THE EXTENT OF MENTAL HEALTH PROFESSIONAL STIGMA ON PEOPLE WITH MENTAL HEALTH PROBLEMS IN SAUDI ARABIA

SEHAM ALYOUSEF

Ph.D. Thesis **2016**

THE EXTENT OF MENTAL HEALTH PROFESSIONAL STIGMA ON PEOPLE WITH MENTAL HEALTH PROBLEMS IN SAUDI ARABIA

SEHAM ALYOUSEF

School of Nursing, Midwifery, Social Work and Social Sciences

College of Health and Social Care

University of Salford, Manchester

United Kingdom

Submitted in Partial Fulfilment of the Requirements of the Degree of Doctor of Philosophy, 2016

Table of Contents

List of Tables

List of Figures

List of Appendices

List of Abbreviations

ANOVA	One-way Analysis of Variance
ASSIA	Applies social science index and abstract
BSN	Bachelor of Science in Nursing
BPD	Borderline personality disorder
CFRE	The Commission for Racial Equality
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CQI	Continuous Quality Improvement
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EBSCO	Elton B. Stephens Company
GAMHSS	The General Administration is currently integrating these standards within the Mental Health and Social Services
HCPRDU	Health Care Practice Research and Development Unit
IBSS	International bibliography of social science
KSA	Kingdom of Saudi Arabia
MHA	Mental Health Act
MOH	Ministry of Health
MEDLINE	A bibliographic database of life sciences and biomedical information
NVivo	A qualitative data analysis (QDA) computer software package produced by QSR International
NAZAHAA	The committee for the Centre of King Abdullah in the KSA has committed to fighting corruption
NHS	National Health Service
PD	Personality disorder
PHC	Primary health care
MPBUH	Prophet Muhammad (Peace Be Upon Him)
MSc	Master degree
PsycINFO	A database of abstracts of literature in the field of psychology
S.A.	Saudi Arabia
SNMHS	Saudi National Mental Health Survey
SAMHA	Saudi Arabian Social and Mental Health Atlas
SPSS	A software package used for statistical analysis
UK	United Kingdom
USA	The United State of America
US	United States
UKCC	The United Kingdom Central Council for Nursing and Health Visiting
WHO	World Health Organization

List of Conference Presentations

No.	Title and Contents
1	Guest speaker of 'War impact of mental disorders' in 40th. International Conference - ICMM World Congress on Military Medicine – CIMM.ICMM 2013, Saudi Arabia - Jeddah.
2	Guest speaker of 'Mental health professional stigma in Saudi Arabia' SPARC 2015 - Salford Postgraduate Annual Research Conference.
3	Guest speaker of 'Social stigma in Saudi Arabia toward people with mental health problems' Saudi Students Conference in the UK - Birmingham University 2016.

List of Research School Presentations

No.	Title and Contents
1	Participated presentation at Celebrating PGR Research Day at Salford University, 2014.
2	Participated presentation at Celebrating PGR Research Day at Salford University, 2016.

List of Conference/Symposium Attendances

No.	Title and Contents
1	Attended 'Spirituality SIG Conference 2016 - Interfaith and Interface', Royal College of Psychiatrists, LONDON, UK.
2	Attended 'The Politics of Location Conference 2015', University of Salford.
3	Attended 'Methods Fair Symposium 2015', University of Manchester.

List of Thesis Including Published Works

The ideas, development and writing up of all the papers in the thesis were, principally, my responsibility as the candidate working on the Degree of Doctor of Philosophy under the supervision of Professor Dr Tony Warne, Dr Gillian Rayner.

No.	Publication title	Publication status
1	'Social stigma in Saudi Arabia toward people with mental health problems' in Saudi Students Conference in Birmingham University-UK, 2016.	Published in Conference Journals
2	'Mental health professional stigma in Saudi Arabia' in SPARC 2015 - Salford Postgraduate Annual Research Conference.	Published in Symposium Journals
3	'The Stigma Surrounding Mental Illness and the Role of the Media in Shaping Public Opinion'.	Under review

Dedication

By the grace and mercy of God, the completion of this thesis has been made possible through the motivation and guidance of highly spiritual and intellectual people.

I dedicate my thesis to my caring parents, Mansour and Sana'a, for inspiring me throughout my life. I appreciate all their support and motivations. Their prayers and love lead me to complete this thesis. I appreciate all their efforts, which made me who I am.

Special thanks from the bottom of my heart to my brothers" Josef, Abraham, and Solomon" and to my friends and colleagues in mental health field Dr. Ahmed Alhariri,

Dr. Norah Alyhya, for supporting and inspiration for my studying and my life.

They gave me unconditional love and encouragement. They provided me with strength, courage, and determination to move through my PhD study. My dream came true due to those love and sacrifices, this work dedicated to them.

I also dedicate this thesis to my little princess, my niece: Danah, she is the source of my joy and happiness without their smile, I would not have overcome the challenges and stress of my PhD journey.

Especially, I dedicate this work to the memory of the departed soul of my grandmother "Badriyah", and Aunty "Wafaa". I never forget their prayers and their love, which motivate me forward. Finally, dedication to my Sisters in law "Rania and Amal", their words and feelings keep me working hard to finish this thesis, and thus I wish to express to him my utmost gratitude and love.

Acknowledgement

I would first like to thank Allah (my God) for enabling me to finish my Ph.D. program thesis. I would like to express my special appreciation and thanks to my advisor Professor Dr. Tony Warne, Dr. Gillian Rayner you have been tremendous mentors to me. Moreover, I offer many thanks to Prof. Christopher Birkbeck, for the support he provided the statistical analysis. I would like to thank you for encouraging my research and for allowing me to grow as a research scientist. Your advice regarding both my research and my career has been invaluable. I would also like to thank my committee members from the University of Salford in Manchester, the Saudi Embassy in the UK, and the King Saud University for serving on my committee even during hardships. I also want to thank you all for letting my defence be an enjoyable moment, and for your brilliant comments and suggestions. I would especially like to thank the mental health team professionals in the mental health department at the University "College of Nursing", hospitals, and all the members of the University of Salford who provided me with the environment to apply my thesis. You have all been supportive while I was recruiting participants and collecting data for my Ph.D. thesis. A special thanks go to my family. Words cannot express how grateful I am to my mother, my father, who will inevitably be proud of his daughter, all mercy on his soul, my brothers " Josef, Abraham, and Solomon" and my brothers' wives, and for all the sacrifices my family have made on my behalf. God has also blessed us with a beautiful gift during this Ph.D. journey, my niece Dana, who has been an inspiration to me. Your prayer for me was what sustained me thus far. I would also like to thank all of my friends who supported me in writing and encouraged me to strive towards my goal. Lastly, I would like express appreciation to the UK, which is my favorite place since I started my journey in these four years ago, and I have learned much and enjoyed this British country during my special journey.

Abstract

Research Aim

The primary purpose of this Saudi-based study is to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. It will focus on mental health experts involved in health care in Riyadh, Saudi Arabia.

Methods

A methodological strategy was devised, via the use of a mixed-method approach, which uses quantitative (phase 1) and qualitative (phase 2) data collection approaches and analytical techniques. In Phase 1 (50 participants), two tools were used to assess stigma; the Emotional Reaction on People with mental health problems Scale, and the Attitude Scale. In Phase 2 (5 participants), a one-hour focus group discussion was the method of data collection. The reliability of the two scales for Phase 1 evaluated by measuring internal consistency using SPSS. In Phase 2, Nvivo, version 10 was used for an analysis of the data. The group discussion was thematically analyzed.

Principal Findings

The findings confirm that many mental health care providers hold a professional stigma against those with mental health problems of varying degrees. And how the existence and extent of these views might impact on the services provided by mental health professionals and the recovery of people with mental health problems. Phase 1 findings indicate factors that lead to professional stigma, wherein ‘exclusion’, ‘rejection and caution’ and ‘risk and fear’ lead to high levels of professional stigma against people with mental health problems. Phase 2 findings, fit into four main themes influence the issue of professional stigma in mental health services: ‘experiences of professional stigma’; ‘causes of professional stigma’; ‘impact of professional stigma on mental health services’ and ‘recommended minimizing stigma’. The findings of the present study point to the significant convergent between emotional reactions with negative attitudes exhibited regarding people with mental health problems. It was also found that interactions with individuals with mental health concerns contributed to an increase in incidences of stigma by professional mental health staff. Also, it has been shown that insufficient knowledge and undesirable perceptions of people with mental health problems remain apparent, both in Saudi Arabian society and in the mental health profession.

Conclusion

It is necessary to focus on reducing professional stigma against people with mental health problems. This can be accomplished through appropriate practices, mental health training, education, and research, as well as professional and social awareness through the media in S.A.; publicize ethical guidelines for mental health care professionals; enhance the provision of mental health practitioners in mental health care services; enact legislation by the Ministry of Health in S.A.

Keywords: Stigma, mental health problems, and mental health professional perspective, Saudi Arabia.

CHAPTER 1: THE RESEARCH CONTEXT: SAUDI ARABIA AND THE IMPACT OF STIGMA ON MENTAL HEALTH PROVISION

Overview

Firstly, this chapter will provide an overall review of mental health problems. Secondly, it will partially consider the pervasive views held in relation to stigma regarding mental health problems. It will also offer an overview of the Kingdom of Saudi Arabia (KSA) and how it maintains its global status. Alongside this, an explanation will be offered as to why religion is highly relevant in understanding the structure and function within the country, in conjunction with the Saudi Arabian cultural context, which will be presented to provide insight as to how this might impact on improving the quality of mental health care in the country. This is then followed by a section, which presents a comprehensive overview of the Saudi Arabian health system. The state's mental health care system will be described, as well as the impact of cultural and religious aspects on the issue of mental health. Moreover, further detail will be outlined relating to the mental health care services in Saudi Arabia by illustrating the way in which they have expanded because of advancements.

In addition, an overall review of these services will illustrate the issues regarding the country's mental health research agenda. An explanation will be advanced regarding how stigma functions in the Arabian Gulf countries, as well as in the UK and a global context. This will then be followed by the impact of mental health stigma on people with mental health problems. It will also offer an overview of the professional aspects of stigmatization and the stigmatization in Saudi Arabia that is demonstrated towards people with mental health problems. Thereafter, an introduction to the fundamental problems associated with personal and professional development will be provided on the topic of stigma. Research studies are if identify the level of stigma by examining both the theory and concepts surrounding it and amongst professionals. The chapter will also include an outline of the various types of stigma, their definitions, and an explanation of the different concepts. Furthermore, it will provide an overview of the underlying meanings of the different categories of stigma. Overall, an outline of the value of the study will be presented through the chapter and the challenges associated with conducting this research. This will then be followed by a discussion of the requirement to carry out work on this topic, as well as the research statement. Finally, the study's main aim, specific objectives, and research questions will be proposed. Hence, this chapter formulates the

rationale for this study, as well as its context, so that the reader can be fully aware of this field of research.

Introductions and Problem Identification

Good health is not merely an absence of physical ailments but is a physical, mental and social state of well-being (World Health Organization [WHO], 2001, p. 7). Thus, health as a concept is not simply a physical state but is also a positive set of mental and social resources that contribute to better quality of life (WHO, 2003). Such a definition reframes mental health as "a sense of positive well-being", rather than simply as a state without mental health problems (Rickwood, Deane, & Wilson, 2007, p. 35). As with physical health, mental health and mental health problems are both the result of complex interactions between psychological, social and biological factors (WHO, 2003). Likewise, as with physical illness, mental health problems vary widely in terms of symptoms and severity from person to person (Carulla *et al.,* 2011). Indeed, mental health problems can emerge at any time in an individual's life, and due to the complexity of mental health problems, everyone's experience will be different (WHO, 2003). Moreover, mental health does not stand in opposition to mental health problems; instead, there is a continuum of mental well-being, as every person moves along at different degrees (Keyes *et al.,* 2008). In general, "mental health problems as a term refers to a wide range of psychiatric disorders that affect a person's thoughts, feelings and behaviours" (Grzywacz & Bass, 2003, p. 248).

Due to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) from 2013, neurotic disorders have been replaced with the overarching term "neurosis". Neurosis is defined as a form of mental disorder, which causes distress without interfering with the sufferer's sense of reality, as common neuroses come in the form of depression, anxiety, eating disorders and phobias. Yet, at the other end of the spectrum is psychosis, which in psychiatric terms describes a mental state that disrupts the sufferer's sense of reality.

This relationship with reality is the key difference between neurosis and psychosis. Psychosis can manifest as hallucinations, delusions, disorganised thinking and personality changes, which will often be physically manifested through bizarre behaviours. Often these will significantly impair the sufferer's ability to continue with daily life. However, psychotic reactions can be short lived, and are often related to or triggered by stress. Additionally, the third form of mental illness is personality disorders. This covers many behavioural disorders, which differ from neurosis and psychosis in that they are long term and persistent thought

patterns and behaviours that derive from a disordered view of the world and the self-image. Because of the distorted ways in which sufferers perceive themselves and others, they often struggle with social conventions. Furthermore, the data from the WHO (2003), mental health problems are responsible for almost 50% of disease burden in teenagers and young adults across the world (Patton *et al*., 2009). It was shown that mental health problems were the most common ailment for young individuals, and were the cause of 45% of total global morbidity (Patton *et al.,* 2009). Additionally, people with mental health problems or behavioural disorders affect more than 450 million people, while one in four people living with mental health problems suffers from one or more such disorders during their lifetime (WHO, 2001). As such, mental health is a global issue of extreme importance (Larkings & Brown, 2012).

Around the world, individuals with mental health problems are increasingly experiencing stigma. Fundamentally, this can be created through attitudes demonstrated by mental health professionals and society toward people with mental health problems (Alonso *et al*., 2009; Thornicroft *et al.,* 2009). Specifically, due to Stain *et al.* (2012) research project based in the UK (2012) found that 87% of people experiencing mental health problems were also suffering the effects of stigma. Such problems ranged from major depression, schizophrenia, and bipolar disorder to substance abuse and related ailments. Psychiatric epidemiologic research is limited in Arab countries, although there has been evidence of mental health problems in these regions to the same degree as in any other developed nation (Karam *et al*., 2006). When trying to comprehend these statistics, family structure, social context, socioeconomic status, the role of religion, and other belief systems must be considered (Karam *et al*., 2006). Most Arab nations do not have fundamental and accurate epidemiological psychiatric data, possibly due to the wide range of mental health problems occurring in various cultures and the fact there are a limited number of valid and reliable research instruments translated into Arabic and tested accordingly. Of concern is the prevalence of these attitudes among professional mental health workers, which are also embedded in Saudi Arabian culture and the community in the KSA. Typical stereotypes applied to people with mental health problems by the public is that they are dangerous, unpredictable, hopeless, or that their problems are their own responsibility (Brohan *et al.,* 2013). This discrimination can take tangible form wherein people are not selected for jobs, or are barred from other societal or learning situations, due to Schomerus *et al*. (2011) and Brohan *et al.* (2013). Such negative stereotypes may also have effects in a medical sense, where practitioners are more inclined to consider the diagnosis and not the patient, under-emphasise recovery, or inadequately refer them on to additional experts for treatment (Klin & Lemish, 2008).

