia.

### **3.2 Population and sample of the study**

The study is a descriptive qualitative research design consisting of a convenient sample of mental health professionals employed at General Directorate of Mental Health Ministry of Health MOH, and six Community Mental Health Centers (CMH Centers) located within the Gaza strip, those CMH Centers managed by General Directorate of Mental Health Ministry of Health MOH and serving all Gaza Strip areas. In order to participate in the study, several criteria had to be met including that, all guidelines for employment of mental health provider as defined by the participating mental health program.

A total of 104 respondents to the G-AQ-23 out of 110 participants with participation rate 94.5%. The six non-responders to the G-AQ-23 were part of the mental health professional sample, and they failed to submit a completed questioner to one of the initially sampled respondents who was asked to transmit additional survey packets to mental health professionals with whom they were acquainted. Of the 104 participants, 46 were female (44.2%) and 58 were male (55.8%).

### **3.3 Study setting**

The study was conduct at several mental health facilities MOH located within the Gaza strip.so that it represented all areas of Gaza Strip regions. The questionnaire was filling by participants each in his/her mental health facilities.

### **3.4 Study period**

The duration of this study about 7 months from April 2015 – October 2015. This period included proposal preparation, designing the instrument tool, collecting data till coming out with result and recommendation on November 2015.

### **3.5 Instruments of the study**

The researcher used the following Instruments General Attribution Questionnaire (G-AQ-23)

#### **3.5.1 Sociodemographic questionnaire**

Five independent variables assessed in this study were those factors related to the professionals' background; these included age and gender of the respondent, highest degree earned, and the numbers of years working directly with persons with schizophrenia. For the purposes of this study, highest degree earned referred to the level of the highest degree achieved by the respondent, and included (a) diploma (b) bachelor's degree, (c) master's degree, and (d) doctoral degree.

In addition, the demographic variable of occupation referred to the specific job title of the mental health professionals who participated in this study, and included (a) psychiatrist, (b) clinical psychologist, (c) counselor/psychotherapist, (d) clinical social worker, (e) psychiatric nurse, (f) case manager and (g) other. The occupation identified by the respondents allowed the researcher to accurately assign respondents to professional categories. The demographic questionnaire is represented in Table 3.

#### **3.5.2 General Attribution Questionnaire (G-AQ-23)**

General Attribution Questionnaire known in this research as the G-AQ-23 as shown in Table 3.1 to measure attitudes, emotional reactions, and behavioral responses that are relevant to schizophrenia and stigma. (G-AQ-23) first created in English language then arbitrated and modified by a panel of expertise in mental health all the panel of expert are academic with PhD level at several universities at Gaza strip also they have more than 20 years of experience.

The expertise added some items in G-AQ-23 such as questions number (19, 20 22, 23), that suite the Palestinian culture in Gaza strip also omitted some other questions for some

rezone such as duplication or not relevant. Then the G-AQ-23 were translated from English to Arabic language by two English language professional (PhD level) at Islamic university, Gaza. In addition to the expertise modification a pilot sample were performed to take several participant opinion. Finally after considering the participants comments, some misunderstood correction on G-AQ-23 were remodified and arbitrated by the same panel of expertise in mental health.

G-AQ-23 consists of 23 items measuring eight constructs using a nine-point scale (1 = not at all, 9= very much) similar to Corrigan et al.'s study (2002) as seen in Appendix-3 the English version and in Appendix-2 G-AQ-23 Arabic version.

The G-AQ-23 was administered to participants to assess five attitudes personal responsibility and three dangerousness; three emotional reactions anger, pity, and help; and two behavioral responses fear and improbable; and four for avoidance. Possible scores range from 23 to 207, with higher scores representing higher levels of perceptions of dangerousness and fear toward those with schizophrenia, and a stronger desire for social distance from that population. G-AQ-23 were grouped to various subscales (Corrigan et al, 2001; Corrigan, et al., 2002; Link et al., 2004). Table 3.2 represents a list of the subscales and their corresponding items on the G-AQ-23.

Table 3.1 Identified Factor Questions on the General Attribution Questionnaire (G-AQ-23)

Factors	Questionnaire items included in mean score
Fear	3,11,18
Dangerousness	2,3,5,9,10
Avoid	17,21
Anger	1,4,8
Pity	6,14,16
Responsible	7,15, 20,22
Help	12,13,19
Improvable	7,23

### 3.6 Validity of the questionnaire

#### 3.6.1 Internal validity

##### 3.6.1.1 Internal consistency

Internal consistency is defined as the strength of correlation between the score of every item of the questionnaire and the mean of the factor it belongs to it. The researcher calculated Pearson's correlation coefficients between the mean scores of pilot sample on each factor with their items, as well as the mean scores of G-AQ-23 and means scores of each factor.

##### 1- Internal consistency of the First Factor: Fear

The researcher computed Pearson's correlation coefficient between the scores of pilot sample on each item of the fear factor, the mean score presented in Table 3.2. the results in Table 3.2 shows that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the fear factor.

Table 3.2 Pearson's correlation coefficient between each item of fear factor and its mean score

No.	Item	Correlation coefficients	P=
1.	Persons with schizophrenia terrify me	0.894**	0.00
2.	How scared of a person with schizophrenia would you	0.901**	0.00
3.	How much concern do you feel for persons with	0.708**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

### 2- Internal consistency of the second factor: dangerousness

The researcher also computed Pearson's correlation coefficient between the scores of pilot sample on each item of the dangerousness factor and its mean score as presented in Table 4.2. The results in Table 3.3 show that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the dangerousness factor.

Table 3.3 Pearson's correlation coefficient between each item of dangerousness factor and its mean score

No.	Item	Correlation coefficients	P=
1.	Would feel unsafe around persons with schizophrenia	0.800**	0.00
2.	Think persons with schizophrenia pose a risk to other people unless they are hospitalized.	0.796**	0.00
3.	How dangerous do you feel a person with schizophrenia is?	0.804**	0.00
4.	I would feel threatened by a person with schizophrenia?	0.885**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

### 3- Internal consistency of the third factor: avoid

Pearson's correlation coefficient between the scores of pilot sample on each item of the avoid factor and its mean score are presented in Table 3.4. Table 3.4 shows that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the Avoid factor.

Table 3.4 Pearson's correlation coefficient between each item of Avoid factor and its mean score

No.	Item	Correlation coefficients	P=
1	Persons with schizophrenia terrify me.	0.488**	0.00
2	Would try to avoid a person with schizophrenia.	0.587**	0.00
3	I feel ashamed when dealing with patient with	0.722**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

#### 4- Internal consistency of the fourth factor: anger

The Pearson's correlation coefficient scores of pilot sample among items of the anger factor and their mean score are presented in Table 3.5. the results in Table 3.5 shows that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the Anger factor.

Table 3.5 Pearson's correlation coefficient between each item of Anger factor and its mean score

No.	Item	Correlation coefficients	P=
1	Would feel aggravated by persons with schizophrenia.	0.860**	0.00
2	How angry do persons with schizophrenia make you feel?	0.798**	0.00
3	How irritated would you feel by a person with schizophrenia?	0.706**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

#### 5- Internal consistency of the fifth factor: pity

The researcher computed Pearson's correlation coefficient between the scores of pilot sample on each item of the pity factor and the mean score as shown in Table 3.6 the values of Pearson's correlation coefficient also significant at  $\alpha \leq 0.05$  for two items.

Table 3.6 Pearson's correlation coefficient between each item of Pity factor and its mean score

No.	Item	Correlation coefficients	P=
1	Feel pity for persons with schizophrenia.	0.746**	0.00
2	How much sympathy would you feel for a person with a schizophrenia?	0.660**	0.00
3	How sorry do you feel for persons with schizophrenia?	0.476**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

### 6- Internal consistency of the sixth factor: responsible

The researcher computed Pearson's correlation coefficient between the scores of pilot sample on each item of the responsible factor and its mean score as presented in Table 3.7. The results in Table 3.7 show that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the Anger factor.

Table 3.7 Pearson's correlation coefficient between each item of Responsible factor and its mean score

No.	Item	Correlation coefficients	P=
1	How controllable do you think schizophrenia is?	0.535**	0.00
2	How responsible do you think a person with schizophrenia is for their present condition?	0.513**	0.00
3	I think that the schizophrenic patient can marry, have children and live a normal life like others'	0.551**	0.00
4	I think that the schizophrenic patient can be dealt with as a normal person	0.744**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

### 7- Internal consistency of the seventh factor: help

The Pearson's correlation coefficient among the scores of the pilot sample on all items of the help factor has been calculated and its mean score as presented in Table 3.8. The results in

Table 3.8 also shows that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which indicate the internal consistency of the help factor.

Table 3.8 Pearson's correlation coefficient between each item of Help factor and its mean score

No.	Item	Correlation coefficients	P=
1.	How likely is it that you would help a person with schizophrenia?	0.727**	0.00
2.	How certain would you feel that you would help a person with schizophrenia ?	0.861**	0.00
3.	If I were a landlord, I probably would rent an apartment to a person with schizophrenia.	0.517**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

#### **8- Internal consistency of the eighth factor: improvable**

The researcher computed Pearson's correlation coefficient between the scores of pilot sample on each item of the improvable factor and its mean score as presented in Table 3.9. The results in Table 3.9 show that the values of Pearson's correlation coefficient are significant at  $\alpha \leq 0.05$  which confirmed the internal consistency of the improvable factor.

Table 3.9 Pearson's correlation coefficient between each item of improvable factor and its mean score

No.	Item	Correlation coefficients	P=
1	How controllable do you think schizophrenia is?	0.776**	0.00
2	I feel improvement of schizophrenic patient through my follow up	0.675**	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

### 9- Internal consistency of all factors with the G-AQ-23

Table 3. 10 presents the Pearson's correlation coefficients between the mean scores of each factor and the mean scores of the G-AQ-23 in order to verify the internal consistency of the questionnaire factors.