The research was undertaken in 14 countries throughout Europe also saw that the people with mental health problems could also apply such discrimination themselves in a form of self-stigma (Brohan, Elgie, Sartorius, Thornicroft, & GAMIAN-Europe Study Group, 2010). In these cases, those with mental health problems start to agree with the stereotypes of the general population, i.e. that they are hopeless, undeserving, dangerous, and that responsibility for their mental health problems lies with them (Brohan *et al*., 2010). Possible side-effects of this self-stigma, according to Corrigan and Rao (2012), can include low self-esteem, humiliation, and lead to them being unable to reach their aims. It can also mean that they believe there is no point in trying to seek help or recovery; the so-called 'why try' effect. Indeed, those experiencing self-stigma may also attempt to conceal or reject their problems by evading professional help to negate the effects of discrimination experienced by those labelled as having mental health problems (Brohan *et al.,* 2013). There is an additional form of stigma that appears in social, professional and organisational policies and practices, which for Wahl and Aroesty (2010) can provide an even greater hurdle for those with mental health problems, as these affect the chances people have for attaining assistance. Furthermore, Schomerus *et al* (2011) found that there is an unequal amount of attention paid to mental health provision, a discrepancy in mental health research funding, and that the previous application of mental health backgrounds in law (e.g. for those seeking custody may put off those with mental health problems from approaching care professionals).

In addition, research undertaken by Wahl and Aroesty (2010) and Corrigan and Rao (2012) found that understanding, culture, and professional and social networks affect the relation of stigma and care opportunities. One instance of this can be seen when stigmas and discrimination are informed more by myths concerning mental health, or its management (Corrigan & Rao, 2012). Due to Corrigan and Rao (2012), cultural factors may also affect what activities are deemed transgressed, and how well those behaving in manners unlike the prevailing norm are treated and understood. A person's social networks, such as family, friends or colleagues also may impact on how likely a person is to seek help, as these groups may either support professional help or reinforce stigmatisation (Corrigan & Rao, 2012). As understanding, culture, professional and social elements all affect a person's choice whether to seek treatment, many governmental approaches have attempted to improve the understanding of mental health to negate the effect of discriminatory stereotypes (Wahl & Aroesty, 2010). In fact, considering such cultural and professional barriers and by incorporating positive care relationships into mental health treatment can positively affect people's decision to seek care, as it lowers the effects of stigma commonly held by mental health professionals in mental

health care institutions to the people with mental health problems (Wahl & Aroesty, 2010; Brohan *et al*., 2013). It is true that stigma has existed throughout history, and is based on social science concepts, which cover a broad range of meanings, and has been described by experts from many different backgrounds (Link, Yang, Phelan, & Collins, 2004). Goffman outlined stigma as "a sign of disgrace or discredit, which sets a person apart from others" (Goffman, 1963, p.248). Nevertheless, the precise definition of stigma has not yet been established, and there is no single agreed meaning (Link *et al*., 2004). Additionally, the global consensus is increasing regarding individuals with mental problems experiencing stigma (Alonso *et al.,* 2009; Thornicroft *et al.,* 2009).

Angermeyer and Matschinger (2005) argue that the German and American public appears to stigmatise mental health problems more now than in the past. Meanwhile, Wahlbeck and Aromaa (2011) observe that the stigmatisation of people with mental health problems is widespread in Finland. Stigma can have a severe impact on people with mental health problems, diminishing their self-esteem (Yang *et al*., 2007), and may lead to the onset of depression or exacerbation of this (Corrigan & Miller, 2004). Additionally, stigma can result in social isolation, a decrease in quality of life by restricting access to work opportunities, housing and other essential needs (Chou, Mak, Chung, Chan, & Ho, 1996). In short, stigma can give rise to a cycle of social deprivation and bestows a chronic nature of the illness (Lee, Lee, Chiu, & Kleinman, 2005). Consequently, excluding people with mental health problems from social life can also lead to the social isolation of their families (Corrigan & Miller, 2004; Kokanovic, Petersen, & Klimidis, 2006).

It is important to recognise that people not only have the symptoms of mental health problems to cope with but also the negative attributions from stigma (Angermeyer & Matschinger, 2003). Due to the negative effects, it can have a person's life, professional and social stigma may further exacerbate mental health problems. This may result in people feeling inferior or unequal (Goffman, 1963; Crocker, 1999), which can make mental health professional's roles in their careers even more challenging (Wahl & Aroesty, 2010). It may restrict access to medical care (Qureshi, Al-Habeeb, & Koenig, 2013). It is important to understand the exists to which mental health professionals are influenced by holding such views when relating to people with mental health problems (Chou *et al.,* 1996). Specifically, the mental health professionals in Saudi Arabia are also members of the public who are also influenced by the pervading culture and may have internalised some of these stigmatising views in regards to those people with mental health problems. In this study, the nature of, and opportunities associated with, phenomenon research on stigma are explored.

It explores the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. The purpose of phenomenon research is to identify, describe and report phenomena as a foundation for later theoretical conceptualization and the development of future research (Barnard, 1968). This study will examine the application of the concept of stigma; will focus on professionals who hold prejudicial or discriminatory attitudes towards people with mental health problems. Overall, stigma is defined as a cultural and professional phenomenon that manifests at both a structural and individual level. Due to the Diagnostic and Statistical Manual of Mental Disorders [*DSM*-5], mentally ill health is a concept used without precision, and this has led to real barriers and stigmas that need to be challenged to redefine the professional approach to mental health problems. The stigma on mental health problems applies to psychotic, neurotic, and personality disorders, regardless of the level and degree of mental health problems.

The phenomena of stigma in this study aim to focus and explore these phenomena from the foundations in the KSA, and whether there is a professional stigma or not. All forms of mental health problems and diagnoses, individuals and ages of people with mental health problems will be identified in this study. Subsequently, through the analysis, the professional stigma experienced by participants in the study will be explored, and how various causes influence the stigma. Particularly, this study will explore whether individuals hold a stigma regarding people with mental health problems or not.

In this study, the focus will be on these phenomena to assess and explore whether there is a professional stigma in Saudi Arabia, which will lead to answering the research questions and objectives. Finally, if evidence is found for the phenomena of a stigma and particularly of a professional stigma present in Saudi Arabia, I will be recommending at the end of the thesis for future research to be more focused on and concerned with stigma for specific psychotic, neurotic or personality disorders.

Pervasive views of stigma in mental health problems

The stigma surrounding mental health problems is described by Martin, Pescosolido, Olafsdottir, and McLeod (2007, p. 50) as "[fundamentally] a social phenomenon rooted in social relationships and shaped by the culture and structure of society", it is considered that mental health stigma is present in both Western (Fabrega, 1991; Angermeyer, Beck, Dietrich, & Holzinger, 2004) and Eastern cultural settings (Chou & Mark, 1998).

A review of attitudes towards people with mental health problems in Western cultures during the period from the 1960s to the 1980s was conducted by Gureje, Lasebikan, Ephraim-Oluwanuga, Olley and Kola (2005), while Fabrega (1991) compared attitudes and stigma of mental health problems in Western and non-Western cultures. Besides, public perceptions towards people with mental health problems in various countries have constituted the focus of a sufficient number of studies (Tsang, Tam, Chan, & Cheung, 2003; Angermeyer *et al.,* 2004; Morgan *et al.,* 2007; Yang *et al.,* 2007). These studies have investigated a range of variables, including, age, sex, a level of education, knowledge of the mental disorder, as well as exposure to mental health problems. These variables provide a framework that can be used to gain an understanding of the cultural variety of mental health professionals and negative attitudes in Saudi Arabia. Moreover, as research participants were selected from different contexts, such as individuals with mental health problems, careers, relatives, migrants and the general public, the studies also addressed cross-cultural differences in the attitudes of professionals such as general practitioners, psychiatrists, psychologists, occupational therapists, nurses, resident doctors and social workers (Lai, Hong, & Chee, 2001).

In all historical periods and many cultures, individuals living with mental health problems have often been perceived negatively by those in the wider society (Fabrega, 1991). The findings of early research revealed that the public made no distinction between milder and more complex manifestations of mental health problems (Angermeyer *et al.,* 2004). Consequently, people living with mental health problems were often indiscriminately labelled as aggressive and troubled, with many people being afraid and suspicious of them (Gureje *et al.,* 2005).

In order, to determine how severe, the stigma attached to people with mental health problems is, researchers have employed three approaches. The first approach involves referring to case history that defined the traits exhibited by people with mental health problems (Alexander & Link, 2003). The second approach entails the use of a social distancing scale to determine the level of avoidance of people living with mental health problems (Lauber, Nordt, Braunschweig, & Rossler, 2006). The third approach is concerned with labelling, in other words, a diagnosis of mental health problems being given by a professional, inferred by contact with a mental health service, or, more rarely, applied by the subjects themselves or by society based on symptom identification (Link *et al.,* 2004).

A review of Saudi Arabia and its status in the world

The official name for Saudi Arabia is the 'Kingdom of Saudi Arabia (KSA).' In the ranking of Arab nations, it is the second largest, coming second only to the North African nation of Algeria. In addition, it is made up of a significant proportion of the Arabian Peninsula regions (Memish, Zumla, Al-Hakeem, Al-Rabeeah, & Stephens, 2013). The separate regions of Saudi Arabia are ruled by a governor (also known as an Ameer- Prince). These regions are presided over as distinct and individual areas, which are referred to as 'governors.' The word 'Ameer' can be dated back to the earliest origins of Islam. It appears many times throughout historical artefacts relating to the history of the religion and the provincial rule of the Arab nations. There are thirteen separate regions in total, and they are as follows: Al-Riyadh, Al-Jouf, Al-Baha, Makkah Al-Mukarramah, Al-Madinah Al-Munawarah, Aseer, Najran, Eastern Region, Hail, Northern Boundaries, Al-Qassim, and Jazan, Tabuk.

The specific regions examined in this study have customs and histories that are. What the regions do have in common, however, is their orientation towards a traditional way of life. Al-Twaijry, Brierley and Gwilliam (2003) highlight how, over the past three centuries, these regions have developed themselves using very limited resources, and therefore, their culture is based thoroughly on antiquity. Saudi Arabia built numerous relationships with countries, such as Egypt, Syria and Iraq, and was not restricted by their distance from civilisation.

Due to Al-Twaijry *et al.* (2003), ancient Arabia was, in fact, a plethora of complex cultures and societies. It must also be considered, however, how cultures can differ within a country - as they do in Saudi Arabia. For example, even though the culture in the United Kingdom differs from the culture in Saudi Arabia, the cultures of Riyadh and Jeddah (two Saudi Arabian cities) are also different too (Al-Zahrani & Kaplowitz, 1993). Cultures are responsible for the way in which people attempt to define or refine conflict, and a difference in culture can lead to a difference in general life. Cultures, thus, are often accountable for conflict within human relationships. Kent and Wahass (1996) explain how cultural differences are more likely to become apparent when they are different to our own, encouraging us to label such behavior as "unusual" or "strange". This concept may partially explain the variation in attitudes held by professionals towards mental health issues across the region, as no two cultures or beliefs are the same.

Population

The population of Saudi Arabia currently stands at approximately 20.5 million native citizens. This figure is not inclusive of the 9 million additional immigrants and foreign nationals. Therefore, in total, the population is thought to be close to 30 million people. As a proportion of 29,018,626, 24% resides in the capital city of Riyadh, which is the biggest city in Saudi Arabia (Alagaili *et al.,* 2014). The country is a very multinational part of the world, as it is home to large populations of Indian, Indonesian and Filipino migrants. The most significant proportion of the migrant population of Saudi Arabia, however, is made up of people from neighbouring Arab nations, such as Egypt, Jordan, Syria, and Lebanon. Indeed, this movement of people has existed for centuries, and there are many examples of shared culture between Saudi Arabia and these regions. The basic figures for these migrant populations are as follows: 90% are Arab migrant, and 10% are Afro-Asian migrants (Anderson*,* 2014). Initially, the emergence of Saudi Arabia as a cultural, social, and political force started in the early 20th century (1901-1930), at a time when more than half of the population was made up of migratory Bedouin or nomad groups (Ramayah, May, & Omar, 2008). Nonetheless, Saudi Arabia would not develop into a fully-fledged international partner until the 1930s. During this period, vast amounts of oil were uncovered within the borders of the country.

The discovery launched an unprecedented phase of socio-economic evolution and wealth. It also resulted in the migratory Bedouin and nomad populations being persuaded to settle in new industrial towns and settlements. These new towns, villages, and hamlets experienced a remarkable level of expansion, as more and more of the population sought work there. The movements of labourers from the internal rural regions to the settlements were significant. Eventually, migrants from the neighbouring African, Arab, and Asian nations also began to seek employment in Saudi Arabia.

To summarise, social and industrial developments have been the driving forces behind the rapid transformation of Saudi Arabia. The country was among the least urbanised on the planet in the fifties, but it is now among the most economically developed. In 1992, the overall proportion of the Saudi Arabian population residing in industrial settlements stood at 77% (Al-Ahmadi, See, Heppenstall, & Hogg, 2009). Over the years, the industrial development of Saudi Arabia has not been the only form of evolution. As the number of specialist professions has increased, so too has the quality of health care. In addition, the service industry has improved significantly, as has the concern for individual happiness and wellbeing.

The state has provided consistent support for educational resources and the enhancement of vocational and higher education provisions. Thus, Saudi Arabia now offers completely free education and medical care at all levels across the region, although it is in no part funded by taxation on citizens (Albejaidi, 2010).