Table 3.10 Pearson's correlation coefficient for each factor and the G-AQ-23

Factor	Correlation coefficients	P=
Fear	0.779**	0.00
Dangerousness	0.846**	0.00
Avoid	0.669**	0.00
Anger	0.672**	0.00
Pity	0.384*	0.03
Responsible	0.663**	0.00
Help	0.619**	0.00
Improvable	0.443*	0.00

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

The results in Table 3.10 show that p-value for the correlation between each factor and mean of G-AQ-23 is less than 0.05, these results indicate that there are statistical significant at  $\alpha \leq 0.05$  level of significance, which confirm the internal consistency and the validity of G-AQ-23 to apply on the sample of the study.

### 3.7 Reliability of questionnaire

The reliability refers to the reproducibility or consistency of scores from one assessment to another (American Educational Research Association, 1999), since the reliability is a measure of consistency, then the association measures are the spirit of the reliability measures. The most common measures of reliability are Split half and the Cronbach's alpha tests as a measure of internal consistency (Gliem and Gliem, 2003). A rule of thumb is suggested by (George and Mallery, 2003): The researcher used two techniques to examine the reliability of the G-AQ-23

### 3.7.1 Split-half method

To determine reliability of the questionnaire the researcher used the split-half method which depends on splitting the items of the factor into two parts, and calculate the correlation between the parts, then make a correction for the correlation coefficient by Spearman Brown prophecy Formula or Guttman equation as given in the following Table 3. 11

Table 3.11 Reliability coefficient by using split half method

Factor	Numbers of items	Correlations coefficients	
		Before correction	After correction
Fear	3	0.611**	0.758**
Dangerousness	5	0.776**	0.874**
Avoid	2	0.433*	0.604**
Anger	3	0.359*	0.528**
Pity	3	0.478*	0.647**
Responsible	4	0.436*	0.614**
Help	3	0.397*	0.568**
Improvable	2	0.412	0.583**
<b>G-AQ</b>	<b>23</b>	<b>0.525*</b>	<b>0.689**</b>

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

Table 3.11 shows that the correlation coefficient of the split half methods are significant for all dimensions at 0.05 level of significance.

Generally, the corrected correlation between the halves of items of the G-AQ-23 is significant at 0.05 which reveals the reliability of G-AQ-23 to study the attitudes of mental health professionals toward patients with schizophrenia in the Gaza strip.

### 3.7.2 Cronbach's alpha method

The researcher also tested the reliability of questionnaire by using Cronbach's alpha formula as given in Table 3.12. A rule of thumb is suggested by George and Mallery (2003, p. 231): (0 .9 or above) is an excellent reliability, (0 .8 – 0.9) a good reliability ,

(0.7 –0.8) an acceptable reliability , (0.6 –0.7) a questionable reliability, (0.6-0.5) is a poor reliability, and (less than 0.5) is an unacceptable reliability.

Table 3.12 Reliability coefficient by using Cronbach's alpha method

Factor	Numbers of items	Cronbach's alpha	Reliability
Fear	2	0.858	Good
Dangerousness	4	0.934	Excellent
Avoid	3	0.754	Acceptable
Anger	3	0.708	Acceptable
Pity	3	0.792	Acceptable
Responsible	5	0.772	Acceptable
Help	3	0.712	Acceptable
Improvable	2	0.705	Acceptable
<b>G-AQ-23</b>	<b>23</b>	<b>0.817</b>	<b>Good</b>

Table 3.12 show that Cronbach's alpha coefficient of each factor and the G-AQ-23 are greater than 0.7 which is considered an acceptable reliability. Based on the previous discussion on the validity and reliability of the research tool, the researcher conclude that the G-AQ-23 is a valid and reliable tool to study the attitudes of mental health professionals toward patients with schizophrenia in Gaza strip.

### 3.8 Data collection

The researcher collected the data after approval was given by the Palestinian Health Research Council (Helsinki committee for ethical approval) as well as Palestinian Ministry of Health (Directorate General of Human Resources Development) to conduct the research. Subsequently, the directors of mental health facilities at Gaza Strip were contacted either by face to face or by telephone for permission to conduct research at their respective site.

During communication with the directors, the following parameters were outlined: anonymity would be assured, participation were be voluntary, the amount of time to answer the survey was be approximately 20 minutes, the G-AQ-23 and the demographic questionnaire would be the only tools utilized to collect data from participants, there were be no expenses or costs to the program, and the data obtained would provide invaluable information about how mental health professionals perceive individuals with schizophrenia, with the potential for increasing knowledge about how such attitudes influence the delivery of mental health services.

Once permission from the directors of the sites was given, the clinical directors were then contacted to discuss details of the research. Thereafter, the clinical directors provided the researcher with invitations to naturally occurring group staff meetings during which time volunteers were recruited. All voluntary participants were oriented to the problem and the purpose of the research project, and were given verbal instructions from the researcher on how to complete the survey instrument. At the time surveys were distributed, informed consent forms were collected and checked for signatures. Participants were asked to complete G-AQ-23, as well as a 5-item demographic questionnaire.

All participants involved in the research project were advised of the bounds of the study, which included an assurance both that their participation would remain anonymous and that the items outlined on the instrument were matters of opinion and/or personal experience, and thus there existed no correct or incorrect answers. At one particular mental health facility, several respondents were given additional survey packets including consent forms and response sheets to distribute to other mental health professionals they knew. The completed packets were then returned to the researcher with the consent forms separate from the survey instruments. Once all response sheets were received, they were checked for completion and placed in one envelope, and the signed informed consent forms were placed in another envelope; all 104 survey forms were complete and were included in the analysis of data.

### **3.9 Statistical analysis**

Data were analyzed using descriptive statistics, all the statistical analysis were performed using SPSS software. one-way analysis of variance (ANOVA), Tukey's post-hoc test, independent t-tests, f-test and the Pearson correlation coefficient. First, mean scores were calculated to create variables to represent the eight G-AQ-23 factors. The mean scores were generated based on the factors and their corresponding items.

Once the values were generated for factor variables, descriptive statistics were run to determine if there were differences in measures of age, gender, highest degree earned, occupation, and number of years working directly with the chronically mentally ill based on the category in which the respondent resided. Means were then generated with category, age, gender, highest degree earned, and years of experience representing the independent variables and the eight factor variables of the GAQ-23. One-way ANOVA and Tukey's post-hoc test were conducted on each of the variables to determine whether mental health professionals differed in their attitudes, emotional reactions, and behavioral responses toward person with schizophrenia.

Also, independent t-tests were performed to determine the significant difference of attitude toward person with schizophrenia with the variable of gender. And lastly, the Pearson correlation coefficient was then used to determine the extent to which demographic variables impacted respondents' attitudes toward schizophrenia clients.

## **Chapter Four: Result**

### **4.1 Introduction**

This chapter presents the result study. The matter of the interpretation of the scores obtained from research instruments is classified under the validity and reliability concepts. The validity refers to the degree to which evidence and theory support the interpretations of test scores entailed by the proposed uses of tests (American Educational Research Association, 1999). Validity can be classified into four types, namely, statistical conclusion validity, internal validity, construct validity, and external validity (Drost, 2011). The most important type of validity tests is the construct validity which contains the face and content validity. To ensure the satisfaction of such type of validity, the researcher present the pre-form of the research instrument (questionnaire) to a panel of experts namely, (Prof Abdelaziz Thabet, Dr Ahmed Elhawajry, Dr Itaf Abed, Dr Jamel Tahrawi) referees, the referees having experience of above 20 years in mental health filed to evaluate the paragraph lengths, order and the consistency of its trends. According to their comments and suggestion, the necessary reframing on the questionnaire were implemented via merging, deletion, addition and rephrasing the mentioned questions to ensure the legibility and appropriateness of the questionnaire to the target population at Gaza strip in Palestine.

### **4.2 Social demographics characteristics of sample**

#### **4.2.1 Demographics**

A total of 110 surveys were distributed to the mental health professionals employed at several mental health facilities located within the Gaza strip. 104 were returned for a 94.5% response rate, with 100% of them were completed. Table 4.1 summarize the descriptive statistics for categorical demographic variables for all participants. The age of participants ranged from 21 to 60 years with mean 37.71 years and SD = 8.67 years. Of the mental health professionals 44.2% were female (No = 46) and 55.8% were male (No = 58). The highest level of education was reported as, 21.2% (No = 22) of participants earned a diploma's degree, 41.3% (No = 43) earned a bachelor's degree, 36.5% (No = 38) earned a master's degree, and there was one person (1.0%) that earned a doctoral degree.

The majority position of participants (33.7%) were Psychiatric Nurse (No =35), followed by Psychologist (No = 16, 15.4%), Clinical Social Worker (No = 16, 15.4%), Psychiatrist (No = 13, 12.5%), other (No = 13, 12.5%) including pharmacists, rehabilitation assistant and administrative staff, Clinical Psychologist (No = 11, 10.6%), and none of participants was a case manager. However, the number of experience years working in the mental health field was ranged from zero to 31 years with mean 9.22 years and SD = 6.40 years.

Table 4.1 Descriptive Statistics for Demographic Data for All Participants

Variable	Category	Frequency	% of sample
Gender	Male	58	55.8%
	Female	46	44.2%
Level of education	Diploma	22	21.2%
	Bachelor	43	41.3%
	Master	38	36.5%
	PhD	1	1.0%
Position	Psychiatrist	13	12.5%
	Clinical Psychologist	11	10.6%
	Psychologist	16	15.4%
	Clinical Social Worker	16	15.4%
	Psychiatric Nurse	35	33.7%
	Case Manager	0	0.0%
	Other	13	12.5%

#### 4.2.2 Attitudes of all participants

Table 4.2 presents the summary statistics of the G-AQ-23 and eight subscales for all participants. The G-AQ-23 was used to measure attitudes, emotional reactions, and behavioral responses of mental health professionals toward patients with schizophrenia in Gaza strip, participants obtained a mean score of 4.32 (SD =1.03), with a range of scores between 1.7 and 6.35 The largest mean was assigned to the Pity subscale (4.97), followed by Responsible subscale (4.89), while the smallest means was assigned to Avoid (3.68) and Anger (3.49). The above values of Pity subscale indicate that, the majority of mental health professional had a sympathy toward a person with schizophrenia. In addition to sympathy most of them believes that the person with schizophrenia is still responsible person. On the other hand, most them feel of avoidance has low attitude then the lowest is the anger.

On the Fear subscale, which assesses emotional reactions toward persons with schizophrenia, participants obtained a mean score of 4.1 (SD =1.93), with a range of scores between 1 and 9. On the Dangerousness subscale, participants obtained a mean score of 4.65 (SD = 1.77), with a range of scores between 1 and 9. On the Avoid subscale, participants obtained a mean score of 3.68 (SD = 1.47), with a range of scores between 1 and 7.67. On the Anger subscale, participants obtained a mean score of 3.49 (SD = 1.62), with a range of scores between 1 and 7.33. On the Pity subscale, participants obtained a mean score of 4.97 (SD = 1.15), with a range of scores between 1 and 7. On the Responsible subscale, participants obtained a mean score of 4.89 (SD = 1.24), with a range of scores between 2.2 and 8.2. On the Help subscale, participants obtained a mean score of 4.89 (SD = 1.24), with a range of scores between 2.2 and 8.2. On the Help subscale, participants obtained a mean score of 4.89 (SD = 1.24), with a range of scores between 2.2 and 8.2. On the Improvable subscale, participants obtained a mean score of 4.21 (SD = 1.51), with a range of scores between 1 and 7.5.

Table 4.2 Means and Standard Deviation of Attitudes in Sample Size , (n=104)

Factors	Min.	Max.	Mean	SD	Rank
Fear	1.00	9.00	4.10	1.93	5
Dangerousness	1.00	9.00	4.65	1.77	3
Avoid	1.00	7.67	3.68	1.47	7
Anger	1.00	7.33	3.49	1.62	8
Pity	1.00	7.00	4.97	1.15	1
Responsible	2.20	8.20	4.89	1.24	2
Help	1.00	7.00	3.83	1.45	6
Improvable	1.00	7.5	4.21	1.51	4
GAQ	1.70	6.35	4.32	1.03	-

#### 4.2.3 Difference in attitudes according to sex

To determine if there were statistically significant differences in attitudes between participants according to their gender, an independent samples t-test was conducted. Table 4.3 presents the results of independent samples t-test. Generally, female means of attitudes are larger than male means, except for Improvable subscale. There are significant statistical differences in Fear, Avoid, Help and GA-Q-23 between means of male and female at 0.05 level of significance. The result of independent samples t-test regarding gender as shown in

Table 4.3 it can indicate that, female feel the person with schizophrenia are Frightening and dangerous more than male therefore these two subscale will leads to avoid and anger toward the person with schizophrenia but for male they feel less Frightening and dangerous toward person with schizophrenia this clearly will result of better attitude regarding avidness and anger than female. On other hand, female had more sense of pity toward person with schizophrenia therefor it may result more feeling of help toward person with schizophrenia.

Table 4.3 Sample Difference in Attitudes According to Sex

Attitude		<i>n</i>	Mean	SD	Mean Difference	T- test	P=
Fear	Male	58	3.50	1.77	-1.35	-3.76**	0.00
	Female	46	4.85	1.87			
Dangerousness	Male	58	4.38	1.81	-0.63	-1.81	0.07
	Female	46	5.00	1.65			
Avoid	Male	58	3.33	1.39	-0.78	-2.79**	0.01
	Female	46	4.12	1.47			
Anger	Male	58	3.26	1.54	-0.52	-1.63	0.11
	Female	46	3.78	1.69			
Pity	Male	58	4.83	1.22	-0.30	-1.34	0.18
	Female	46	5.14	1.05			
Responsible	Male	58	4.79	1.41	-0.23	-0.92	0.36
	Female	46	5.01	1.00			
Help	Male	58	3.44	1.34	-0.88	-3.23**	0.00
	Female	46	4.33	1.44			
Improvable	Male	58	4.47	2.40	0.55	1.26	0.21
	Female	46	3.91	1.98			
GA-Q	Male	58	4.09	1.07	-0.52	-2.64**	0.01
	Female	46	4.61	0.91			

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

#### 4.2.4 Difference in attitudes according to level of education

One-way ANOVA's test was conducted to understand the differences on attitudes for participants with different level of education, participants earned Master or PhD were combined together because there is only one participant earned PhD. Table 4.4 presents the results of the test, and in order to understand where the differences existed, Tukey's post-hoc tests were performed when differences were significant. Eta-squared ( $\eta^2$ ) is a

proportion of the total variance that is attributed to an effect size which measure the magnitude of a treatment.

Results showed there are significant differences between participants with diploma's degrees and participant's with master or doctoral degrees on the subscale of Fear (p-value = 0.041). Significant differences were also found between participants with bachelor's degrees and participants with master's or doctoral degrees on the measure of Anger (p-value=0.022). Furthermore, we notice that -squared ( $\eta^2$ ) has highest values of Fear and Anger subscales with 6.1% and 7.3%, respectively.

Table 4.4 Difference in Attitude According to Level of Education Toward Patients with Schizophrenia

Attitude	Level of Education	n	Mean	SD	F- test	P=	$\eta^2$
Fear	Diploma	22	4.95	2.10	3.302*	0.041	0.061
	Bachelor	43	4.05	1.94			
	Master or PhD	39	3.67	1.69			
Dangerousness	Diploma	22	4.95	1.53	1.046	0.355	0.020
	Bachelor	43	4.78	1.88			
	Master or PhD	39	4.34	1.75			
Avoid	Diploma	22	4.27	1.52	2.388	0.097	0.045
	Bachelor	43	3.47	1.55			
	Master or PhD	39	3.57	1.28			
Anger	Diploma	22	4.30	1.85	3.975*	0.022	0.073
	Bachelor	43	3.16	1.41			
	Master or PhD	39	3.39	1.58			
Pity	Diploma	22	5.35	0.92	1.558	0.216	0.030
	Bachelor	43	4.89	1.43			
	Master or PhD	39	4.84	0.88			
Responsible	Diploma	22	4.99	1.35	0.164	0.849	0.003
	Bachelor	43	4.91	1.35			
	Master or PhD	39	4.81	1.08			
Help	Diploma	22	4.17	1.83	2.111	0.126	0.040
	Bachelor	43	3.99	1.52			
	Master or PhD	39	3.47	1.03			
Improvable	Diploma	22	4.59	2.44	0.952	0.389	0.019
	Bachelor	43	4.37	2.25			
	Master or PhD	39	3.85	2.08			
GA-Q	Diploma	22	4.74	1.13	2.677	0.074	0.050
	Bachelor	43	4.30	1.08			
	Master or PhD	39	4.11	0.85			

\* Significant at 0.05 level of significance.

#### 4.2.5 Difference in attitudes according to type of work

One-way ANOVA's test was conducted to understand the differences on attitudes for participants with different position/occupation. Table 4.5 presents the results of the test, the results showed there are significant differences between participants whom reported their positions as Psychiatrist and participants were identified as Psychologist on the subscale of Fear (p-value = 0.009). Significant differences were also found between participants whom reported their positions as Psychiatrist and participants were identified as Psychologist, Clinical Social Worker or other on the measure of Responsible (p-value=0.006). Furthermore, there are significant differences were found between participants whom reported their positions as Psychiatrist and participants were identified as other on the GA-Q-23 (p-value=0.034).

Moreover, we notice that Eta-squared ( $\eta^2$ ) has highest values of Fear and Anger subscales and GA-Q-23 with 14.2% , 15.1% and 11.4%, respectively.

Table 4.5 Difference in Attitude According to Type of Work Toward Patients with Schizophrenia

Attitude	Position	n	Mean	SD	F- test	P=	$\eta^2$
Fear	Psychiatrist	13	2.85	0.90	3.252**	0.009	0.142
	Clinical Psychologist	11	3.27	1.42			
	Psychologist	16	5.06	1.89			
	Clinical Social Worker	16	4.72	1.96			
	Psychiatric Nurse	35	3.89	1.97			
	Other	13	4.65	2.16			
Dangerousness	Psychiatrist	13	3.58	1.32	1.687	0.145	0.079
	Clinical Psychologist	11	4.09	1.00			
	Psychologist	16	4.86	1.78			
	Clinical Social Worker	16	5.20	1.90			
	Psychiatric Nurse	35	4.79	1.84			
	Psychiatrist	13	3.15	1.37			
Avoid	Clinical Psychologist	11	3.52	1.09	0.721	0.609	0.035
	Psychologist	16	4.17	1.24			
	Clinical Social Worker	16	3.77	1.84			
	Psychiatric Nurse	35	3.65	1.60			
	Psychiatrist	13	2.97	1.63			
	Clinical Psychologist	11	2.94	0.99			
Anger	Psychologist	16	3.75	1.54	0.889	0.492	0.043
	Clinical Social Worker	16	3.29	1.61			

	Psychiatric Nurse	35	3.79	1.73			
	Other	13	3.56	1.83			
	Psychiatrist	13	4.79	1.12			
	Clinical Psychologist	11	5.12	0.79			
Pity	Psychologist	16	4.75	0.89	1.968	0.090	0.091
	Clinical Social Worker	16	4.81	1.75			
	Psychiatric Nurse	35	4.83	0.98			
	Other	13	5.85	1.02			
	Psychiatrist	13	3.85	0.85			
	Clinical Psychologist	11	4.64	0.92			
Responsible	Psychologist	16	5.15	1.63	3.485**	0.006	0.151
	Clinical Social Worker	16	5.16	0.97			
	Psychiatric Nurse	35	4.83	1.30			
	Other	13	5.62	0.77			
	Psychiatrist	13	3.51	1.02			
	Clinical Psychologist	11	3.39	1.32			
Help	Psychologist	16	4.50	1.58	1.834	0.113	0.086
	Clinical Social Worker	16	4.02	1.43			
	Psychiatric Nurse	35	3.50	1.37			
	Other	13	4.36	1.72			
	Psychiatrist	13	3.69	2.43			
	Clinical Psychologist	11	3.91	1.97			
Improvable	Psychologist	16	5.00	2.34	0.989	0.429	0.048
	Clinical Social Worker	16	4.88	2.22			
	Psychiatric Nurse	35	3.97	2.16			
	Other	13	3.92	2.29			
	Psychiatrist	13	3.62	0.81			
	Clinical Psychologist	11	3.98	0.52			
GA-Q	Psychologist	16	4.64	0.97	2.519*	0.034	0.114
	Clinical Social Worker	16	4.54	1.12			
	Psychiatric Nurse	35	4.29	1.12			
	Other	13	4.75	0.96			
	Psychiatrist	13	2.85	0.90			
	Clinical Psychologist	11	3.27	1.42			

\*P<0.05    \*\*P<0.01    \*\*\*P< 0.001

#### 4.2.6 Difference in attitudes according to age

The strength of relationship between age of participants and their attitudes toward patients with schizophrenia in Gaza Strip was investigated by Pearson correlation coefficients as given in Table 4.6 The results of correlation analysis show that there are a significant negative correlation between age and all attitudes, except responsible and improvable were insignificantly negatively correlated with age.