The religious and cultural background in Saudi Arabia

As one of the most prevalent religions in the world, Islam has always been at the forefront of social and cultural developments in Saudi Arabia. The region can claim host to its birth and continued evolution, with the area known as the 'Land of the Two Holy Mosques' believed to be its place of origin. The Masjid - el Nabwi Mosque, in Medina, and the Masjid-al-Haram mosque, in Makah, are the two holiest structures within the Islamic religion. Therefore, around two million devout Muslims travel to the KSA every year for the religious pilgrimages of Umrah and more than five million Muslims travel to the KSA for Haj every year. These sites represent two of the five pillars of Islam (Bowen, 2014). The work of Littlewood and Yousuf (2000) states that the Islamic Kingdom of Saudi Arabia is primarily made up of Muslims living in the towns and cities. However, a small proportion is still thought to consist of migratory groups. In fact, the makeup of the Islamic population has changed significantly over the last four decades, especially in line with economic developments. From 1970 to 1991, the distribution of rural to urban settlements moved from 49% to 78%. Likewise, it is important to note that the socioeconomic characteristics of Saudi Arabia have been similarly influenced by the distribution and evolution of Islamic beliefs. Nowadays, Saudi culture is clearly influenced by the teachings of the Muslim faith.

The legal system (sharia law) is founded upon doctrines from the Qur'an and a series of prophetic standards originally offered by the Prophet Muhammad (Peace Be Upon Him) (MPBUH) (Abdul Salam, 2013). A range of additional factors (i.e. health, education, culture, media, the spread of wealth, etc.) has also greatly influenced the distinct characteristics of Saudi Arabia (Al-Shahri, 2002). One of the most important Islamic teachings (and one which informs much of the social and cultural makeup of Saudi Arabia) is the belief that illness is a result of sin. The Islamic faith considers sickness to be both a punishment and a method of atonement for immorality (Al-Shahri, 2002). This means that it is not uncommon for medical help to be refused, as it conflicts with the judgment of Allah. In Muslim communities, people are encouraged to perceive illness as a deserved state. This does not mean that the Islamic faith has no interest in self-care.

However, as healthy eating, frequent exercise, abstinence from alcohol and tobacco, the breastfeeding of infants, and the maintenance of strict personal hygiene are all encouraged (Rassool, 2000). Overall, the lessons and teachings of Islam provide a constant foundation and background for these practices. Meanwhile, in some of the more rural regions of Saudi Arabia, more ancient forms of medicine are practised; for example, cauterising, herbal remedies, and cupping (Al-Shahri, 2002).

The health care service in Saudi Arabia

The work of Al-Yousuf, Akerele and Al-Mazrou (2002) investigated the Saudi health care sector. It focused on the importance of examining all areas of the sector, with the goal of improving the provision of medical resources and health-based education. Health care systems differ not only across different nations but also within them too. In Saudi Arabia, it is essential that the state can cater for and adapts to fit a range of different objectives and populations. It is becoming increasingly clear that the health of the Saudi population has been notably influenced by the accelerated socio-economic changes of the last thirty years. What is more, the morbidity and mortality figures have started to appear much more optimistic and demonstrate a definite improvement in the general quality of life (Al-Yousuf *et al*., 2002). In 2014, the government in Saudi Arabia unveiled details in relation to its national spending. The plans stated that medical care and education would continue to be the top priorities for the country. They accounted for around 37% of the overall spending budget. Thus, the government established (using this money) thirty-four new hospitals and medical care buildings. It also invested in the long-term development of an additional 132 hospitals and five ‘medical cities’; these medical cities are currently being built (Memish *et al*., 2013).

Mental health care provisions in Saudi Arabia

Due to Pinto, Hickman, Logsdon and Burant (2012), there have been vast improvements in the awareness and treatment of mental health conditions in Saudi Arabia, over the last two decades. This development has been primarily concentrated over the past twenty years. At present, the mental health care system is making significant progress when it comes to providing for the needs of citizens. This is not to say that the work is over because there is still a lot of development, which needs to happen if medical care is to be provided to the whole country (inclusive of expatriates).

There is still a need for sophisticated medical training resources in Saudi healthcare structures and centres of learning, especially in the form of psychiatry provisions and research that are designed to modernise and streamline the wider health care sector (Pinto *et al.,* 2012). Now, there are plans to homogenise, universalise, streamline, and extend mental health care provisions right across the nation. They consider everything from infant and teenage services to medical care for senior patients, addiction counselling, regular consultations, and even forensic psychiatry. Within Saudi Arabia, there are some remarkable opportunities for methodical investigation into the diagnosis, assessment, treatment, and care of mental and emotional conditions. Yet, as psychological disciplines progress and develop rapidly in that part of the world, it becomes harder to disregard the towering impact of culture, relationships, and faith on the awareness, identification, treatment, and care of mental health problems in Saudi Arabia today (Littlewood & Yousef, 2000; Pinto *et al.,* 2012).

Over the last six years, the General Administration of Mental Health and Social Services department of the Ministry of Health has attempted to enhance the provision of mental health care service to the citizens of Saudi Arabia (Qureshi *et al*., 2013). As part of this objective, many of significant health care achievements have been fulfilled. For example, the delivery of inpatient mental health care reinforced and assisted by an improved and government endorsed the Mental Health Act. Unfortunately, mental health care provisions at the local level are not quite as advanced and still have some way to go before they can meet the quality of resources in other developed economies. Furthermore, a large and expertly trained mental health workforce are still necessary (across all aspects of the health care system), to fulfil the demands of an increasingly complex Saudi population (Pinto *et al*., 2012).

Religion and Culture as factors in mental health issues in Saudi Arabia

Considering the significance and influence of social and religious factors on the native Saudi population and the enormous number of migrants and expatriates (almost a third of the population) in the country (Abdul Salam, 2013), mental health should be considered following its diverse cultural makeup. In other words, medical care must be provided in a way, which treats a range of different religious beliefs with the same level of respect. The population of Saudi Arabia is extremely varied and diverse, with citizens from all over the globe currently residing and working there. The three primary social influences, however, are the Islamic religion, Islamic culture and heritage, and the Bedouin culture. For 5,000 years, Arab traders

have formed merchant routes and channels, which stretch all the way across two regions around the Mediterranean Sea, the Persian Gulf, South Asia, and Africa.

For a lot of Arab citizens, the ancient Bedouin customs of desert cultivation, basic fishing, artisanship, migratory tracing, and creative culture continue to be imperative and significant. For some, regional and kin-based groups and identities are also still revered. Ever since the 7th century, the significance of the Islamic faith has contributed to almost every part of work, family, leisure, community, and society. In Saudi Arabia, Sharia law governs the population; a legal system based on teachings from the Qur'an. Moreover, for Muslims, Ramadan is the holiest period of the year. During this time, there can be no consumption of food or drink, no smoking, and no sexual actions from sunrise (Sahoor) to sunset (Iftar) – Ramadan lasts for one month. The Hajj pilgrimage to Mecca also occurs once a year, during the Zu-lHajja Arabic period, when millions of Muslims across the globe join in observing religious rites and customs. For Muslims, prayer is something which happens every single day at sunrise, midday, mid-afternoon, sunset, and just after sunset. During these times, all activities must be put on hold and all businesses temporarily closed.

The prayers are accompanied by a call for prayer from every place of worship – all Muslims are expected to stop, pray, and listen to the call. For men, it is necessary to attend the mosque every Friday to pray and observe the teachings of the Imam (also known as khutba). In Saudi Arabia, regular prayer and observation of the Holy Qur'an is an essential part of maintaining mental health and caring for mental conditions. Hence, it is not unusual that so many Saudis would also come to believe that the Qur'an is the best cure for physical ailments too. Crucially, and in comparison, to ancient Arabic wisdom, the modern Islamic faith does not consider all mental health problems as being a consequence of supernatural forces. In fact, at least one eminent Muslim academic, Ibn Sina, challenged the idea that malevolent spirits were to blame for mental health problems (Al-Krenawi & Graham, 2000). Indeed, at present, Islamic law works to safeguard people with mental conditions. While the responsibility is thought to belong to the family, if they are unable to provide protection, an award may be elected to hold and protect the possessions of persons with mental health problems. If an individual suffers from serious and recurring or permanent psychotic illness, they are not expected to carry out the five daily prayers or observe the customs of Ramadan (Dols, 2007). It is interesting to note that the 'not guilty due to insanity' plea existed in Islamic communities long before any western nation decided to incorporate it as a legal judgment. If you are 'insane,' you are not held responsible for your actions, even if they are in breach of the law (Wahass & Kent, 1997).

Furthermore, the Islamic faith and sharia law also include a few important social rules. For example, females must conceal the whole of their face and body with a unique covering (called an Abaya) while outside the home. This is an obligatory offering of modesty and humility. Also, females are not permitted to drive, talk with males outside the home (excepting husbands, brothers, and another male family member), or get involved with more social interactions than are needed to maintain a functional life. In fact, only females who are married or taking part in a formal education course can visibly socialise. Within academic institutions, females and males are entirely segregated during seminars, workshops, conferences, lectures, and meetings. If a respectful family chaperone (mother, father, husband, brother) is present, a female can speak with a male psychologist, counsellor, mental health worker, or another doctor. However, all forms of physical touching are forbidden, including a handshake. The diagnosis and treatment of mental health problems are, unsurprisingly, very much influenced by these rigid social rules and customs. Therefore, it is essential that mental health care professionals take them into consideration when attempting to treat patients (Ratner & El-Badwi, 2011).

The development of mental health care services in Saudi Arabia

The number of mental health centres in Saudi Arabia has doubled almost ten times during the last three decades. At present, the country is home to 21 dedicated psychiatric hospitals. This number includes three special buildings called Al-Amal hospitals, which are situated in Jeddah, Dammam, and Riyadh and are designed to treat patients with addictions and mental health problems. A fourth Al-Amal building was recently completed with a fifty-bed capacity at Al-Qassim Psychiatric Rehabilitation Centre in Buraidah. After 2012, the number of dedicated psychiatric departments for children and teenagers also increased considerably. Over the last five to ten years, the amount of psychiatric ‘beds’ in psychiatric centres across Saudi Arabia has remained stable, with a count of around 3,000 (12 per 100,000 citizens) (Qureshii *et al.,* 2013).

Since deinstitutionalization has not yet happened in Saudi Arabia, the current amount of psychiatric beds is still significantly smaller than it should be for a country of this size. Many mental health professionals have continued to rise sharply. In 1983, there were, remarkably, just three psychiatrists for the whole population (Al-Krenawin & Graham, 2000). In 1997, however, the figure had doubled around ten times. By 2006, there were 205 mental health professionals for a population of 23 million (0.9 per 100,000 citizens) (Qureshi *et al*., 2013).

Then, in 2010, there were more than 700 psychiatrists (3.0 per 100,000 citizens), including eight dedicated to outpatient services and 263 employed by specialist mental health centres (Qureshi *et al*., 2013). Some mental health professionals, social workers, and general nurses employed in the mental health sector has steadily risen too. The statistics presented by the Saudi National Mental Health Survey (SNMHS) Koenig *et al.* (2014) state that there are currently around 1980 nurses employed in outpatient facilities and 1176 in dedicated mental health centres (Qureshi *et al*., 2013). There are also 515 psychologists, social workers, and occupational therapists employed at outpatient facilities and 611 in dedicated mental health centres. Crucially, most nurses who work with people with mental health problems do not begin their training with specialist psychiatry qualifications. Additionally, much of psychologists and social workers do not hold post-graduate degrees (Qureshi *et al*., 2013). Besides, a few undergraduate and post-graduate training courses in psychology and counselling are now taken at learning institutions across Saudi Arabia. These courses are available at the following locations; the University of Tabuk, King Khaled University in Abha, King Saud University in Riyadh, the University of Dammam in the Eastern Province, the and Princess Noura Bent Abdurrahman University in Riyadh. Also, a total of thirteen (out of 21) Saudi Arabian medical schools now provide post-graduate training for combined health disciplines like nursing, psychology, social work, and counselling. While mental care provisions continue to improve, a significant proportion of the carefully designed for individuals with mental health problems is still handled by family members.

In Saudi Arabia, a family is a sacred unit, and the process of protecting that unit is a religious duty. The children in a family are not permitted to leave the parental home until they are married and older relatives are usually cared for within the same environment too. It is unusual for elderly family members to be sent to nursing homes or external care facilities. Thus, family units in Saudi Arabia are very large, with many different people residing together. This can mean that mental health care becomes limited; with so many people to provide for, families often decide to keep health issues under wraps for fear of the social stigma or being perceived as unable to care for the family unit.

Within Arabic communities, people with mental conditions are frequently stigmatised, mocked, derided, and disregarded. This is because, for a very long time, mental health problems were linked with evil forces, the evil eye, malevolent magic, violence, addiction, suicide, and sin (Pridmore & Pasha, 2004). The guilt and potential embarrassment of having mentally ill family members often cause people to ignore the issues and refuse to address them all together, especially with expatriates (Farooqi, 2006). In addition, the Muslim faith bestows special

favours for people who can take care of ill relatives, whether they are suffering from physical or mental ailments (Qureshii *et al.,* 2013). The Islamic teachings of the Qur'an and the Hadiths believe that Muslims have a responsibility to protect the sick. Consequently, family units in Saudi Arabia go to great lengths to independently care for their relatives. Nonetheless, these beliefs may be dissolving gradually.

Improvements in mental health care services in Saudi Arabia

In 1978, Saudi Arabia created to establish primary health care (PHC) centres across the nation, in a bid to enhance the identification and treatment of medical issues within tight-knit communities (AI-Osimy, 1994). The objective was to encourage Saudi citizens to seek medical care in these centres, as many people did not at the time. To increase the quality of diagnosis and treatment methods for mental health problems, in 2000, the WHO advised affiliated nations to rebrand primary health care centres as the earliest point of contact for individuals with mental health problems (Pridmore & Pasha, 2004). In circumstances where primary health care professionals were underqualified to deal with certain cases, the advice was to defer to the expertise of psychiatrists in general hospitals (secondary tier). If these psychiatrists were also unable to handle the cases, the patients would be moved to dedicated psychiatric centres or teaching (university) hospitals (third tier) (Farooqi, 2006). As most people tend to consult their local doctor first, whether they have physical or mental health problems and because a great many physical and mental health problems are closely related, the WHO considered this structure to be the most valuable approach to diagnosis and treatment (Pridmore & Pasha, 2004).

For Saudi Arabia, adhering to these WHO guidelines has been a big success, and the new health care structure continues to work efficiently and effectively (Qureshi *et al*., 2013). It is a reasonably productive approach, which has the power to care for a growing population, with ever more complex mental health requirements. It is also possible for people with mental health issues in Saudi Arabia seek mental health care assistance more directly at specialist mental health care centres and hospitals. Plus, there are also some individuals who look for support with the help of the emergency services, regular hospitals, or mental health care centres without a previous referral. Lastly, there is a private mental health care sector in the country, which treats patients in return for a charge. This is different to the public provisions, which are all free to use and funded by the state (Qureshi *et al*., 2013).