Table 4.6 The Relationship Between Age and Attitudes

Factor	Correlation Coefficients	P=
Fear	-0.331**	0.001
Dangerousness	-0.259**	0.008
Avoid	-0.211*	0.031
Anger	-0.230*	0.019
Pity	-0.221*	0.024
Responsible	-0.112	0.259
Help	-0.308**	0.001
Improvable	-0.096	-0.096
<b>G-AQ-23</b>	<b>-0.323**</b>	<b>0.001</b>

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

#### 4.2.7 Difference in attitudes according to years of experience

The strength of relationship between years of experience of participants and their attitudes toward patients with schizophrenia in Gaza Strip was investigated by pearson correlation coefficients as given in Table 4.7 The results of correlation analysis show that there are a significant negative correlation between years of experience and all attitudes, except responsible and improvable were insignificantly negatively correlated with years of experience.

Table 4.7 Difference in Attitude According to Years of Experience Toward Patients with Schizophrenia

Factor	Correlation Coefficients	P-value
Fear	-0.359**	0.000
Dangerousness	-0.211*	.032
Avoid	-0.286**	0.003
Anger	-0.208*	0.034
Pity	-0.288**	0.003

Responsible	-0.147	0.138
Help	-0.340**	0.000
Improvable	-0.080	0.420
G-AQ	-0.345**	0.000

\*\* Significant at 0.01 level of significance.

\* Significant at 0.05 level of significance.

Generally, there is a strong positive significant correlation between age and experience ( $r=0.681$ ,  $p\text{-value}=0.00$ ).

## **Chapter Five: Discussion**

### **5.1 Introduction**

This chapter discusses the findings of the presents study about mental health professionals regarding to their attitudes toward persons with schizophrenia. The hypotheses of the current study are also addressed and interpretations of the results are offered. Moreover, an examination of the methodological strengths and limitations of the study is given. Lastly, the recommendations of future work have discussed.

### **5.2 Effects of age, gender, education, experience and type of work**

This study gives better understanding of how mental health professionals specifically, Psychiatrist, Clinical Psychologist, Psychologist, Clinical Social Worker, Psychiatric Nurse and others (directorates and pharmacies) view people with schizophrenia, and to understand the impact that age, gender, level of education, and years of experience treat persons with schizophrenia what type of attitudes they may had. However, negative attitudes might harmfully effect the providing of mental health good services, treatment adherence. Therefore, the attitudes of mental health professionals toward the schizophrenia patients was clearly understood and identified, then the negative attitudes among professionals may contribute to the reduction of barriers and bring about sufficient treatment for patients with schizophrenia in their hopes of recovery.

#### **5.2.1 Effects of age**

Regarding age factor, the present study found that older age was a consistent predictor variable for more positive attitudes, and included less desired social distance and anger toward the mentally ill, and a willingness to help them. In addition, older mental health professionals were less likely to perceive the patients with schizophrenia as dangerous to society. These finding were inconsistent with past findings (Alexander & Link, 2003; Cohen & Struening, 1962; Geskie & Salasek, 1988; Tanaka et al., 2004), which found that younger age corresponded with more positive attitudes toward the mentally ill. Given these conflicting results, the most prudent conclusion is that age itself may not be related to

differences in attitude and thus, differences should be attributed to the influence of other variables, such as general knowledge or experience.

### **5.2.2 Effects of gender**

In terms of gender, findings of the current study indicated that male tended to behave more favorably toward the patients with schizophrenia than females this finding is contrasted with (Corrigan et al., 2001; Corrigan et al., 2007; Leong & Zachar, 1999). For example, females tended to respond with more anger toward the patients with schizophrenia, and perceived them as more dangerous and unlikely to respond successfully to psychological interventions similar to (Leong & Zachar, 1999) study. Female were also found to be more likely to believe that people with schizophrenia are frightening and they trying to avoid them. Female also believes schizophrenia case having a less chance of improvable than male at the same time female are response opposite for the responsible subscale. On the other hands, female behave more favorably toward the patients with schizophrenia than male on pity and help than male. These findings showed that women have demonstrated more favorable attitudes toward the schizophrenia person than men regarding emotional subscale such as pity and help.

The fact that male in this study were more positive in their perceptions of patients with schizophrenia may be explained by the idea that those who adopt stereotypically masculine attitudes, especially restricted emotionality and limited expression of affect toward others, may have difficulty expressing compassion for patients with schizophrenia and therefore, are more likely to hold negative attitudes regarding pity and help subscale toward patients with schizophrenia. Despite this idea, it seems premature to correlate male with more positive beliefs about, or a greater willingness to interact with persons with schizophrenia.

### **5.2.3 Effects of education**

A higher education level those who possessed a doctoral and master degree was a consistent predictor of more positive attitudes for two attributes namely, Fear and Dangerousness than other (Diploma and Bachelor) this finding is consistent with the findings by Alexander and Link (2003) and Geskie (1985),. This finding may due to facts that those who possessed a doctoral and master degree more understanding of schizophrenia case across those who hold (Diploma and Bachelor). However for other attributes such as (pity, responsible, help and improvable) a diploma holder response more

positively than people having bachelor or doctoral and master level. The fact that diploma holder response positively to earlier attributes may be explained by the idea that the emotional feeling may be Effect on their behavior without deep understanding of the case similar to female in terms of gender. On other hand, people who possessed a bachelor's degree behave more positive than (diploma and doctoral or master) regarding the two attributes avoid and anger. In general, diploma holder were more benevolent toward schizophrenia people finding is consistent with the findings by (Leong & Zachar, 1999). also doctoral or master holder having less prejudicial attitudes.

#### **5.2.4 Effects of experience**

Due to the fact that the relationship between level of familiarity with mental illness and years of experience providing direct services to people with schizophrenia was highly significantly correlated, it is fair to discuss participants' experience with schizophrenia people in terms of their level of familiarity with them. The evidence that familiarity with mental illness reduces discriminatory responses found in previous research (e.g., Alexander & Link, 2003; Corrigan et al., 2003) is consistent with evidence found in the current investigation, and provides strong evidence for the importance of contact in reducing stigmatizing attitudes, as well as the potential value of incorporating contact into any stigma reduction intervention.

The researcher investigate in this, mental health professionals who were more experienced were found they have less desire to social distance from people with schizophrenia. Experienced mental health professionals also tended to view the person with schizophrenia as less dangerous to society, and were more willing to help them. On the other hand, veteran mental health practitioners were found to perceive schizophrenia persons as more personally responsible for their conditions than novice professionals, and were more fearful of the mentally ill. With regard to fearfulness, because the more experienced clinicians have worked longer in the field of mental health, they are more unlikely to have witnessed patient assault, or less experience. Thus, because decreased years of experience did not positively influence scores on the fear subscale, it may be that fearfulness is a dimension of attitudes toward the mentally ill which may be less responsive to modification through continuing education or increased contact with person with schizophrenia. These findings provide some support for the expectation that years of experience would have interaction effects with familiarity. These findings support the

hypothesis that positive attitudes increase as longer time the professional has worked with the schizophrenia people this finding is differ from (Kramp, 2004). However, more positive attitudes than negative attitudes were found among the more experienced participants, in fact the recognition that contact with persons with disabilities has a powerful influence on attitude formation, with high levels of contact generally associated with positive attitudes (e.g., Allport, 1954; Cohen & Struening, 1962; Genskow & Maglione, 1965; Livneh, 1982). Furthermore, the existence of differences between attitudes of highly skilled professionals and those of their less experiences counterparts is consistent with past findings that years of service working with the mentally ill had an effect upon attitude development (Perry, 1974; Yuker, 1988).

### **5.2.5 Effects of type of work**

With regard to position, the results of the current investigation found that direct contact with people having schizophrenia resulted in less stigmatizing attitudes toward this population same as (Corrigan et al., 2003) finding. That is, psychiatrist and clinical psychologist were found to hold significantly more positive attitudes than other professional toward people with schizophrenia. Explicitly, Psychologist and clinical Psychologist were significantly more likely than other professionals such as psychiatric and clinical social worker, nurse and other to fear persons with mental illness and perceive them as dangerous.

Also, Psychologist, clinical social worker, psychiatric nurse and others were significantly more likely to socially distance themselves from people with schizophrenia, and perceive them as dangerous similar to (Schulze, 2007). But, for responsible subscale psychiatrist and clinical psychologist were also found to be less likely than the other mental health professional to perceive persons with schizophrenia as less personally responsible for their conditions than others mental health professional. And lastly, the Psychologist was found to be significantly more benevolent in their opinions than others mental health professional and diminished in their helping behaviors also for pity subscale the Psychologist was found to be the superior positively behave and Psychiatrist was found to be more negative regarding pity subscale consistent with (Kingdon et al., 2004). Also, improvement subscale Psychologist obtained the highest positive attitude. It is important to note that while the attitude of mental health professional was positive on some subscales can be also found

negative for some other subscales that maybe due to personal understanding or interpretation of subscale.

The study results showed a difference in some attitudes among mental health professionals or workers, these differences found that women are more negative in all factors except help and bitty were positive, this explain the nature, behavioral and emotional combination of the women, on other hand this explains the lack of women deal and avoid with schizophrenia patients in emergency and critical conditions this showed a differ from (Magliano et al., 2004).

There is also a clear difference between a diploma and other education degrees where the diploma more bitty and help for patients with schizophrenia, this explain extent of scientific, awareness and cognitive deficits of schizophrenia disorder.

The surprise in the above findings that the psychologist more afraid from schizophrenia patients than other professionals, this elucidate the psychologist does not deal with psychotic patients in emergency critical and not insight condition. The result also showed that more age increased and years of experience of professionals cause more positive attitudes towards patients with schizophrenia with exception of the responsibility and improvement was negative with increased age and years of experience, the interpretation of it was due to their experience, knowledge and long follow-up for patients and their hopeless, frustration, and responding to treatment.

### **5.3 Limitations**

The study did not include the kind of probability sampling and stratification strategies that are needed to ensure good external validity. That is to say, while nonprobability sampling proved to be an acceptable, cost-effective method, therefore the sample was limited to those participants found in the chosen groups (i.e., mental health professionals employed or serving within a mental health facility in Gaza Strip), and thus the study was predicated on opinions from a restricted geographic area. Another potential drawback to the use of group administration was the possibility that participants may not have treated the survey as seriously when filling it out as part of a group than if they were permitted to fill it out unaccompanied.

Also, because of the self-reported nature of the measurement, participants were vulnerable to social desirability biases, which may have affected the ability on the part of the researcher to draw meaningful conclusions from the data. Socially desirable responding can be defined as the tendency for participants to present a favorable image of themselves, such as when participants make himself idealist 'fake good' in order to conform to socially acceptable values and norms, avoid criticism, or gain social approval (Nederhof, 1985). Due to the fact that the survey instrument included items that could be deemed socially sensitive, socially desirable responding impediment was occur.

A final drawback to group administration of the survey instrument concerned the participant's right to decline participation (Bordens & Abbott, 2002). Namely, participants may have felt pressured to participate in the survey due to the observation that all others were participating, despite the researcher's efforts at emphasizing the understanding that participants should not feel compelled to participate. As such, a conformity effect may have occurred because participation in the project became the norm defined by the behavior of fellow participants. Also, while use of snowball sampling proved to be efficient and cost-effective, limitations of this approach included the nonrandom selection procedure, reliance on the subjective judgments of the initially sampled respondents chosen to transmit the survey to other persons believed to have the characteristics of interest, and confidentiality concerns. Another possible limitation is the idea that the sample size may have been too small to sufficiently enable all analyses to be completed with good statistical power.

Another limiting factor may be due to the fact that the meaning of the pattern of findings across demographic and professionals variables is unclear. It could be the analyses lacked the power to find a significant relationship between each professional or demographic variable and the various stigma measures and that every professional and demographic variable is meaningfully related to stigma. It is also possible that one or some of the professional and demographic variables are more strongly related to stigma than others. For example, years of experience may foster the development of both professional and personal relationships with people with mental illness, enabling individuals to see people with mental illness acting acuity in different social roles and thereby reducing the desire for social distance, along with the likelihood that such a population will be feared.

## **5.4 Strengths**

While the study's limitations potentially constrained the interpretations of the findings, several strengths were noted. The present research is unique in that it is the only one of its kind to compare the attitudes different mental health professional toward persons with schizophrenia . Also, because the present research study captured 94.5% of the sample, the data can be viewed as strongly representative of the population surveyed. In order to make sampling more manageable, the researcher identified naturally occurring group staff meetings from which to gather the data. Using this group administration approach to data collection allowed the researcher to collect large amounts of data in a relatively short period of time. In addition, the group administration method served to reduce any concern that participants would misplace or forget about the survey should they have been permitted to complete the survey on their own. It appears that the researcher was also able to reduce potential volunteer bias due to the fact that very little effort was required on the part of participants to complete the survey particularly because it was administered during naturally occurring staff meetings.

## **5.5 Recommendation for future work**

- Future studies in this area can consider the use of an experimental research design to see if changes to attitudes and perceptions can be accomplished. In order to make strides in increasing the positive perceptions of individuals with mental illness, research needs to be designed to increase awareness through specially designed sensitivity training and discussions of mental illness professional. Sensitivity training and programs aimed at promoting positive contact has been found to be successful with mental ill professionals (Corrigan et al., 2002; Thornicroft et al., 2008; de Sousa, Marques, Curral, and Queirós, 2012). Using such measures of educational training can optimize the level of awareness of the negative effects of stigma on individuals with mental illness, their families, and society.
- Future research may consider the replication of the current study with a larger, diverse, and randomized population such as people serving mental illness individual but they considers as nonprofessionals for comparison of their attitudes.

- In addition, the focus of the present study was within Gaza strip; however, different geographical locations can provide additional insight to the particular factors influencing attitude for those populations therefore its recommended by the researcher to carry similar study in different area across Palestine or regional places.
- The present research study focused on predictors of current perceptions of individuals with schizophrenia. Future studies might also focus on examining additional variables that could explain variance and minimize unaccounted for variance on the outcome measures.
- The present research study focused on predictors of current perceptions of individuals with schizophrenia. Future studies might also focus on examining other mental disorder.
- Furthermore, it is recommended by the researcher to conducts training or awareness programs that allows to improve own their attitude and in the overall reduction in negative attitudes toward persons with schizophrenia.
- Future research may consider the replication of the current study with mental health professionals employed or serving on nongovernment organization who serving mental health illness to identify whether the work nature effects the attitudes of the mental health professional or otherwise.
- The researcher also recommend a study to measure families attitude of patient with schizophrenia and carry a comparison with the current study.

## 6. References

- Adler, A. K., & Wahl, O. F. (1998). Children's beliefs about people labeled mentally ill. *American Journal of Orthopsychiatry*, 68, 321-326.
- Alexander, L. A., & Link, B. G. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, 12(3), 271-289.
- Allport, G. W. (1954). *The nature of prejudice*. Cambridge, MA: Perseus Books.
- Alonso, J., Buron, A., Bruffaerts, R., He, Y., Posada-Villa, J., Lepine, J-P., Angermeyer, M.C., Levinson, D., De Girolamo, G., Tachimori, H., Mneimneh, Z.N., Medina-Mora, M.E., Ormel, J., Scott, K.M., Gureje, O., Haro, J.M., Gluzman, S., Lee, S., Vilaguti, G., Kessler, R.C., & Von Korff, M. (2008). Association of perceived stigma and mood and anxiety disorders: results from the World Mental Health Surveys. *Acta Psychiatrica Scandinavica*, 118, 305–314.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.), text rev. Washington, DC.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.), text rev. Washington, DC.
- Amir, Y. (1969). Contact hypothesis in ethnic relations. *Psychological Bulletin*, 71, 319- 342.
- Angermeyer, M. C, Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science & Medicine*, 43(12), 1721-1728.
- Angermeyer, M. C, Matschinger, H., & Corrigan, P. W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophrenia Research*, 69(2-3), 175-182.
- Antonak, R. F., & Livneh, H. (2000). Measurement of attitudes towards persons with disabilities. *Disability and Rehabilitation*, 22(5), 211-224.
- Appleby, L., & Wessely, S. (1988). Public attitudes to mental illness: The influence of the Hungerford Massacre. *Medicine, Science, and the Law*, 28(A), 291-295.
- Auerbach, D. C, & Johnson, M. (1977). Research on the therapist's level of experience. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapies: A handbook of research*. New York: Pergamon.
- Ay, P., Save, D., & Fidanoglu, O. (2006). Does stigma concerning mental disorders differ through medical education? A survey among medical students in Istanbul. *Social Psychiatry & Psychiatric Epidemiology*, 41, 63-67.
- Baker, F., & Schulberg, D. C. (1967). The development of a community mental health ideology scale. *Community Mental Health Journal*, 1, 216-225.
- Barlow, D. (2007). *Clinical handbook of psychological disorders: A step-by-step manual* (4th ed.). New York: Guilford.

- Beck, A., & Rector, N. (2001). Cognitive therapy of schizophrenia: A new therapy for the new millennium. *American Journal of Psychotherapy, 54*, 291-300.
- Beck A., & Rector, N. (2005). Cognitive approaches to schizophrenia: theory and therapy. *Annual Review of Clinical Psychology, 1*, 577-606.
- Beck, A, Rector, N., Stolar, N., & Grant, P. (2009). *Schizophrenia Cognitive Theory, Research, and Therapy*. New York, NY: Guilford Press.
- Beltran, R. O., Newton Scanlan, J., Hancock, N., & Lockett, T. (2007). The effect of first year mental health fieldwork on attitudes of occupational therapy students toward people with mental illness. *Australian Occupational Therapy, 54*, 42-48.
- Bernstein, B. L., & Lecomte, C. (1982). Therapist expectancies: Client gender, and therapist gender, profession, and level of training. *Journal of Clinical Psychology, 38(4)*, 744-754.
- Bordens, K. S., & Abbot, B. B. (2002). *Research design and methods: A process approach* (Fifth Edition). San Francisco, CA: McGraw-Hill Companies, Inc.
- Bordieri, J. E., & Drehmer, D. E. (1986). Hiring decisions for disabled workers: Looking at the cause. *Journal of Applied Social Psychology, 16*, 197-208.
- Bhugra, D. (1989). Attitudes toward mental illness. A review of the literature. *Acta Psychiatrica Scandinavica, 80*, 1-12.
- Brown, S. A., (2008). Factors and measurement of mental illness stigma: A psychometric examination of the attribution questionnaire. *Psychiatric Rehabilitation Journal, 32(2)*, 89-94.
- Byrd, E. K., & Elliott, T. R. (1998). Media and disability: A discussion of research. In H. E. Yunker (Ed.), *Attitudes toward persons with disabilities* (pp. 82-95). New York, NY: Springer.
- Canter, F. M. (1963). The relationship between authoritarian attitudes, attitudes toward mental patients, and effectiveness of clinical work with mental patients. *Journal of Clinical Psychology, 19*, 124-127.
- Canter, F. M., & Shoemaker, R. (1960). The relationship between authoritarian attitudes and attitudes toward mental patients. *Nursing Research, 9*, 39-41.
- Cavelti, M., Beck, E., Kvrjic, S., Kossowsky, J., & Vauth, R. (2012). The Role of Subjective Illness Beliefs and Attitude Toward Recovery Within the Relationship of Insight and Depressive Symptoms Among People With Schizophrenia Spectrum Disorders. *Journal Of Clinical Psychology, 68*, 462-476.
- Cavelti, M., Kvrjic, S., Beck, E., Rusch, N., & Vauth, R. (2011). Self-stigma and its relationship with insight, demoralization, and clinical outcome among people with schizophrenia spectrum disorders. *Comprehensive Psychiatry*.
- Christodoulides, T., Dudley, R., Brown, S., Turkington, D., & Beck, A. (2008). Cognitive behaviour therapy in patients with schizophrenia who are not prescribed antipsychotic medication: A case series. *Psychology & Psychotherapy: Theory, Research & Practice, 81*, 199-207.
- Cohen, J., & Struening, E. L. (1959). Factors underlying opinions about mental illness in the personnel of a large mental hospital. *American Psychologist, 14*, 339.

- Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology, 64*(5), 349-360.
- Cohen, J., & Struening, E. L. (1963). Opinions about mental illness: Mental hospital occupational profiles and profile clusters. *Psychological Reports, 12*, 111-124.
- Cohen, J., & Struening, E. L. (1964). Opinions about mental illness: Hospital social atmosphere profiles and their relevance to effectiveness. *Journal of Consulting Psychology, 28*(A), 291-298.
- Corrigan, P. W. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice, 5*(2), 201-222.
- Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology Science and Practice, 7*, 48-67.
- Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614-625.
- Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52*(1), 31-39.
- Corrigan, P. W. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing, 46*(1), 42-48.
- Corrigan, P. W., Backs, A., Green, A., Lickey, S. E., & Perm, D. L. (2001). Prejudice, social distance, and familiarity with severe mental illness. *Schizophrenia Bulletin, 27*(2), 219-225.
- Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin, 27*(2), 219-225.
- Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services, 52*(1), 953-958.
- Corrigan, P. W., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 44*(2), 162-179.
- Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., Goldstein, H., Bergman, M., Gagnon, C, & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28*(1), 91- 102.
- Corrigan, P. W., Rowan, D., Green, A., Lundin, R., River, P., Uphoff-Wasowski, K., White, K., & Kubiak, M. A. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin, 28*(2), 293- 309.
- Corrigan, P. W., Watson, A. C, Otey, E., Westbrook, A. L., Gardner, A. L., Lamb, T. A., Fenton, W. S. (2007). How do children stigmatize people with mental illness? *Journal of Applied Social Psychology, 37*(7), 1405-1417.

- Couture, S. M., & Penn, D. L. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of Mental Health, 12*, 291-305.
- Couture, S. M., & Penn, D. L. (2006). The effects of prospective naturalistic contact on the stigma of mental illness. *Journal of Community Psychology, 34*(5), 635-645.
- Creech, S. K., & Prewett, C. B. (1972). Opinions about mental illness held by personnel of a state psychiatric hospital and community mental health centers. *Journal of Community Psychology, 4*, 347-356.
- Dielman, T. E., Stiefel, G., & Cattell, R. B. (1973). A check on the factor structure of the opinions of mental illness scale. *Journal of Clinical Psychology, 29*(1), 92-95.
- Dietrich, S., Heider, D., Matschinger, H., & Angermeyer, M. C. (2006). Influence of newspaper reporting on adolescents' attitudes toward people with mental illness. *Social Psychiatry & Psychiatric Epidemiology, 41*, 318-322.
- Druss, B. G., Rosenheck, R. A. (1998). Mental disorders and access to medical care in the United States. *American Journal of Psychiatry, 155*(12), 1115-1111
- Feldman, D. B., & Crandall, C. S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology, 26*(2), 137-154.
- Finkelstein, J., Lapshin, O., & Wasserman, E. (2008). Randomized study of different anti-stigma media. *Patient Education and Counseling, 71*(2), 204-214. doi: 10.1016/j.pec.2008.01.002
- Freeman, H. E., & Kassenbaum, G. G. (1960). Relationships of education and knowledge to opinions about mental illness. *Mental Hygiene, 44*, A3>-A1.
- Gaebel, W., & Baumann, A. E. (2003). Interventions to reduce the stigma associated with severe mental illness: Experiences from the open the doors program in Germany. *The Canadian Journal of Psychiatry, 48*(10), 657-662.
- Gaebel, W., Zaska, H., & Baumann, A. (2006). The relationship between mental illness severity and stigma. *Acta Psychiatrica Scandinavica, 113*, 41-45.
- Genksow, J. K., & Maglione, F. D. (1965). Familiarity, dogmatism and reported student attitudes toward the disabled. *Journal of Social Psychology, 67*, 329-341.
- Geskie, M. A. (1985). Relationship between empathy, attitudes toward disabled persons and level of nursing education. *Dissertation Abstracts International, 47*, 850B.
- Geskie, M. A., & Salasek, J. L. (1988). *Attitudes of health care personnel toward persons with disabilities*. In H. E. Yuker (Ed.), *Attitudes toward persons with disabilities* (pp. 187-200). New York, NY: Springer.
- Goldin, G. J. (1966). Some rehabilitation counselor attitudes toward their professional role. *Rehabilitation Counseling Bulletin, 14*, 20-26.

- Grob, G. (1985). The Origins of American Psychiatric Epidemiology. *American Journal Of Public Health*, 75, 229.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.
- Heinemann, W., Pellander, F., Vogelbusch, A., & Wojtek, B. (1981). Meeting a deviant person: Subjective norms and affective reactions. *European Journal of Social Psychology*, 11, 1-25.
- Hinsie, L. (1999). The treatment of schizophrenia: a survey of the literature. 1929. *The Psychiatric Quarterly*, 70, 5-26.
- Holmes, E. P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. A. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin*, 25(3), 447-456.
- Hugo, M. (2001). Mental health professionals' attitudes towards people who have experienced a mental health disorder. *Journal of Psychiatric and Mental Health Nursing*, 8, 419-425.
- Jackson, D., & Heatherington, L. (2006). Young Jamaicans' attitudes toward mental illness: Experimental and demographic factors associated with social distance and stigmatizing opinions. *Journal of Community Psychology*, 34(5), 563-576.
- James, N. M. (1993). On the perception of madness. *Australian and New Zealand Journal of Psychiatry*, 27, 192-199.
- Jamison, K. R. (2006). The many stigmas of mental illness. *Lancet*, 367, 533-534.
- Johnstone, M. J. (2001). Stigma, social justice and the rights of the mentally ill: Challenging the status quo. *Australian and New Zealand Journal of Mental Health Nursing*, 10, 200-209.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.
- Keane, C. (1991). Socioenvironmental determinants of community formation. *Environment & Behavior*, 23, 27-46.
- Kindgon, D., Sharma, T., Hart, D., & the Schizophrenia Subgroup of the Royal College of Psychiatrists' Changing Minds Campaign (2004). What attitudes do psychiatrists hold towards people with mental illness? *Psychiatric Bulletin*, 28, 401-406.
- Kish, G. B., Solberg, K. B., & Uecker, A. E. (1971). The relation of staff opinions about mental illness to ward atmosphere and perceived staff roles. *Journal of Clinical Psychology*, 27(2), 284-287.
- Kramp, P. (2004). Schizophrenia and crime in Denmark. *Criminal Behaviour and Mental Health*, 14(4), 231-237.
- Leong, F. T., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. *British Journal of Guidance and Counseling*, 27(1), 123-132.

- Levey, S., & Howells, K. (1994). Accounting for the fear of schizophrenia. *Journal of Community & Applied Social Psychology, 4*(5), 313-328.
- Link, B. G., Andrews, H., & Cullen, F. T. (1992). The violent and illegal behaviour of mental patients reconsidered. *American Sociological Review, 57*, 275-292.
- Link, B. G., & Cullen, F. T. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior, 27*, 289-303.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*, 400-423.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.
- Link, B. G., Yang, L., Phelan, J. C., & Collins, P. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin, 30*, 511-541.
- Livneh, H. L. (1982). On the origins of negative attitudes toward people with disabilities. *Rehabilitation Literature, 43*(11-12), 338-347
- Livneh, H. L. (1988). A dimensional perspective on the origin of negative attitudes toward persons with disabilities. In H. E. Yuker (Ed.), *Attitudes toward persons with disabilities* (pp. 35-57). New York, NY: Springer.
- Lyons, M., & Hayes, R. (1993). Student perceptions of persons with psychiatric and other disorders. *The American Journal of Occupational Therapy, 47*(6), 541-548.
- Madianos, M. G., Priami, M., Alevisopoulos, G., Koukia, E., Rogakou, E. (2005). Nursing students' attitude change towards mental illness and psychiatric case recognition after a clerkship in psychiatry. *Issues in Mental Health Nursing, 26*, 169-183.
- Martin, J. K., Pescosolido, B. A., Olafsdottir, S., McLeod, J. D. (2007). The construction of fear: Americans' preferences for social distance from children and adolescents with mental health problems. *Journal of Health and Social Behavior, 48*, 50-67.
- Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of 'disturbing behavior,' labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior, 41*, 208-223.
- Maslin, A., & Davis, J. L. (1975). Sex-role stereotyping as a factor in mental health standards among counselors-in-training. *Journal of Counseling Psychology, 22*, 87-91.
- Mendel, W. (1979). Staff burnout: Diagnosis, treatment, and prevention. *New Directions in Mental Health Services, 2*, 75-83.
- Murray, M. G., & Steffen, J. J. (1999). Attitudes of case managers toward people with serious mental illness. *Community Mental Health Journal, 35*, 505-514.