As well as independent private mental health care clinics, there are an additional 125 private general hospitals – most of these buildings are directly connected to, or geographically close to, mental health care clinics (Mobaraki & Soderfeldt, 2010; Okasha, Karam, & Okasha, 2012). Regarding social stigma surrounding mental health problems and this direct access to private care, wealthy families often choose to work with private health care centres and fund the treatment by themselves (Almazeedi & Alsuwaidan, 2014). These private clinics provide psychotherapy, psychotropic medications, and different forms of addiction counselling, speech therapy, and rehabilitation services for adults, teenagers, and infants. Shortly after Saudi Arabia embraced the WHO endorsed the structure of primary, secondary, and tertiary tier care, many of its academics started to investigate the referral data and attributes of individuals sent to specialist mental health care hospitals. One of these investigations discovered that around three-quarters of referrals forwarded to the Buraidah Mental Health Hospital could be traced back to a primary health care centre and the rest were associated with public hospitals (Qureshi, Al-Habeeb, Al-Ghamdy, Magzoub, & Schmidt, 2001). The referrals from public hospitals (as opposed to PHC centres) were always more likely to relate to psychotic illnesses (20% and 10%, respectively), mood dysfunctions (28% and 23%, respectively), and psychosomatic conditions (7% and 2%, respectively). On the other hand, the referrals from primary health care centres (as opposed to public hospitals) have been always more likely to describe somatic symptoms (35% and 23%, respectively) and neurological symptoms (8% and 4%, respectively) (Qureshi *et al*., 2013). Nonetheless, mental health provisions in Saudi Arabia have consistently improved and increased in scope over the decades.

In 2006, the nation created a fully established mental health act and a range of specially designed resources for people with addictions, rehabilitation requirements, and sophisticated infant and adolescent problems. For the first time, a high level of mental health care could be sought at public hospitals and clinics. Perhaps the most significant development came in the form of the 2007 Saudi Arabian Social and Mental Health Atlas (SAMHA). This scheme aims to systematically define, describe, and recommend solutions for the diverse mental health requirements of the Saudi population (Qureshi *et al.,* 2013). Therefore, to guarantee that its objectives were fulfilled, the decision was made to carry out a comprehensive four-year 'follow up' investigation (Albejaidi, 2010); this investigation has now been conducted. One of the most prominent aims of SAMHA has been to construct a suitable schedule for the development of mental health care provisions designed to boost the number of mental health care professionals, enhance the integrity of medical resources, extend provisions for people with addictions, create

more training and awareness, carry out research which informs new medical interventions, and launch new quality measures.

The SAMHA scheme hopes to expand the scope and range of services on offer for people who present with mental health issues and increase the quality of mental health infrastructures across the whole of Saudi Arabia. In fact, a primary objective has been to boost the number of psychiatric beds for the population, so that the figures reflect the global average of 16 beds per 100,000 citizens. Despite this, the figure stayed constant at 12 beds per 100,000 citizens for five years (from 2005-2010). Additionally, one of the more long-term objectives was the creation of a procedural guidebook for all mental health hospitals in the country. This guidebook was completed in 2012 and it offers insights into a broad selection of treatments, reporting methods, and integrity of care measures (Qureshi *et al.,* 2013).

Moreover, the Mental Health Act (MHA) created by the Saudi Arabian government, in 2012, has since afforded the support and endorsement of the legal system to many of these developments. At present, all mental health hospitals in the country are run in accordance with the 2012 MHA standards and guidelines. The General Administration is currently integrating these standards within the Mental Health and Social Services (GAMHSS) at the Ministry of Health (MOH) in Riyadh. Whilst the size of the MOH budget has grown every year; there continues to be no independent source of funding for GAMHSS. Nonetheless, developments are currently underway in this area too – there are now distinct and separate sources of funding for two of the biggest mental health sectors: Developmental and Behavioural Disorders in Children and the Saudi Society for the Care of Psychiatric Patients and Families. However, significant enhancements still need to be made within the Saudi health care sector, especially in the form of regulation and mental health care ethics and standards. It is also important for the government to continue its support of educational resources that relate to the eradication of professional and social stigmas and the maintenance of personal health and wellbeing.

Developments in mental health research in Saudi Arabia

The health care system in Saudi Arabia needs more in-depth research, particularly if individuals with mental health problems are to be diagnosed and treated as efficiently as possible (Zaini *et al*., 2011; Qureshi *et al.,* 2013). It is essential that health care professionals understand the complex demographic, cultural, social, and behavioural variables, which can raise or lower the chance of people with mental health problems.

They must also be willing to make compromises, whilst always trying to prescribe treatments, which suit the unique religious, and lifestyle based needs of Saudi Arabian citizens (Qureshi *et al*., 2013). These treatments may incorporate forms of psychotherapy, psychotropic medications, different kinds of biological therapy, and even very new or alternative remedies. Likewise, a great deal more research is also required when it comes to the skills of mental health professionals. Hence, the number of psychiatrists, psychologists, social workers, nurses, and counsellors should be continuously monitored, as should the level and quality of training which they are given. Subsequently, this form of research is vital in directing the development and funding of training courses that are designed to allow health care workers to cater for the complex needs of an expanding population. The good news stems from the fact that mental health research in Saudi Arabia has been afforded more focus over the last thirty years. Whilst it was barely present in any form before 1975, several extremely important health care investigations have been conducted during the past decade. For example, a review of mental health studies published between 1987-2002 (and focusing on the Arab world) discovered that, of five key nations (Egypt, Saudi Arabia, Kuwait, Lebanon, and the United Arab Emirates), many studies released in Saudi Arabia were the second highest of that group (Qureshi *et al*., 2013). In fact, it was beaten only by Kuwait (Afifi, 2005). In recent years, academics have also discovered that several mental health studies published each year, in Saudi Arabia, rose from a mere zero to just one, between 1966 and 1985. Yet, in the years between 1996 and 2006, the number had risen to eighteen. This figure meant that it ranked only second to Egypt, among the other 21 Arab nations (Jaalouk, Okasha, Salamoun, & Karam, 2012). For Saudi academics and researchers, the subject of treatment resistant depression has been a prominent area of investigation (Qureshi *et al*., 2013; Zaini *et al.,* 2011). It is still the case, though, that Saudi Arabia struggles to compete with Western nations, particularly when it comes to the psychological and behavioural sciences.

Many of studies published in the USA and Great Britain, over the course of just a decade (1992-2001) numbered just under 60,000. If you contrast this with the 299 studies published in Saudi Arabia, over the course of a four-decade timeframe (1966-2006), it is clearly exhibited how far behind the nation still is in comparison to Western superpowers (Qureshi *et al*., 2013). Therefore, whilst a great deal of development has taken place, there is still a huge amount of work, which needs to be carried out within the Saudi Arabian mental health sector. Nevertheless, there are many reasons to look at the Saudi health care system with great hope. In 2009, a national competency model was created for Saudi medical schools, which reinforced the value of reliable research and dedicated a whole chapter to relationships between doctors

and comprehensive scientific investigations (Zaini *et al*., 2011). The model made it clear that comprehensive research conducted by medical institutions will continue to be a big part of progression within the Saudi health care system. The initiative has been seized by several of these institutions. For instance, the King Abdulaziz City for Science and Technology has established a venture, which focuses on the quality of health care research in Saudi Arabia. It has requested that the King Faisal Specialist Hospital and Research Centre in Riyadh begin to form research objectives, which consider a more national perspective (a national board) (Qureshi *et al*., 2013; Koenig *et al.,* 2014).

The objective of the board is to assess and set suitable research targets and goals for the whole nation. It has highlighted the following key subjects for further research; genetics, non-communicable diseases, cell therapy, communicable diseases, disability, and environmental health. The significance of mental health research is made clear for two of these subjects: neurodegenerative disease and disability (Qureshi *et al.,* 2013; Koenig *et al.,* 2014). In recent years, research isn't carried out into the influence and development of mental health stigmas within Saudi Arabia. Yet, such research is of fundamental importance, as it influences which types of treatments are offered and how they are administered to patients. It is necessary to understand the reasons why a person may refuse professional help to determine how best to provide it. Moreover, it is important to understand how the existence of professional stigma plays a role in the quality of mental health care provided to people with mental health problems.

Stigma aspect in the Arabian Gulf

As the views and opinions of health professionals can affect the information and services, they offer to patients and the public, outlining these views regarding mental health is necessary. What is more, anti-stigma campaigns are often initiated and managed by the professionals themselves who hold-stigmatising views toward people with mental health problems, which can increase the performance and efficiency of health services. The WHO (2001) embarked on an international campaign to reduce the stigma surrounding mental health problems, to promote social inclusion and end discrimination. Qureshi *et al*. (2013) and Ciftci, Jones and Corrigan (2013) warned that in Qatar, a lack of awareness on the part of health professionals regarding their stigma could have an adverse impact on the efficiency of the anti-stigma campaigns. As previously mentioned, research has only recently begun to address the issue of the stigma of mental health professionals (Schulze & Angermeyer, 2003; Lauber & Rossle, 2007).

Mental health problems have become a common occurrence throughout the world, consuming a substantial part of many healthcare budgets, and thus, putting a strain on economies (Haque, 2005; Almazeedi & Alsuwaidan, 2014). Despite this, the fear of social stigmatisation means that many individuals living with mental health problems are not receiving the proper treatment they need (Coverdale, Nairn, & Claasen, 2002). In some cultures, a diagnosis of mental health problems has broad negative implications. One such culture is that of Kuwait, where many individuals choose not to seek help at the Psychological Medicine Hospital (the national institute for mental health), due to the stigma attached to their mental health problems (Thornicroft, Rose, & Kassam, 2007).

Instead, individuals with mental problems, seek help at local primary care clinics, which are more socially accepted. However, primary care doctors do not have the necessary expertise, and therefore, often cannot offer appropriate psychiatric treatment. What is more, whilst they can make referrals to mental health institutions, many patients refuse to go there (Almazeedi & Alsuwaidan, 2014). Attitudinal surveys have found that people living with mental health problems would prefer not to go to a psychiatrist, but would rather go to other health care specialists for their treatment and care, to avoid the stigmatising attitudes that are presented through the interaction with mental health professionals (Corbiere, Samson, Villotti, & Pelletier, 2012). A possible solution to this problem is to incorporate mental health care into general health services, as has been proposed by the WHO (2001).

Stigma aspect in the UK and a global context

Due to Ciftci, Jones and Corrigan (2013), the stigma often shown toward people with mental health problems is a global phenomenon and is not confined to one single country. Alonso *et al*. (2009) write that there appear to be lots of difference in how different countries perceive mental health problems and that less developed countries seem to stigmatise more generally. Also, Corrigan and Watson (2002) recognised that the actual experiences of those people with mental health problems experiencing professional stigma must be considered. Stigma and prejudice remain the primary sources of human rights abuse that is so frequently encountered in some outmoded psychiatric institutions and social care homes (Mansell, 2005). Such abuse takes various forms; even outside psychiatric institutions, as community-based care, which is implemented in many Western European countries, can lead to individuals with mental health problems, feeling excluded from society (Schomerus & Angermeyer, 2008).

Public policy-makers may also be reluctant to allocate funding to mental health due to the same stigma, as the provision of mental health care does not figure prominently in the process of allocation of health system budgets (Schomerus, Matschinger, & Angermeyer, 2006). Indeed, external perceptions are also affected by the personal status of the individual living with mental health problems, for example; stigma tends to increase the lower socioeconomic position of individuals with mental health problems (Read & Law, 1999). As noted previously, research by Stain *et al.* (2012) in Australia, on stigma and discrimination, found that 87% of people with mental health problems had experienced stigma and discrimination, while 71% had been put off doing certain actions because of stigma, and even more 73% stated that the fear of stigma and discrimination deterred them from certain actions. Furthermore, people with mental health problems note that stigma and discrimination have repercussions in every area of their lives, such as work, socialising, learning, taking a role in their community, or even just mentioning their mental health problems to others. 53% of those caring for people with mental health problems state that they also feel put off from certain activities due to stigma and discrimination, while 43% stated that they feel deterred by the fear of these factors (Stain *et al.,* 2012).

Stigma, and the anxiety of stigma may prevent people taking steps towards treatment for mental health problems (Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007). Furthermore, the findings of research in the UK were that two-thirds of people with mental health problems reside on their own, which is quadruple that of the general population (Collier & McQuarrie, 2014). They also found that, per the Oslo Social Support Scale, over half of those with mental health problems are deprived of social contact in contrast with only 6% of the general populace, as people with mental health problems tend to meet their friends less than those without these problems [averaging one to three social encounters with friends per week, contrasting with four to six for the common population] (Collier & McQuarrie, 2014). In addition, according to Psarra *et al*. (2008) research conducted in Greece has shown that many of the police officers thought that those people living with mental health problems were more dangerous than those of sound mental state. Additionally, Psarra suggests almost half of the police officers thought that people with mental health problems should be on constant medication and two-thirds thought permanent hospitalisation was suitable.

Furthermore, it was widely believed that mental health problems made individuals incapable of work, as well as incapable of getting married and raising a family (Psarra *et al*., 2008). The highest proportion of people with mental health problems being processed by the criminal justice system is attributable to a multiplicity of factors. Significant influences

contributing to this imbalance are indigent; sub-standard residential accommodation; the psychological and emotional effects of mental health problems; the latter possibly impacting on individuals' behavioural patterns, thereby, triggering the unleashing of criminal justice processes. "Criminalisation" is the word that has been coined to explain the existence of a disproportionate number of mental health patients passing through the criminal justice system (Padela *et al.,* 2012). More widely, the stigmatisation of people with mental health problems with the criminal justice system is largely the consequence of the limited availability of suitable medical therapies and social networking resources for mental health problems (Hartford, Carey, & Mendonca, 2007). In addition, people with mental health problems can sometimes have negative dealings with law enforcement agencies, which can push them deeper into a life of crime and the judicial system.

However, incarceration can cause significant exacerbation of a person with mental health conditions and cause their well-being to deteriorate (Strauss *et al.,* 2005). This can intensify their sense of detachment from society and hinder their return to their community (Padela *et al.,* 2012). The professionally held stigma towards people with mental health problems can prevent them from receiving adequate care and treatment while they are incarcerated, whilst prisons may lack the appropriate resources to facilitate care for people with mental health problems (Strauss *et al.*, 2005).