- Nagler, M. (1993). *Perspectives on disability*. Palo Alto, CA: Health Markets Research. National Alliance on Mental Illness (2007). *Mental illness: Facts and numbers*. Arlington, VA: Author.
- National Alliance on Mental Illness (2009). *Mental health professionals: Who are they and how to find one*. Arlington, VA: Author.
- Nederhof, A. J. (1985). Methods of coping with social desirability bias: A review. *European Journal of Social Psychology*, 15(3), 263-280.
- Nordt, C, Rossler, W., & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin*, 32(A), 709-714.
- Onken, S., Craig, C., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31, 9-22.
- Overcoming the Stigma of Mental Illness. (2000, September 20). *Jamaica Gleaner*. December 7, 2008, from [http://www.jamaica-gleaner.com/gleaner/20000920/medicine/medicine\\_1.html](http://www.jamaica-gleaner.com/gleaner/20000920/medicine/medicine_1.html)
- Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling and Development*, 86, 143-151.
- Page, S. (1983). Psychiatric stigma: Two studies of behavior when the chips are down. *Canadian Journal of Community Mental Health*, 2, 13-19.
- Penn, D. L., Guynan, K., Daily, T., Spaulding, W. D., Garbin, C. P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, 20(3), 567-574. doi: 10.1093/schbul/20.3.567
- Penn, D. L., Kommana, S., Mansfield, M., & Link, B. G. (1999). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin*, 25(3), 437-446.
- Perry, R. J. (1974). The effect of long term experience on the attitudes of psychiatric aides. *Journal of Community Psychology*, 2, 166-173.
- Phelan, J. E., & Basow, S. A. (2007). College students' attitudes toward mental illness: An examination of the stigma process. *Journal of Applied Social Psychology*, 37(12), 2877-2902.
- Pryer, M. W., & Distefano, M. K. (1977). Relationship between opinions about mental illness and mental health knowledge among psychiatric aides. *Psychological Reports*, 40, 241-242.
- Pennington, B. (2002). *The Development of Psychopathology. Nature and Nurture*. New York, NY: Guilford Press.
- Rabkin, J. G. (1972). Opinions about mental illness: A review of the literature. *Psychological Bulletin*, 77(3), 153-171.
- Rabkin, J. G. (1974). Public attitudes toward mental illness: A review of the literature. *Psychological Bulletin*, 10, 9-33.

- Rabkin, J. G. (1979). Who is called mentally ill: Public and professional views. *Journal of Community Psychology*, 7, 253-258.
- Richmond, I. C., & Foster, J. H. (2003). Negative attitudes towards people with comorbid mental health and substance misuse problems: An investigation of mental health professions. *Journal of Mental Health*, 12(4), 393-403.
- Rollins, H. R. (2006). The mentally ill should be in hospital, not in jail. *Journal of Forensic Psychiatry & Psychology*, 17(2), 326-329.
- Rosenbaum, M., Elizur, A., & Wijssenbeek, H. (1976). Attitudes toward mental illness and role conceptions of psychiatric patients and staff. *Journal of Clinical Psychology*, 32, 167-173.
- Roth, D., Antony, M. M., Kerr, K. L., & Downie, F. (2000). Attitudes toward mental illness in medical students: Does personal and professional experience with mental illness make a difference? *Medical Education*, 34, 234-236
- Sadow, D., & Ryder, M. (2008). Reducing stigmatizing attitudes held by future health professionals: The person is the message. *Psychological Services*, 5(4), 362-372.
- Sadow, D., Ryder, M., & Webster, D. (2002). Is education of health professionals encouraging stigma towards the mentally ill? *Journal of Mental Health*, 11, 657- 665.
- Schaller, M., & Maass, A. (1989). Illusory correlation and social categorization: Toward an integration of motivational and cognitive factors in stereotype formation. *Journal of Personality and Social Psychology*, 56(5), 709-721.
- Schnittker, J. (2000). Gender and reactions to psychological problems: An examination of social tolerance and perceived dangerousness. *Journal of Health and Social Behavior*, 41, 224-240.
- Servais, L. M., & Saunders, S. M. (2007). Clinical psychologists' perceptions of persons with mental illness. *Professional Psychology: Research and Practice*, 38(2), 214- 219.
- Sibitz, I., Unger, A., Woppmann, A., Zidek, T., & Amering, M. (2011). Stigma resistance in patients with schizophrenia. *Schizophrenia Bulletin*, 37, 316-323.
- Smith, J. J. (1969). Psychiatric hospital experience and attitudes toward "mental illness." *Journal of Counseling and Clinical Psychology*, 33(3), 302-306.
- Smith, V., Reddy, J., Foster, K., Asbury, E., & Brooks, J. (2011). Public perceptions, knowledge and stigma towards people with schizophrenia. *Journal Of Public Mental Health*, 10, 45-56.
- Spiegel, D., & Keith-Spiegel, P. (1969). Opinions of mental illness among nursing personnel in a large mental hospital. *Journal of Clinical Psychology*, 25(4), 451- 452.
- Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*, 42(2), 106-117.
- Stuart, H., & Arboleda-Florez, J. (2008). Community attitudes toward people with schizophrenia. *Canadian Journal of Psychiatry*, 46(3), 245-252.

- Tabachnick, B. G., & Fidell, L. S. (1989). *Using multivariate statistics* (2nd ed.). New York: Harper & Row.
- Tanaka, G., Inadomi, H., Kikuchi, Y., & Ohta, Y. (2004). Evaluating stigma against mental disorder and related factor. *Psychiatry and Clinical Neuroscience*, *58*, 558-566.
- Teplin, L. A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist*, *39*, 794-803.
- Thornton, J. A., & Wahl, O. F. (1996). Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology*, *24*, 17-25.
- Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination. *British Journal of Psychiatry*, *190*, 192-193
- Trute, B., & Loewen, A. (1978). Public attitudes toward the mentally ill as a function of prior experience. *Social Psychiatry*, *13*(2), 79-84.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute for Mental Health.
- Vauth, R., Kleim, B., Wirtz, M., Corrigan, P. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. *Psychiatry Research* *150*, 71–80.
- Vernallis, F. P., & St. Pierre, R. G. (1964). Volunteer workers' opinions about mental illness. *Journal of Clinical Psychology*, *20*, 140-143.
- Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, *25*, 467-478.
- Wahl, O. F., & Harman, C. R. (1989). Family views of stigma. *Schizophrenia Bulletin*, *51*(1), 131-139.
- Wahl, O. F., & Lefkowitz, J. Y. (1989). Impact of a television film on attitudes towards mental illness. *American Journal of Community Psychology*, *20*, 343-352.
- Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, *55*(5), 738-748.
- Wicas, E. A., & Carluccio, L. W. (1971). Attitudes of counselors toward three handicapped client groups. *Rehabilitation Counseling Bulletin*, *15*(1), 25-34.
- World Health Organization. (2015). *Mental health: New understanding, new hope*. New York: Author.
- Wu, E., Birnbaum, H., Shi, L., Ball, D., Kessler, R., Moulis, M., & Aggarwal, J. (2005). The economic burden of schizophrenia in the United States in 2002. *Journal Of Clinical Psychiatry*, *66*, 1122-1129.
- Wright, B. A. (1988). Attitudes and the fundamental negative bias: Conditions and corrections. In H. E. Yaker (Ed.), *Attitudes toward persons with disabilities* (pp. 3-21). New York, NY: Springer.

Yogev, H., Sirota, P., Gutman, Y., & Hadar, U. (2004). Latent Inhibition and Overswitching in Schizophrenia. *Schizophrenia Bulletin*, 30, 713-726.

Yuker, H. E. (1988). *The effects of contact on attitudes toward disabled persons: Some empirical generalizations*. In H. E. Yuker (Ed.), *Attitudes toward persons with disabilities* (pp. 262-274). New York, NY: Springer.

Yuker, H. E., Block, J. R., & Campbell, W. J. (1960). *A scale to measure attitudes toward disabled persons*. Albertson, NY: Human Resources Center.

## Appendix-1

عزيزي المشارك هذه الاستبانة جزء من رسالة الماجستير في الصحة النفسية بجامعة القدس ( أبو ديس) والتي تهدف الى قياس اتجاهات العاملين في الصحة النفسية نحو مرضى الفصام في قطاع غزة .