The stigma and prejudice that people with mental health problems are exposed to in prison may be greater than any such treatment they had previously experienced. Hence, when dealing with people with mental health problems who are caught up in the criminal justice system, mental health professionals should ensure they are provided with the entire medical and social services they require (Strauss *et al.,* 2005; Padela *et al*., 2012). On the other hand, there are, generally increased incidences of mental health problems among the Irish sector of the UK population, with a level of incidence that exceeds that of other migrant communities (Karlsen, Nazroo, McKenzie, Bhui, & Weich, 2005). The Commission for Racial Equality (CFRE) also notes a high incidence of suicide that is especially concentrated among male Irish travellers (Law, 2012). In common with other minorities, mental health problems may be cause actively linked to discrimination, unemployment, poor housing and homelessness (Hogg & Holland, 2010). Another determinant may be Jorm's (2000) observation that Irish people tend to experience difficulties in securing primary care treatment. The reasons given for these difficulties are particularly problematic and due to the pejorative stereotyping of Irish people as being alcohol-dependent, culturally misunderstood and linguistically misunderstood.

From the research by Hogg and Holland (2010), the National Institute for Mental Health in England considered the matter of discrimination within mental health services and its elimination, with the aim of concentrating health organisations efforts towards providing services that are characterised by cultural and ethnic flexibility and non-discriminatory practice. The research findings, presented in a final report, identified a need for a mental health workforce that can provide services to a diverse populace, and one that is capable of expansion both within the public sector and voluntary organisations to enable the effective treatment and care of people with mental health problems (Hogg & Holland, 2010). Mental health problems are generally prevalent in societies and cultures of all kinds and all locations. Mental dislocation, emotional disturbance, feelings of anger or unhappiness may all be conceptualised as mental health problems, and are commonly felt by all people from time to time (Hogg & Holland, 2010).

The term culture, "race and ethnicity are frequently used interchangeably by the public and by mental health care professionals alike, so that some clarity may be achieved in terms of culture", which is the definition offered by Taylor *et al.* (2010, p. 348). It may be useful that this definition describes culture as stemming from the beliefs, values, behavioural and lifestyle norms, and the knowledge endowed through learning and communication that informs the coherent and consensual activities and thoughts of a community. In the UK, the Department of Health has facilitated a growing sensitivity to the religious and cultural beliefs of people with mental health problems and their families, and have taken care to ensure that relevant procedures are established that apply at all levels and within all functions throughout the NHS and its ancillary community-based services (Department of Health, 1996).

The Department of Health (1996) explicitly assures the preservation of patients' dignity and privacy and respect for their culture and religion in all places always, and administrative measures are emplaced to ensure that these elements of the NHS mission are met. In response to increasing ethnic and religious diversity within the UK, NHS trusts have implemented staff education program and procedures to be followed in respect of according with the various cultural sensibilities and requirements of their clientele, particularly in relation to their treatment and care. Comprehensive guidance in respect of patients' beliefs and religious needs, published in 1996, not only offered prescriptive advice to NHS staff but also presented examples from real-life practice scenarios and provided references to other sources of information (Department of Health, 1996). In addition to this, in Western cultures, such as that of the UK, culture is a primary determinant of societal norms and heresies. Culture, however, like health, is conceptualised differently per its contextual locus. Hogg and Holland (2010)

offer some elucidation in this regard, denoting norms as being the artefacts emerging from accepting and consensual beliefs and values. Meanwhile, the Department of Health in the UK initiated cultural changes in the health care context by requiring NHS trusts to meet the stipulations set out in the Patients' Charter in respect of personal dignity, privacy and sensitivity to cultural mores and religious belief (Department of Health, 1996). In 2009 the Department of Health published further guidance for the NHS in relation to matters of belief and religion, so that the NHS may meet the general legislative provisions enacted in this regard; this also extends to advice on associated issues that fall outside the remit of the NHS (Department of Health, 1996). Even though recent years have seen a plethora of research into and guidance concerning culture and religious belief in relation to NHS patients and the care they receive, the mechanisms by which implementation is to be achieved remain lacking. The United Kingdom Central Council for Nursing and Health Visiting (UKCC), 1992 Code of Professional Practice, prescribed the ways in which nurses and health visitors were to engage with the public in their professional capacities (Hogg & Holland, 2010). Particularly, the prescriptions included respecting and recognising the dignity and individuality of patients and other concerned people, whilst attending to the care that everyone requires without discrimination based on ethnic origin, religious belief, personal attributes, the state of mental health or other issues (Hogg & Holland, 2010).

The Impact of mental health stigma on people with mental health problems

Mental health problems are a greatly stigmatised issue worldwide. Thornicroft *et al.* (2009) found that stigma could have an adverse impact on the lives and well-being of people who experience mental health problems. Many articles have shown that there is the stigma, as well as negative attitudes towards people living with mental health problems (Schulze & Angermeyer, 2003; Chang & Horrocks, 2006). Indeed, many reports indicate that stigmatisation can have significant psychological or emotional effects on people living with mental health problems and their relatives (Veltman, Cameron, & Stewart, 2002; Seloilwe, 2006). Schizophrenia, mood disorders, and obsessive-compulsive disorders (OCD) were the problems most commonly related to different families' concepts of stigma (Seloilwe, 2006). As stated above, the harmful effects of mental health stigma can be varied and extensive, often with serious consequences.

According to Watson, Corrigan and Ottati (2004) the criminalisation of people with mental health problems occurs when the individual is dealt with by the criminal justice system instead

of the mental health service; for example, research consistently shows that a person with a mental health problem is more likely to be arrested for a minor criminal offence than those who present without (Padela, Killawi, Forman, DeMonner, & Heisler, 2012). Due to Druss, Bradford, Rosenheck, Radford, and Krumholz (2001) people with mental health problems often do not receive sufficient preventative or diagnostic care or high-quality medical treatment, as mental health services have not had the same level of financial support as the physical health services. Likewise, Lai *et al.* (2001) argued that the mental health problems are more stigmatised than those of the body.

In addition, Corrigan *et al.* (2000) observed that the same applies to individuals with anorexia or bulimia. Consequently, this shows that mental health issues appear to be 'ranked', and that people with these issues are stigmatised more than people with physical diseases. Moreover, some studies discovered that some members of the general population consider that individuals living with mental health problems should be treated with alternative medicines and therapy, rather than with the standard methods available in the health care system (Lauber, Nordt, & Wulf, 2005).

Professional aspects of Stigmatisation

It has been argued that health care experts, acting in accordance with prejudicial regulations and guidelines regularly subject people with mental health problems to stigmatisation from their institutions (Thornicroft *et al*., 2009). Such prejudicial approaches, exemplified by condescending treatments and shielding practices, can acerbate their lack of acceptance in society (Corrigan, Larson, & Kuwabara, 2007). People with mental health problems can require a unique medical approach and the majority are often separated from general patients (Dziak & Fox, 1999).

Moreover, there is a perception that people with mental health problems are challenged by everyday tasks and self-care, as well as behaving childishly and requiring assistance to make routine decisions (Corrigan, 2000). It has been argued that the entire mental health care program vigorously inhibits people with mental health care problems from appreciating their own personal qualities (Crocker, 1999). Additionally, people with mental health problems who are regularly readmitted to mental health care often become reclusive and withdrawn from their family and friends (Corrigan, 2000).

Others have suggested that individuals from minority groups routinely experience more stigmatisation, and have more chance of being unwillingly admitted under the Mental Health Institution to receive mental health care services (Kuoppala, Lamminpää, & Husman, 2008).

The level of prejudice is also thought to be influenced by gender (Hinkelman & Granello, 2003), sexual preference (King *et al.,* 2003), and the degree of physical impairment (Schulze & Angermeyer, 2003). However, it is interesting to note that, whilst mental health patients are seen to be at higher risk of physical ailments, many of these conditions are often analysed by healthcare experts (Phelan, Link, Stueve, & Pescosolido, 2000). In addition, Corrigan, Watson and Barr's (2006) systematic review included 57 research studies of stigma reduction. All the measures that were used in this research involved some form of a psychometric element. The results of the systematic review indicated: 79% of the research studies of people with mental health problems investigated perceived social stigma, 46% investigated the experiences of professional stigma, and 33% investigated self-stigma. The findings of the research show stigma usually restrict the work and housing opportunities for individuals with mental health problems, whilst also showing disruptive effects upon their social relationships and diminishing their self-esteem. Additional effects related to health, such as social isolation, discrimination, and prejudice, also accompany mental health problems (Lee *et al*., 2005). Nonetheless, Doody and Doody (2015) have argued that these negative outcomes can be prevented with simple modifications to everyday life, better health care provisions, and improved clinical approaches.

Overview of stigma in Saudi Arabia towards people with mental health problems.

This study will consider mental health professionals' stigma and their perceptions of people with mental health problems. While there are socio-cultural influences on a person, which are then re-enacted within their professional role, this will encompass relevant social, self-view, media, mental health care services, family and religious factors, all of which may lead to stigma amongst professionals.

The issues and theories of mental health professionals holding stigmatising beliefs and the factors behind it will be further explored in the literature review. The phenomenon of professional stigma exhibited toward people with mental health problems is clear in Saudi Arabia society, and as such, the impact of stigma towards people with mental health problems may cause a delay in providing mental health care services (Alshareef, 2014), due to the lack

of mental health awareness in Saudi Arabian society (Ratner & El-Badwi, 2011). Moreover, this study is context-specific, as it relates only to Saudi Arabia, a country with its culture and beliefs which may be exemplified by its professional mental health workers, causing them to contribute to the creation of professional stigma against people with mental health problems. Such professionals are products of their environment and are influenced by the cultural, social and moral norms prevalent in the Saudi Arabian society in which they were raised and live. The prevalence of professional stigma towards people with mental health problems is possibly attributable to a form of cultural conditioning, which health care workers have been subjected to as part of their upbringing. For example, in Saudi Arabia, on Monday the 8th of April 2014, there was a news report published in the Al-Riyadh newspaper - the first newspaper in Saudi Arabia, identifying the lack of quality in mental health hospital, in Saudi Arabia providing psychiatric care. The committee for the Centre of King Abdullah in the KSA has committed to fighting corruption (NAZAHAA), and consequently, this hospital is under inspection. Please see the page link in Riyadh newspaper in Arabic and English languages due to (Alshareef, 2014).

The report makes clear the extent of people living with mental health problems, and how stigma held by professional mental health teams and workers at the hospitals has led to a shortage of medical resources, a lack of rehabilitation and therapeutic activities and has resulted in a poor therapeutic environment. In Saudi Arabia, where the system of mental health services has long suffered from several deficiencies in infrastructure, logistics, and a lack of epidemiological data (Alshareef, 2014).

I attribute my interest in this area to personal encounters with those people living with mental health problems that attend clinics, see experts, and have experienced the provision of stigmatised care. I spent some time working at In-patient and community health centres, and I experienced the kind of stigma described above on a regular basis. I also experienced its negative impact on both patients and wider society, and this drove my ambition to get involved with this research. To begin with, my attitudes towards mental health problems were very narrow. As my awareness and insight into stigmatization developed, I decided to enrol on the first-degree course in community mental health nursing. During my studies, it was easy to see that the stigma was not a simple subject, but a far-reaching and extensive problem. The more research I conducted, the more complex it became. I quickly noticed the complete deficit of insight into the reasons behind professionally held stigma. As I went on to study for an MSc, I continued to investigate stigma regarding people with mental health problems because of lack of awareness and cultural unfamiliarity, as well as a heavy reliance on a positive approached

to research. It was the latter that prompted me to include a focus group discussion within this PhD study. This will also be the first study in KSA of psychiatric and mental health nurses using this technique in the field of psychiatry. The following section introduces the main topics and ideas of this study, which will be discussed and considered later in greater detail.

Personal and Professional Development regarding interest in stigma

As a nursing professional from the Kingdom of Saudi Arabia (KSA), and for the last seven years having worked as a lecturer at the University of King Saud University (College of Nursing), my interest in this topic has grown. My master's degree was completed at King Saud University, Riyadh in 2011, entitled 'psychiatric and mental health nursing'. I was a member of the community and psychiatric/ mental health nursing course team, which sits in the 'College of Nursing' in Saudi Arabia. This course is a pre-requisite for registration as a nurse in Saudi Arabia. When I worked as a team member, I accompanied the students in their practical rotations in hospitals providing psychiatric treatment; primary health care centres and on outpatient clinic visits. I appreciated how important these visits were, for students to gain experience of the societal, cultural and other factors influencing health.

Even though Saudi Arabian universities do not offer the opportunity for nurses to graduate in the field of mental health without completing a master's degree or post-graduate 'diploma' in mental health, all nurses that were taught at the University had a bachelor degree in general nursing, which included certain specific mental health nursing courses. Those who graduated from the nursing college as a general nurse could work in hospitals with people with mental health problems in the "in/out patient department" as registered nurses. Usually, when nurses start working in hospitals, they work across all hospital departments in the first year, including the mental health department and are thus exposed to more training and experiences (Almalki *et al.,* 2011).

From my experience, I know that mental health nursing covers all aspects of health within a community and provide solutions and preventable measures regarding health and social issues. In this research study, I will be closely looking at the existence and impact of mental health professionals' stigma towards people with mental health problems in Saudi Arabia. The aim of this study to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. I chose this topic because

the professional attitudes of the mental health team can have an immense influence on improving the mental health care of people with mental health problems.

Thesis structure

The remainder of this chapter will consist of an exploration of the level of Stigma theory, and principles associated with stigma studies, particularly of professionals who uphold stigmatising views towards people with mental health problems. The aim is to clearly define these attitudes of professionals, in terms of both historical development and the current effect on those with mental health problems and wider communities. In chapter two, the literature review is designed to identify issues, which may have an impact on levels of stigma; for example, social components, self-stigma, professional stigma, media, family, religion, barriers to help-seeking, barriers to work opportunities. The results from this section will be used as further justification for the methodologies employed within this study. In regards to the section of the methodology, it will show an investigation into the cultural and social foundations on which the study rests, and introduce the reasons behind the decision to work within a conceptual framework of professional stigma. It will also outline the study design, information strategies, statistical evaluations, and any moral and ethical issues. It will provide an in-depth insight into the value of the methodologies chosen, and the importance of sourcing relevant academic literature on the subject. What is more, the chapter will include information associated with carrying out the study, which will be undertaken throughout both the pilot and actual execution phases. It seeks to clearly explain why the study has been carried out in the manner that it has.

The fourth chapter will provide an in-depth presentation of the study findings, demonstrated in different formats. Subsequently, the fifth and sixth chapters include an evaluation of these outcomes, in accordance with the overall study field of professional stigma. In addition, this section will feature a synthesis of the findings, a conclusion, the potential limitations of the study, and provide advice for further studies. These things, however, can only be provided once the value of the study has been made clear, and personal considerations on its use are outlined. This introductory section is designed to explain precisely why this research is so valuable, and why it is essential for both mental health care professionals to contribute to the development of the mental health care services they provide and for people with mental health problems with feedback on the standard of mental health care they receive.

Level of Stigma: Theory & Epistemology

According to Goffman (1963), Corrigan (2004; 2007, p. 39) and Ahmedani (2011, p. 4), isolating the constructs that underlie the concept of stigma helps researchers to investigate the main categories of stigma. Such categories include: a) social stigma, b) self-stigma (See Table 1.1). It is essential to note that these categories do not exist within a scale structure; no one is ranked above another; they simply exist alongside each other. To broaden our understanding of stigma in general, each of these categories is required to be further explained. Social stigma stems from how members of a community perceive the people with mental health problems. This category tends to coincide with self-stigma, which refers to the self-internalisation of how one perceives their mental health problems. Indeed, people's attitudes towards their mental health problems are often reflective of how other people perceive it to be. In this study, professional stigma refers to how the professional mental health care providers view individuals with such disorders and illnesses (mental health problems). Even though these professional individuals form part of the public, and could, therefore, contribute to social stigma, their role as health care professionals keeps them separate, due to their more thorough understanding of and involvement with those who have mental health problems. It is possible for people with mental health problems to become aware of stigma in one of two ways. The first is via a journey of self-awareness (Goffman, 1963). Hence, they reach a place where they can conduct their actions with existing stigmas and clearly define the differences. It has been suggested that patients expect to be neglected by the community, as most had already seen how the public treats people with mental health problems, even before they were diagnosed (Link *et al*., 2004).

For these people, this kind of self-awareness makes the thought of being stereotyped all the more frightening, due to the fact that they can see how different their actions are to the widely held beliefs in regards to mental health problems (Corrigan, 2004); the second is through awareness of the responses of the general public (Goffman, 1963; Corrigan, 2004). For people with mental health problems, it can often feel like people do not want to communicate with them, and many describe feelings of shyness, shame, regret, and self-loathing as a key component of their self and social stigma (Crocker, 1999; Corrigan, 2004). In addition, Stuart (2005) points out that the professional stigma demonstrated towards people living with mental health problems not only directly affects them through the way others interact with them, but also influences their lives indirectly, in terms of prejudice and discrimination**.**

Table 1.1 *Components of Public and Self Stigma*

Public-stigma	Self-stigma
Stereotype: Negative belief about a group, such as incompetence, character weakness, and dangerousness.	*Stereotype: Negative belief about the self, such as incompetence, character weakness, and dangerousness.*
Prejudice: Agreement with belief and/or negative emotional reaction such as anger or fear.	*Prejudice: Agreement with belief, a negative emotional reaction such as low self-esteem or low self-efficacy.*
Discrimination: Behavioural response to prejudice, such as: avoidance of work and housing opportunities, withholding help.	*Discrimination: Behavioural response to prejudice, such as: fails to pursue work and housing opportunities, does not seek help.*

Definition and Concept of Stigma

The term 'stigma' derives from ancient Greek descent, about the physical markings that were attributed to individuals who disobeyed or acted against authority, such as criminals or slaves (Goffman, 1963). In addition, much research has explained how widespread stigma manifests within our society, by focusing on conceptualisations of stigma. However, research has not solely concentrated on the people with mental health problems, or on individuals with drug addictions; it has also been applied to different races, sexual orientations and genders (Goffman, 1963; Crocker, 1999). With regards to the initial proposal by Goffman (1963, p.248), stigma is defined as "a collection of negative attitudes or as stereotypes towards individuals whose characteristics are different from one's own, or that differ from society's norms". In addition, Goffman outlined stigma as "a sign of disgrace or discredit, which sets a person apart from others" (Goffman, 1963, p. 248).

In fact, in relation to mental health problems, stigma has been found to have a particularly negative influence on people living with mental health problems; thus, playing an important role in the subject matter of stigma (Dudley, 2000). In addition, the term 'stigma' can be described as "the circumstances of the mental health patient who is excluded from complete social inclusion" (Goffman, 1963, p. 248). Corrigan (2000) created a framework to explain the dichotomy between public stigma and self-stigma.

Each of these categories further explains how stigma is classified and recognises three primary elements of cognitive, emotional and behavioural influence: 1) stereotypes, also known as cognitive knowledge structures, 2) prejudices, which are the emotional results of stereotypes, and 3) discrimination, which are the behavioural results of prejudice. Therefore, these elements and their integral components are interlinked. Existing models, which are applied to explain the stigmatisation of those who have mental health problems, utilise certain cognitive, emotional and behavioural constructs to provide cultural support. For example, Crocker (1999, p.102) noted, "stigmatised individuals possess (or are believed to possess) some attribute or characteristic, that conveys a social identity that is devalued in a particular social context". Conflict based on race occurs when individuals are subjected to racism. Racism may be defined as the agglomeration of prejudice (attitude) and discrimination (behaviour) that is ethnically or racially located (Silton, Flannelly, Milstein, & Vaaler, 2011); while it may be either individual or institutional (Silton *et al*., 2011).

As discussed, there are many other contexts, in which stigma is a prominent and relevant, such as about different races or sexual orientation. Additionally, explaining the underlying concepts and constructs of stigma can help to explain how particular negative attitudes develop. Corrigan (2007, p.31) isolated six main dimensions of stigmas:

Conceivability – refers to how overt a characteristic or symptom is to others.

Course – refers to the duration of the feature, whether it is temporary or permanent.

Disruptiveness – refers to how significantly the function affects the individual and their lifestyle.

Aesthetics – refers to the initial reaction to the feature, such as one of disgust.

Origin – refers to the cause of the feature, about whether it was avoidable or not.

Peril – refers to the threat or danger of the feature, about avoidable or not.

Operational Definitions

Self-stigma: The loss of self-esteem and self-efficacy that occurs when people internalise the public stigma as feelings of shame, guilt, and wish for secrecy and concealment.

Social stigma: The phenomenon of the major social groups endorsing stereotypes about, and acting against a stigmatised group, such as people with mental health problems.

Professional stigma: The climate of prejudice and discrimination that surrounds mental health patients by professional mental health team views and opinions.

Statement of the Research significance and Research Questions

Significance of the study

It is important to understand the extent to which mental health professionals are influenced by holding such views when relating to people with mental health problems (Chou *et al.,* 1996). Additionally, research concerning the issue of stigma among mental health professionals towards people with mental health problems is in its nascence (Schulze & Angermeyer, 2003; Lauber & Rossle, 2007). Due to Nordt *et al.* (2006), although no research to date has incorporated the views of mental health professional counsellors. In addition, regarding Corrigan *et al.* (2014), there has been much research regarding stigmatize, which has been on an international scale. Undoubtedly, there are many individuals whose professions include interacting with people with mental health problems, particularly in the role of providing treatment, such as psychiatrists and psychiatric/mental health nurses, social workers and psychological researchers.

Many individuals in the wider community may also work with people with mental health problems as well. Even though these individuals interact with people with mental health problems, and Corrigan *et al.* (2006) describe how, with respect to individual circumstances, various emotional and behavioral responses arise in individuals to whom achievements or failings are attributed. Furthermore, it is true that stigma has been described by experts from many different backgrounds (Link *et al.,* 2004). For example, such individuals could apply their own personal experiences or upbringings to their work, which are reflected in how they perceive and behave towards people with mental health problems (Acker & Lawrence, 2009). As described by Corrigan (2004, p.614), perceptions about mental health among the public are reflected in the wide range of perceptions of stigma displayed by mental health professionals, and are therefore frequently noted.

They are all likely to adopt different approaches towards their interactions, based upon their respective training, regulations, job descriptions, legislative constraints, or personal preferences. Holmesland, Seikkula, Nilsen, Hopfenbeck, and Arnkil (2010) explained how this creates the issue of professional identity, which can hinder the progress of cooperation and interdisciplinary action. Furthermore, as psychological disciplines progress and develop rapidly in that part of the world, it becomes harder to disregard the towering impact of culture, relationships, and faith on the awareness, identification, treatment, and care of mental health problems in Saudi Arabia today (Littlewood & Yousef, 2000; Pinto *et al.,* 2012).

Internationally, there has been a surge in the research that has been conducted into mental health problems, largely to remove the negative stigma that is often attached to people with mental health problems (Penn & Martin, 1998; Corrigan & Watson, 2002; Aphroditi, 2010; Parle, 2011). To reduce the stigma rate for people with mental health problems, it has been argued that preventative measures should be applied to mental health care (Strauss *et al.,* 2005). These preventative measures include: therapy sessions, rehabilitation initiatives and creativity programs, where people with mental health problems are encouraged to focus on their creative abilities, although this may require changes in social and political policies (Strauss *et al.,* 2005).

The Ministry of Health in the Saudi Arabian government has not passed legislation to deal with discrimination suffered by people living with mental health problems or to reduce the stigma held by professionals; nor has it adopted policies to raise awareness of people living with mental health problems in Saudi Arabian communities. The failure of the government to address mental health problems and to provide a higher quality of mental health care services and professional mental health teams, as well as raise the standard of training for mental health service practitioners, may be partly attributable to the unavailability of adequate empirical data in Saudi Arabia in relation to professional views on stigma towards people with mental health problems. Importantly, Corrigan, Watson and Miller (2006) stressed that the theories behind mental health problems and the associated stigmas are of interest to researchers.

Aims and Objectives of Study

The aim of this study is to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia.

Specific Objectives

The literature suggests that people living with mental health problems still experience high levels of stigma, although there are many possible social and cultural reasons for this. Internationally, much work is being undertaken in addressing ways in which such stigma and its impact on individuals might be reduced (Corrigan, Druss, & Perlick, 2014). The potential perspectives and views of professional stigma towards individuals with mental health problems are currently an under-researched aspect of mental health care (Corrigan, 2007; 2014). This research study seeks to examine professionals who may hold stigmatising views and beliefs towards people with mental health problems and how the existence and extent of these views

might impact on the services provided by mental health professionals and the recovery of people with mental health problems. Therefore, the specific objectives of this study are as follows:

1. To explore the possible social, cultural and educational factors in Saudi Arabia that may lead to the mental health professional holding stigmatising views toward people living with mental health problems.
2. To measure the extent of stigmatising attitudes and beliefs, that mental health professionals demonstrate towards people living with mental health problems.
3. To investigate the impact of professionally held stigmatising views on the attitudes, beliefs, and quality of mental health care planning and provision within the Saudi Arabian mental health care services.
4. To develop recommendations for improving mental health services in Saudi Arabia by identifying the important factors in promoting best practices and by providing training, education and research to raise the quality of mental health services and reduce the stigmatisation of people with mental health problems.

Research Questions

In developing the research aims and objectives, several related questions have also been generated:

1. To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?
2. What are the causes or factors in Saudi Arabia that may lead to mental health professionals holding stigmatising views towards people living with mental health problems?
3. How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?
4. Explore how Saudi Arabia's mental health care service has enhanced the level of resources and standards of care available to mental health care users, and to what extent can the provision of a mental health care service contribute to the diminishment of the stigma that surrounds people living with such a problem?

Conclusion

This chapter has outlined a desire to explore the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. International research studies have been drawn upon to promote an understanding of the cause, mechanisms and implications of stigma, which will be discussed in the following chapter.

CHAPTER 2: CURRENT LITERATURE CONCERNING STIGMA AND MENTAL HEALTH PROBLEMS

Overview

This chapter is subdivided into two corresponding review sections. The literature review has sought to explore existing studies on the issue of stigma towards people living with mental health problems, as demonstrated by mental health professionals. Firstly, this chapter will present an explanation of the search strategy used, as well as sources and criteria for selection. It also includes a summary of data extraction table of the papers retained for review. This is followed by a critical evaluation of the articles included forming an evidence base, using critical appraisal tools (Health Care Practice, Research and Development Unit [HCPRDU]) (Long & Godfrey, 2004). Secondly, the main findings put forward in the studies will then be explored, and, lastly, the contribution of the literature to the research will be discussed.

Comprehensive search strategy

Nursing research is defined by Polit and Beck (2008, p. 3) as "a systematic inquiry designed to develop knowledge of issues of importance to the nursing profession, including but not limited to, nursing practice, education, administration, and informatics". Furthermore, the literature review is designed to assist in the development of the study's methodology (Nieswiadomy, 2012, p. 71). The literature review was defined as "the identification and analysis, or review of the literature and information related to what is intended to be studied" (Kazdin, 2011, p. 480). To determine an integrative review and the quality, due to Whittemore and Knafl (2005, p. 547) "integrative review has the potential to play a greater role in evidence-based practice for nursing research"; the same assessment criteria were applied to all studies through a comprehensive approach consisting of appraisal and quality 'a critical evaluation' of evidentiary data.

Whittemore and Knafl (2005, p. 546) consider "integrative reviews to be detrimental to the identification, analysis, and syncretisation of the results of any independent study; they are also fundamental to establishing the foundations of subject knowledge". Such a review has the potential to influence the quality of care that patients receive positively. "The highest quality of care is delivered in accordance with scientific recommendations, which is why the integrative review has been identified as a unique tool in health care for synthesizing the investigative results available on a given topic and for directing practice based on scientific knowledge" (Gawronki & Bodenhausen, 2006, p. 692).

"The integrative review method is the only approach that allows for the combination of diverse methodologies and synthesis of the results, such as experimental and non-experimental research" (Whittemore & Knafl, 2005, p. 553). Consequentially, "it is imperative to establish an integrative review as a valid instrument of evidence-based practice, primarily in the current provision of nursing" (Gawronki & Bodenhausen, 2006, p. 692).

Rationale

In fact, the literature has served to outline the factors, which have a greater or lesser impact on the formation of stigma amongst professionals working in the field of mental health. It will also be devised to investigate how it contributes towards stigma globally; how it relates to the Saudi Arabian cultural context; and to demonstrate the efforts that have been made to improve the quality of health care in the country. It is anticipated that this literature review will expand existing knowledge, stimulate further research, and explore the possible existence of stigmatisation demonstrated by mental health professionals towards people living with mental health problems.