شاكرين لكم حسن تعاونكم

العمر:-----

الجنس:-----

اعلى درجة علمية تم الحصول عليها ؟

١- دبلوم ( )      ٢- بكالوريوس ( )      ٣- ماجستير ( )      ٤- دكتوراه ( )

كم عدد سنوات الخبرة التي قضيتها في مجال الصحة النفسية؟

----- سنوات

الرجاء وضع دائرة حول الوصف الوظيفي الأقرب لك من الآتي:

١- طبيب نفسي      ٢- أخصائي نفسي كينيكي      ٣- أخصائي إرشاد نفسي      ٤- أخصائي خدمة اجتماعية  
٥- ممرض نفسي      ٦- مدير حالة      ٧- أخرى-----

## Appendix-2

### Demographic Questionnaire

Age: \_\_\_\_\_

Gender:            Male            Female

**What is the highest level of education that you have completed?**

A. Diploma            B. Bachelor's Degree            C. Master's Degree            D. Doctoral Degree

**How many years of experience do you have providing direct services to clients?**

----- Years

**Please circle the option that most closely matches your current position/job:**

A. Psychiatrist                            B. Clinical Psychologist            C. Counselor/Psychotherapist

D. Clinical Social Worker            E. Psychiatric Nurse            F. Case Manager

G. Other: \_\_\_\_\_

### Appendix-3

استبانة لقياس اتجاهات العاملين في الصحة النفسية نحو مرضى الفصام في قطاع غزة

يرجى وضع دائرة حول الإجابة الأنسب لديك مما يأتي:

١. الأشخاص المصابون بالفصام يشعرونني بالغضب  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٢. أشعر بأنني غير آمن في وجود الأشخاص المصابين بالفصام  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٣. الأشخاص المصابون بالفصام يرهبونني  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٤. أشعر بدرجة من الغضب من الأشخاص المصابين بالفصام  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٥. أعتقد أن الأشخاص المصابين بالفصام يشكلون خطراً على الآخرين ما لم يكونوا داخل المستشفى  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٦. أشعر بالشفقة على الأشخاص المصابين بالفصام  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٧. برأيي من الممكن السيطرة على مرضى الفصام  

1	2	3	4	5	6	7	8	9
							كثيراً	
								تماماً تحت السيطرة
								لا على الإطلاق تحت السيطرة
٨. أشعر بالانزعاج من شخص مصاب بالفصام  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
٩. الشخص المريض بالفصام خطر على الآخرين  

1	2	3	4	5	6	7	8	9
							كثيراً	
								على الإطلاق
١٠. أشعر بالتهديد من الشخص المصاب بالفصام  

1	2	3	4	5	6	7	8	9

								لا، على الإطلاق	
								١١. أشعر بالخوف من المصابين بالفصام	
9	8	7	6	5	4	3	2		1
	كثيراً							على الإطلاق	
								١٢. أقوم بمساعدة شخص مريض بالفصام إذا طلب مساعدتي	
9	8	7	6	5	4	3	2		1
	بالتأكيد ممكن							مطلقاً غير ممكن	
								١٣. أرغب في مساعدة شخص مصاب بالفصام	
9	8	7	6	5	4	3	2		1
	بالتأكيد متيقن							غير متيقن	
								١٤. أشعر بالتعاطف مع مريض الفصام	
9	8	7	6	5	4	3	2		1
	كثيراً							على الإطلاق	
								١٥. أعتقد أن مريض الفصام في حالته المرضية ممكن أن يكون في محل مسؤولية	
9	8	7	6	5	4	3	2		1
	مسؤول تماماً							غير مسؤول مطلقاً	
								١٦. أشعر بالأسف تجاه الأشخاص المصابين بالفصام	
9	8	7	6	5	4	3	2		1
	كثيراً							على الإطلاق	
								١٧. أحاول تجنب مريض الفصام	
9	8	7	6	5	4	3	2		1
	بالتأكيد لا							بالتأكيد	
								١٨. أشعر بالقلق في وجود الأشخاص المصابين بالفصام	
9	8	7	6	5	4	3	2		1
	كثيراً نعم،							على الإطلاق لا	
								١٩. من المحتمل لو كنت مالكا لعقار ان اؤجر مريض الفصام	
9	8	7	6	5	4	3	2		1
	بالتأكيد لا							بالتأكيد ممكن	
								٢٠. أعتقد أن مريض الفصام يستطيع الزواج والإنجاب والعيش في حياة طبيعية كالآخرين	
9	8	7	6	5	4	3	2		1
	بالتأكيد لا							بالتأكيد ممكن	
								٢١. أشعر بالخجل عند التعامل مع مريض الفصام	
9	8	7	6	5	4	3	2		1
	كثيراً نعم،							على الإطلاق لا	
								٢٢. أعتقد أن مريض الفصام يمكن التعامل معه كإنسان طبيعي	
9	8	7	6	5	4	3	2		1
	بالتأكيد نعم،							على الإطلاق لا	

٢٣. أ شعر بتحسن مريض الفصام من خلال متابعتي له

9 8 7 6 5 4 3 2 1  
بالتأكيد لا بالتأكيد ممكن







## Appendix-5



# المجلس الفلسطيني للبحوث الصحية Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

## Helsinki Committee For Ethical Approval

Date: 03/08/2015

Number: PHRC/HC/58 /15

Name:

الاسم: عمر يوسف سكر

We would like to inform you that the committee had discussed the proposal of your study about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

### Attitudes of Mental Health Professionals Toward Patients with Schizophrenia in Gaza Strip

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/58 /15 in its meeting on 03/08/2015

و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Member

Signature

Member



#### General Conditions:-

٥٨. Valid for 2 years from the date of approval.
٥٩. It is necessary to notify the committee of any change in the approved study protocol.
٦٠. The committee appreciates receiving a copy of your final research when completed.

#### Specific Conditions:-

The subject was approved following the World Medical Association Declaration of Helsinki-Ethical principles for medical research involving human subjects, adopted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008.

E-Mail: pal.phrc@gmail.com

Gaza - Palestine

غزة - فلسطين  
شارع النصر - مفترق العيون

## Appendix-6

The Palestinian National Authority  
Ministry of Health  
Directorate General of Human Resources Development



السلطة الوطنية الفلسطينية  
وزارة الصحة  
الإدارة العامة لتنمية القوى البشرية

التاريخ: 2015/08/17م

الرقم: .....

الأخ / د. فؤاد العيسوي المحترم،،

وكيل الوزارة المساعد

السلام عليكم ورحمة الله وبركاته،،

### الموضوع/ تسهيل مهمة باحث

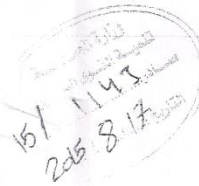
بخصوص الموضوع أعلاه، يرجى تسهيل مهمة الباحث/ عمر يوسف سكر  
الملتحق ببرنامج ماجستير الصحة النفسية - المجتمعية - كلية الصحة العامة - جامعة  
القدس أبو ديس في إجراء بحث بعنوان :-

### “Attitudes of Mental Professionals Toward Patients With Schizophrenia in Gaza Strip“

حيث الباحث بحاجة لتعبئة استبانته من عدد من العاملين في مجال الصحة النفسية والمجتمعية في مستشفى  
الطب النفسي وعيادات الصحة النفسية في قطاع غزة، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات  
البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسؤولية.

وتفضلوا بقبول التحية والتقدير،،

د. ناصر رأفت أبو شعبان  
مدير عام تنمية القوى البشرية



صورة لـ/

- الإدارة العامة للرقابة الداخلية  
- صاحب العلاقة

## Appendix-7

الملخص باللغة العربية:

اتجاهات العاملين في الصحة النفسية نحو مرضى الفصام في قطاع غزة

اعداد الباحث: عمر يوسف سكر

اشراف: البروفيسور محمد وفاني الحلو

تم تصميم هذه الدراسة لقياس مواقف "اتجاهات" العاملين في الصحة النفسية نحو مرضى الفصام في قطاع غزة اشتملت عينة الدراسة على ١٠٤ مشارك من من يعملون في الادارة العامة للصحة النفسية في وزارة الصحة الفلسطينية والست مراكز التابعة لها بواقع ١٣ طبيب نفسي، ١١ اخصائي نفسي كلينيكي، ١٦ اخصائي ارشاد نفسي، ١٦ اخصائي خدمة اجتماعية، ٣٥ ممرض نفسي، ١٣ اخرى (اداريين و صيادلة)، ٥٨ ذكور (٥٥.٨%) و ٤٦ اناث (٤٤.٢). استخدم الباحث مقياس التنسيب العام ٢٣ موزع على ٨ عوامل وهم الخوف، الخطورة، التجنب، الغضب، الشفقة، المسؤولية، المساعدة و التحسن. وتراوحت اعمار المشاركين من ٢١ الى ٦٠ سنة حيث كان متوسط اعمارهم ٣٧.٧١ سنة.

و اظهرت النتائج فروق ذات دلالة احصائية بين الذكور و الاناث حيث اظهرت ان الاناث لديها مواقف سلبية تجاه جميع العوامل باستثناء عوامل الشفقة والمساعدة والمسؤولية كانت ايجابية، و اظهرت النتائج ايضاً ان هناك فروق كبيرة بين المستوى التعليمي للدبلوم و الماجستير و الدكتوراه في عوامل الخوف والتجنب و الغضب حيث كانت درجة الدبلوم اكثر سلبية. بينما كانت درجة الدبلوم ايجابية في عوامل اخرى مثل الشفقة والمساعدة. اظهرت ايضاً اختلاف بين البكالوريوس و الماجستير في عامل الخوف حيث كانت درجة البكالوريوس اكثر سلبية، بينما كانت درجة البكالوريوس اكثر ايجابية بالنسبة لعامل التحسن.

و قد استخدم الباحث اختبار ANOVA ذات اتجاه واحد لفهم الاختلاف في المواقف بين المشاركين في مختلف مساهم الوظيفي، حيث اظهرت النتائج فروق ذات دلالة احصائية بين المشاركين وتبين اختلاف في عوامل الخوف والمسؤولية ، بين الطبيب النفسي و اخصائي الارشاد النفسي حيث كان اخصائي الارشاد النفسي اكثر سلبية في العوامل السابقة، و بينت الدراسة مواقف الطبيب النفسي و اخصائي الارشاد النفسي و اخصائي الخدمة الاجتماعية والاخرون (الصيدلة و الاداريين) ان مريض الفصام على قدر من المسؤولية.

استخدم الباحث معامل الارتباط لبيرسون لتحديد قوة العلاقة بين عمر المشاركين و مواقفهم تجاه المرضى الذين يعانون من الفصام و اظهرت النتائج ان كبار السن لديهم مواقف ايجابية تجاه جميع المواقف باستثناء المسؤولية و التحسن كانت سلبية مع تقدم العمر و هذه النتيجة تدل على ان كبار السن لديهم مواقف ايجابية تجاه مريض الفصام عوضاً عن مواقف الشباب.

واظهرت النتائج ايضاً ان المواقف كانت ايجابية كلما زادت سنوات الخبرة في جميع المواقف باستثناء المسؤولية و التحسن ترتبط سلباً مع سنوات الخبرة، كما تبين النتائج ان هناك انسجاماً مع نتائج البحوث السابقة ودعم موقف زيادة المعرفة والامام والالفة مع المرض النفسي لخلق وجهات نظر اكثر ايجابية.