The analysis was performed using relevant aspects of the 27-item checklist devised by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) organisation (Moher, Liberati, Tetzlaff, & Altman, 2009: Appendix I), which advises systemic reviews and meta-analyses of the optimum practice guidelines. The review utilised the PRISMA flow diagram, which was established to ensure that the systematic reviews were presented as accurately as possible. Moher *et al.* (2009; 2015) formulated the PRISMA statement, which enabled authors to assess the advantages and disadvantages of a health care intervention, in accordance with the findings of the systematic review. In view of the way in which systematic reviews are highly beneficial in the context of health care owing to the usefulness they offer regarding the formulation of clinical guidelines and the acquisition of data that accounts for knowledge gaps (Moher *et al.,* 2015), they play a distinctive role in the context of health care (Shamseer *et al.,* 2015). Shamseer *et al.* (2015), that highlights the extent to which systematic reviews are comprehensive and trustworthy is largely determined by a priori planning and the implementation of a methodical approach (namely, protocol).

It is notable that by extending the Preferred Items for Reporting Systematic Reviews and Meta-analyses (PRISMA) framework, a reporting guideline for systematic review protocols has been formulated (Panic *et al*., 2013; Shamseer *et al*., 2015). The author will closely draw on this in the present report. As noted by Shamseer *et al*. (2015, p. 5), the underlying intention

of PRISMA is to facilitate and direct the formulation of systematic review protocols and meta-analyses which evaluate the effectiveness of therapeutic mechanisms. It will be worthwhile to define what we mean by protocol and, moreover, to underline that this paper conceives of the definition in a broad sense; namely, "as constituting a form of plan, prepared prior to the commencement of the systematic review, which provides an account of the basis and intention of the review in combination with its methodological and analytical approach" (Khangura *et al*., 2014, p. 20).

As reported by Shamseer *et al.* (2015) and Tricco *et al.* (2015), numerous factors feed into the importance of a systematic review protocol, and these will be outlined in the following paragraph. First, a systematic review protocol ensures that the researcher conducting the systematic review engages in comprehensive planning; consequently, any relevant issues or obstacles are forecasted. Second, the protocol facilitates the researcher's clear documentation of their intentions prior to the commencement of the process of the review; owing to this, readers could consider the protocol in relation to the finished review (thereby allowing them to determine whether selective reporting has taken place), to repeat the review methods if necessary, and to evaluate the extent to which the planned methods were valid. Third, the protocol is useful in enabling the researcher to bypass random and uninformed decision-making regarding the inclusion criteria and the extraction of data. Fourth, protocols are valuable in limiting the researcher's duplication of processes and, in cases where it is relevant, improving collaborative practice.

It is important to recognize that when researchers engage in selective reporting too directly and potentially manufacture the significance of findings, this has serious implications for health care decisions and policies. This is because the findings of the systematic review are what informed such decisions and policies. As emphasised by Khangura *et al.* (2014) and Shamseer *et al.* (2015), it is viable to regard a critical function of systematic review protocols as pertaining to the part they play as a documentation of planned review methods, results, and analyses that stakeholders can consider in relation to finished reviewing, thereby allowing them to determine the degree to which unintentional and unrecorded alterations took place.

Objectives

The literature review was undertaken to evaluate the existing data on mental health professionals' views toward people living with mental health problems. Due to Collins and Fauser (2005), stigma has often not been afforded enough emphasis and is often a peripheral concern for nursing and mental health professionals. However, this review has focused on the areas of social work, psychology and psychiatric and mental health nursing. This paper will aim to review the available literature regarding the existence of professional stigma towards people with mental health problems in mental health care services. The question the review will attempt to answer is: to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia.

Methods

Eligibility Criteria

In this study, there are many of the articles that analyse the possible reasons why a mental health stigma from professionals on people with mental health problems exists, which were evaluated to ensure their eligibility for inclusion in this review. Research that aimed at establishing the perceptions of professionals were central (Table 2.1). Regarding limited research on this issue, a large scope was used during meta-analyses, using data from various countries and demographics worldwide. This included non-experimental, qualitative, and mixed method studies. The basis for inclusion of the diverse research types was defined in conjunction with the setting, sample, study design and measures, and outcomes as defined by the HCPRDU, Appendix II.

Table 2.1 *Inclusion and Exclusion criteria for the Articles*

Inclusion criteria	Exclusion criteria
Using a qualitative or quantitative approach as a method of research. Professional held stigma against people living with mental health problems. Drawn from the disciplines of psychiatry, psychology, social worker, and mental health nurse, and faculty of mental health nurse. Written in English, the articles in medical or nursing field published in the English language; the main science articles analysed in this area are published in the English language. All articles must have been published between 1990 and 2016, and all articles must be original research from the database, the rationale of this requirement is to ensure that research is of high quality, thereby ensuring that the articles are of a high validity (Sun, Xu, & Feng, 2004). The search terms used to describe the experience of the study subjects included: "mental health problem* and stigma*" along with "stigma*', "prejudice and stigma*", "stereotype and stigma*", "mental health professional* and stigma*" and "discrimination and stigma*", and for selecting research material were depression, bipolar, paranoid, mania, personality disorder, schizophrenia, and stigma of mental health problems, mental health problems, mental illness, and mental disorders, according to Jackson and Heatherington (2006) and Crisp, Gelder, Goddard and Meltzer (2005), the people with mental health problems are most commonly stigmatised are depression, bipolar disorder, personality disorder and schizophrenia, so these conditions were selected as search terms.	Articles duplicates. Article published before 1990. Articles not in the English language. Articles not focusing on depression, bipolar, paranoid, mania, personality disorder, schizophrenia, and stigma of mental health problems, mental health problems, mental illness, and mental disorders. Articles for non-available full texts, dissertations, essays, and conference papers. Articles not focusing on professionals held the stigma toward people with mental health problems.

And only articles concerning the impact, attitudes, views and observations of mental health professionals are selected, this form of research offers further insight into stigma and its related factors and thus makes a valuable contribution to the topic (Schulze & Angermeyer, 2003).	

Information Sources

In searching for data, many of electronic databases were utilised, including PsycINFO, CINAHL and MEDLINE and Science Direct, British Humanities Index, British nursing index, and Social Services Abstracts, Applies social science index and abstract (ASSIA), International bibliography of social science (IBSS), EBSCO, PsycARTICLES Full Text, and grey literature.

Search strategy

The key search terms used were "mental illness", 'exclusion' and 'inclusion'. The search terms used to describe the experience of the study subjects included: "mental health problem* and stigma*" along with "stigma*", "prejudice and stigma*", "stereotype and stigma*", "mental health professional* and stigma*" and "discrimination and stigma*". Please see the full Search Strategy (Appendix III).

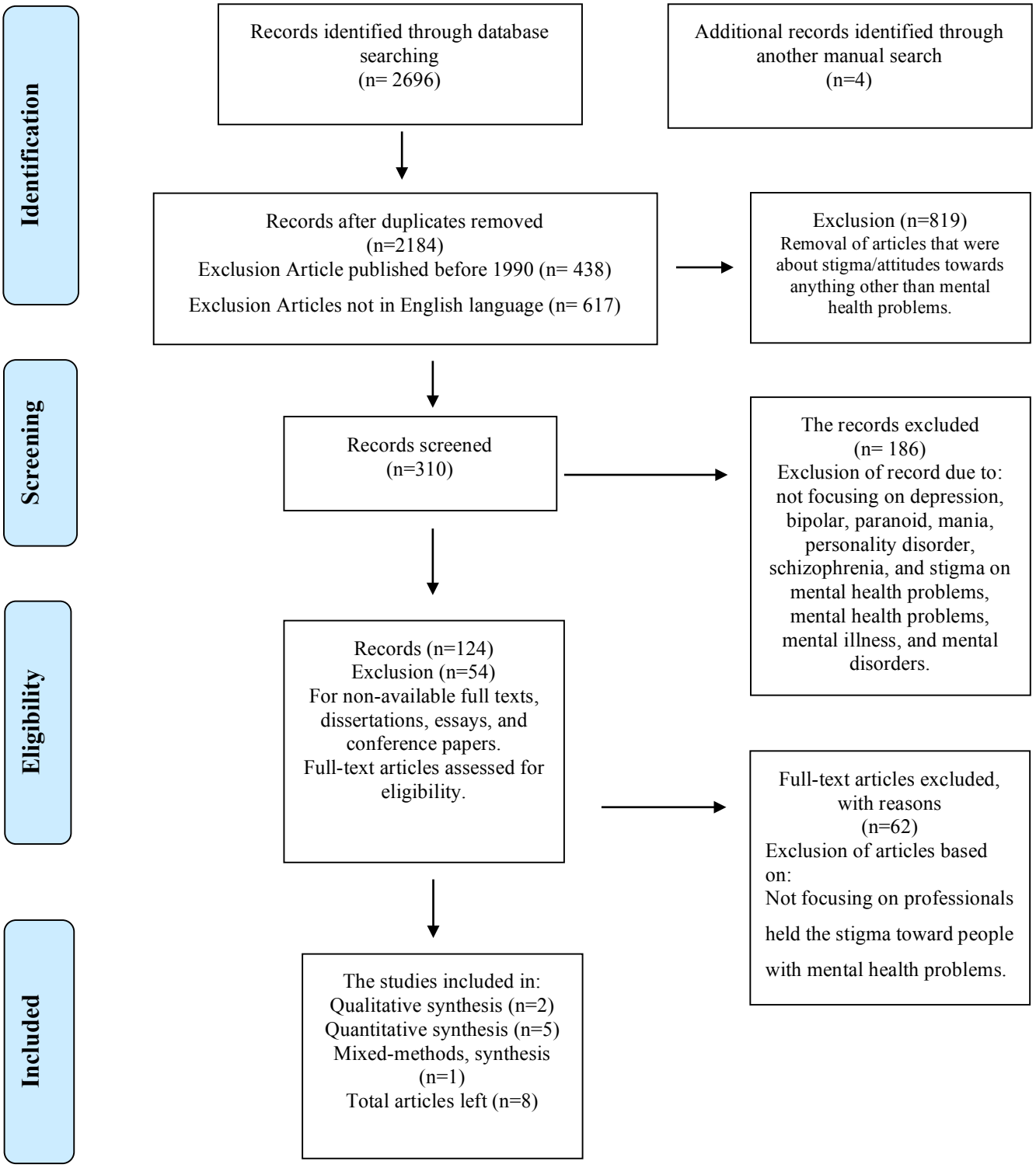

Figure 2.1 PRISMA flow diagram of search strategies' process

Study Selection

The search of the electronic databases resulted in the identification of over 2700 different articles, while 8 of them related to the inclusion criteria. The other papers did not match the inclusion criteria. The search parameters applied by PRISMA were established to ensure the professional stigma towards people living with mental health problems remained at the centre of the study, following on from the PRISMA Flow Diagram (Moher *et al.,* 2009). (See Figure 2.1: PRISMA flow diagram of search strategies' process). This review was conducted in 2015 and all publications that adhered to the imposed search parameters were selected. All search results were closely screened for eligibility based on the criteria described above.

Data Collection Process

Data extraction was completed with utilizing relevant aspects of the quality level of the chosen study, evaluated in accordance with the scheme developed by (HCPRDU), which were used when undertaking the critical appraisal - the quality of available literature is discussed within four key areas, which are study setting, aims, sample, method, measure and results, which are examined in turn below. The quality level of the chosen study was evaluated in accordance with the scheme developed by (HCPRDU) by undertaking a critical appraisal of experimental and non-experiential studies (Long & Godfrey, 2004, p. 181). Throughout the development, the methodology has grown to include an evaluative tool to be employed in research involving qualitative data collection and a quantitative research study, known as 'mixed method' studies [HCPRDU] (Long *et al.,* 2002). Appraising either qualitative or quantitative studies necessitate a level of judgment, and the goal is to use the tool to limit the disparity between judgments and outlooks regarding a study's value and importance (Long *et al.,* 2002).

Through this process, integration techniques, which focus on accessibility and communication teamwork, values and culture, and the dedication and enthusiasm for providing integrated care, were used (Johnson *et al.,* 2001). In addition, by acknowledging the way in which users share their requirements, finding evidence for inclusion in systematic reviews is simplified. This review of the results of mental health care services for people with mental health problems, allow the reader to understand the crucial components of a study and the clinical weight (Long *et al.,* 2002). Thus, there is substantial benefit contributed towards sharing important messages regarding the study in a condensed representation. This piece has explained the general procedure of the development of an evaluative tool used in the evaluation

of studies and its benefit described. By examining this tool, a collection of informative aspects and outcomes are presented to show the main study content. Hardy, Mur-Veemanu, Steenbergen and Wistow (1999) propose that due thought must be paid to the political, economic and social setting that influences wider issues of integration, legal considerations, and sources of financing, as they represent important indicators of the effectiveness of integrated service provision approaches.

Results

Findings from the Review of the Literature

Using international studies as a signpost towards Saudi Arabia

There were many of research studies undertaken that looked at mental health care professionals who stigmatise people with mental health problems. A total of 8 papers identified that particular present issues (See Appendix IV. Data extractions of Search Strategies studies). The first is that studies have been focused on mental health professional held stigma toward people living with different mental health problems, outside of Saudi Arabia. There was some literature, which was not applicable to the context of Saudi Arabia due to cultural differences, socio-demographic issues, and lifestyle.

Description of the Studies Retrieved

This review of the literature above has revealed significant evidence related to the stereotype, prejudice and discrimination (stigma) of mental health care professionals towards people with mental health problems. Furthermore, there is only limited evidence from other Middle Eastern countries and no articles, until now, on S.A.

Sample: The samples included in these papers ideally have common properties as established by the authors before data collected. This practice used in the current study as well, in the form of inclusion criteria.

Methodology: quantitative, qualitative and mixed-method studies all needed to be granted ethical approval from a recognised ethical committee, for example, a University or hospital, which is a point discussed by Cohen *et al.* (2013), these papers tackle the problem of ethics with participant consent forms, in conjunction with a related organisation's ethical approval. The specific data collection tools used varied considerably. However, five (5) studies used quantitative approaches during data collection procedures, two (2) studies used qualitative

approaches during data collection procedures, and one (1) study used a mixed method approach during data collection procedures.

All these studies conducted data collection via cross-sectional survey questionnaires in quantitative studies and cross-sectional-interviews in qualitative and mixed method studies.

The aims of the quantitative, qualitative and mixed method measures mirrored the aims of the study. Where also identified stigma-related enabling factors that facilitated professional stigma in the study selected where the methodology was undertaken measuring the professional perspective, social distance and attitude of mental health workers towards people with mental health problems. Across the eight studies included in the review, summarising the questionnaire results attempted to identify professional stigmas, which lead to a clear picture of the prevalence stigmas found; stereotyping, prejudice, and discrimination. To measures, stigmas were dominant throughout various interactions, including during diagnosis and community views of stigma. The following section discusses the total of 8 papers that were identified to present certain issues surrounding professional mental health stigma.

Appraisal and quality review of the studies included

Eker and Arkar (1991) examined the attitudes towards people with mental health problems held by mental health nurses working in two general hospitals in the Turkish city of Izmir. The research sample consisted of 91 psychiatric nurses, who were working with people living with depression, anxiety, and paranoid schizophrenia. Within the data acquisition phase, the subjects presented to participants included queries on levels of exposure to those with mental health problems, especially regarding social contact with family members or acquaintances. In addition, it was found that the responses demonstrate that psychiatric nurses aim to avoid people with paranoid schizophrenia than people with anxiety or depression. Indeed, it can be argued that at least based on first impressions, unless mental health professionals can engage with those who are living with all mental health problems, the stigma surrounding some mental health problems is unlikely to change through simple interaction alone, particularly with people with the certain diagnosis.

Furthermore, the attitudes of mental health practitioners towards the people living with mental health problems in schizophrenia, major depression and mania were explored by Kua, Parker, Le and Jorm (2000), who explored the attitudes of Singaporean out-patient and in-patient department mental health practitioners towards three vignette descriptions of people with schizophrenia, major depression and mania. Conducted a survey of 42 out-patient

department practitioners in professional mental health, 41 in-patient department practitioners in professional mental health. The perceptions of the mental health professionals regarding aspects of patient care and social distance. Mental health professionals from an in-patient department expressed the greatest optimism about illness outcome following treatment, while outpatient department practitioners in professional mental health expressed negativism by a professional stigma towards people living with mental health problems. Consequently, the findings revealed that many participants in out-patient departments argued that people with depression were less likely to be stigmatised than those with schizophrenia or mania. These results may be explained in terms of mental health practitioners in the in-patient department, who typically receive referrals for people diagnosed with schizophrenia, major depression and mania in Singapore, who most often observe successful medication treatments. Additionally, mental health practitioners in the in-patient departments were also the most likely to observe the complete recovery of patients suffering from schizophrenia, depression or mania, regardless of the occurrence of relapse following treatment (Kua *et al.,* 2000). It can be argued that individuals with schizophrenia, depression or mania were rated by a considerable number of out-patient mental health practitioners use only achieving partial recovery. The lack of consistency in treatment outcomes, as envisioned by mental health practitioners, could be attributed to the possibility that each of them had observed patient recovery. Moreover, even though many participants argued that people with depression were less likely to be stigmatised than those with schizophrenia or mania, out-patient mental health practitioners represent a higher proportion of professionals holding a stigma toward those people living with mental health problems than mental health practitioners in in-patient departments.

In Asian countries, such as Malaysia, mental health care appears not to be a popular research field (Crabtree, 2003). Crabtree applied an ethnographic approach that involved close observation of everyday practices, an examination of hospital records, and interviews to gain an understanding of workplace culture in Sarawak, East Malaysia, conducted a survey of 32 psychiatric nurses and 15 psychiatrists, to explore the issue of professionals holding stigma towards people living with mental health problems. The perceptions of the mental health professionals regarding aspects of patient care, and in scenarios where people lived with mental health problems, were clearly reflected in their use of the term ‘asylum’ when referring to the hospital. Furthermore, psychiatrists mentioned the likelihood of patients who are psychotic becoming violent during assessment prior to hospitalisation, whereas mental health nurses were more concerned with the possible dangers related to the monitoring of non-psychotic patients. Due to these concerns, it might be argued that no trusting relationship appeared to be created

by the health professionals and the patients. In this study, it appeared that no appropriate measures were taken to address the violent behaviour of patients towards staff; the latter feeling that their job did not offer them security against personal harm. In addition, it can be argued that psychiatrists and mental health nurses are affected, both professionally and psychologically, by the stigma attached to people with mental health problems. Additionally, mental health professionals were shown to hold these views due to external perceptions of the risk of 'catching' mental health issues in the manner of a contagious disease. Hence stigma was the major obstacle, which hinders people living with mental health problems from integrating into society and receiving the treatment course. This can lead participants to express doubts about the rehabilitation of some people living with mental health problems.

A comparative analysis of the attitudes of hospital employees from several psychiatric clinics at Ataturk University Hospital in the Turkish city of Erzurum was carried out by Aydin Yigit, Inandi, and Kirpinar (2003). The 160 participants were chosen at random and included 40 academics, 40 psychiatrists, 40 psychiatric nurses and 40 hospital workers. Vignette descriptions of schizophrenia and depression were used, and participants were asked about preferred social distance, mental health problem identification, diagnosis, and hospital admission. Positive attitudes, as reflected in reduced social distancing, were observed mostly among hospital workers, even though they were less educated compared to the rest of the participants. Consequently, the results suggest that this discrepancy led the authors to conclude that an education within the mental health profession may exacerbate these negative attitudes towards people with mental health problems. The results of that specific research also appear to show that, overall, mental health professionals have a more pessimistic, and negative view of the immediate and longer-term outlook for people living with mental health problems than other types of hospital workers; a viewpoint associated with more frequent interaction between mental health professionals and people living with mental health problems.

Likewise, in a Turkish study, Ucok, Polat, Sartorius, Erkoc and Atakli (2004) analysed the attitudes psychiatrists had towards people with schizophrenia. The participants were asked to complete a questionnaire that comprised 12 items related to the way they conveyed a diagnosis to the patients and their family members, the way in which they discussed recovery aspects, as well as their views on social contact with the patients; 60 psychiatrists took part in the study. Due to the results, most participants, 95% named schizophrenia as the most serious mental health problems from the perspective of the public, while 88% considered that the public used the word 'schizophrenia' in a negative way. Additionally, 43% of participants admitted to keeping patients in the dark about a diagnosis of schizophrenia and 41% decided due to case

whether to inform the patients or not. In comparison to the diagnosis of depression, mania and delusional disorder, the diagnosis of schizophrenia was withheld from patients more often. This decision was justified by 33% of participants who argued that patients or their relatives did not have knowledge of what schizophrenia entailed, and therefore, they did not inform them in order not to determine them to stop the treatment. Moreover, only 33% of the participants diagnosed schizophrenia officially, while 53% did so only with the approval of the patients or their relatives, and 14% admitted that they had never made an official diagnosis of schizophrenia. Additionally, almost half of the participants, 43% stated that they would not make home visits, whilst 55% mentioned that contact with patients in a social context made them feel awkward. These figures appear to indicate that individuals with mental health problems may behave in an unconventional manner that causes them to be perceived with stigma from the professionals in the mental health team. Similarly, the societal and professional stigma against mental health problems is brought to the forefront and pressed to change through the increasing use of the term 'discrimination'. The impact of society's and different professional's negative judgments of people living with mental health problems is enhanced through the specific terminology used. Furthermore, those living with mental health problems still encountering – and believe there to be – discrimination and stigma in the world around them.

Liggins and Hatcher (2005) observed that mental health problems often attracted social and professional stigma toward those people with mental health problems. The authors found this to be the case in their observational study in a general hospital in Auckland, New Zealand, the 5 participants of mental health professionals were chosen with the purpose of investigating how people with mental health problems and mental health professionals experienced stigma based on a Liaison Psychiatry service. The audio-recorded interviews with participants from general hospitals were analysed by applying a grounded theory technique. The different perspectives on people with mental health problems were grouped into several categories within stereotyping and labelling the people with mental health problems. Thus, "Relating Mind to Matter" was a key category, which was connected to many of other categories, including: "It's a Scary Business," "It's All Hopeless," "She's One of Them," "Expressions of Relatedness," "You are Not Genuinely Ill" and "Playing by the Roles." It was revealed that, whether perceived or real, mental health problems in the context of a general hospital had detrimental implications. Arguably, there were two main research interests being explored in the previous study. Whilst the first interest concerns the stigma that some service users experience from professional staff, the second research interest is the subsequent effect that

this has on service users. There is much to be said about the power of the majority and normality. It is important to keep in mind that people with mental health problems will normally experience strong stigmatisation from the professional health teams. In general, society finds it difficult to comply with others' perceived normality. The subsequent effect of this is that they feel less than equal in society and their life opportunities are restricted. The "Relating Mind to Matter" category pointed to uneasiness in the relationship between patient and health professionals, as well as to a lack of body-mind equilibrium. Studies conducted into the behaviour of employees at psychiatric inpatient and outpatient centres in the Switzerland were examined and compared with the behaviour of the public (Nordt, Rossler, & Lauber, 2006). Observed that mental health problems often attracted social and professional stigma. Conducted a survey of 1073 mental health professionals' (social workers, psychiatrists, physiotherapists, mental health nurses, and psychologists), and 1737 public participants in 29 hospitals. The results showed that mental health professional staff encounters are often found in more extreme cases, such as those with a recent onset acute illness, or those with chronic illnesses that frequently present for help. Indeed, psychiatrists were shown to have preconceived negative opinions of those with mental health problems more so than members of the public or other mental health professionals such as psychologists. Nevertheless, it could be considered that the negative attitudes of professional staff could be found in their daily experiences of mental health.

Their views founded on these experiences, however, are likely to be biased because of this. Mathews (2007) conducted a survey of 79 psychiatric nurses and 21 psychiatrists in Singapore to explore the issue of professionals holding a stigma against people with mental health problems. A proportion of 60% of the nurses stated that they were derided، humiliated, and frustrated due to their line of work, while 30% mentioned that their own relatives attempted to dissuade them from entering the field of psychiatry. Furthermore, 51% of psychiatric nurses and 15 %of psychiatrists admitted that, if they had the choice again, they would avoid the psychiatric profession and people with mental health problems. Due to these concerns, it can be argued that participants stated that others stigmatised them through the community, who believed that they would be negatively impacted by working with people living with mental health problems. This reflected professional health workers' perceptions of how the community viewed people with mental health problem.

A summary of Evidence

Four Quantitative studies found evidence of professional stigma toward people with mental health problems during the diagnostic process (Eker & Arkar, 1991; Kua *et al.,* 2000; Aydin *et al.,* 2003; Ucok *et al.,* 2004). In addition, two studies of quantitative and qualitative found minimal evidence of the effect mental health professionals have on the stigmatization of people with mental health problems by labelling people with mental health problems (Liggins & Hatcher, 2005; Ucok *et al*., 2004). Moreover, only one qualitative study viewed stigma as an indication of fear, insecurity, and doubt from people with mental health problems among participants (Crabtree, 2003). Furthermore, five quantitative studies and one qualitative study recorded the perceptions of mental health professionals involving aspects of patient care, social distance, and interactions with those diagnosed with mental health problems (Eker & Arkar, 1991; Kua *et al.,* 2000; Crabtree, 2003; Aydin *et al.,* 2003; Ucok *et al.,* 2004). Finally, eight studies (five quantitative, two qualitative, and one mix-method study) found evidence to suggest that there is a negative and pessimistic pre-conception of stigma towards people with mental health problems (Eker & Arkar, 1991; Kua *et al.,* 2000; Crabtree, 2003: Aydin *et al*., 2003; Ucok *et al.,* 2004; Liggins & Hatcher, 2005; Nordt *et al.,* 2006; Mathews, 2007).

Discussion

This review of the literature above has revealed significant evidence related to the stereotype, prejudice and discrimination (stigma) of mental health care professionals towards people with mental health problems. Furthermore, there is only limited evidence from other Middle Eastern countries and no articles, until now, on S.A. Across the eight studies included in the review, summarising the methods, results attempted to identify professional stigmas, which resulted in a clear picture of the prevalence stigmas were dominant throughout various interactions, including during diagnosis, preview, pre-convention and perspective of stigma, community views of stigma, labelling people with mental health problems, risk and fear.

Moreover, most of the literature recommends conducting continuing mental health improvement among mental health care professionals with education and research to improve mental health care professionals' role in mental health care services concerning the active prevention of stigma. These issues support the need to conduct this study, which will fill the gap in the literature regarding mental health care provided and services for mental health care professionals in the specific context of S.A.

This will involve a survey and interactive focus group discussion to know the practicalities of these aspects in the mental health professionals who demonstrated stigma. Some studies identify how these factors also exert influence and cause stigma among professional mental health workers toward people with mental health problems, which are discussed in the following section. It is considered that being involved with literature will boost the thematic data analysis by making the researcher more aware of minor details in the data (Tuckett, 2005).

These literature reviews are tied to this piece through a focus on specific elements of professional stigma, and methodology while giving less attention to other areas that are possibly relevant, for example, the review of studies involving numerous aspects, pinpointing and appraising related material and making up information from different sources (Kitchenham *et al*., 2006). When it comes to these contribution factors, it should be noted that these reviews are usually peer-reviewed in the same way as research papers (Oxman & Guyatt, 1988). In most cases, the use of feedback from reviewers has a significant benefit for the review of professional stigma element (Pautasso, 2010).

Conclusion

A systematic review was performed on available, relevant literature on the topic of professional stigmas towards those with diagnosed mental health problems. Some preliminary evidence suggests that there is an extant stigma from professionals, demonstrated by prevalent stereotypes, prejudice, and discrimination. These stigmas could contribute to other stigmas, including, but not limited to, relationships and interactions, social aspects, fear, conceptions, and labelling. However, any findings should be interpreted with care, as research suggests that there is limited knowledge regarding a professional stigma towards people with mental health problems in mental health care services regarding professional help and social attitudes. Thus, a clearer understanding is required of any potential stigmas and their effects to further develop research areas. Several studies identified how these elements exert influence and cause stigma among mental health professionals towards individuals with mental health problems, which discussed in the following section.

What the literature tells us about stigma

Through the previous data critical appraisal with inclusion and exclusion criteria, applying the "eligibility "PRISMA follow diagram in Figure 2.1, with Full-text articles excluded, reasons (n = 62) found many studies reviewed different factors and aspects of stigma among people with mental health problems. With more explanations and in-depth discussions of the causes of stigma present a picture of how people live with mental health problems. The following section will discuss shared themes identified in the included studies, which are: a few factors have emerged in review literatures around what might influence the beliefs held by professional mental health teams: social stigma, self-stigma, stigma held by professionals toward people with mental health problems, diagnosis, barriers to help-seeking, barriers to work opportunities, and the effect on families, additionally influenced by religion and media. The importance of these factors is reinforced in other papers focusing on the factors that might foster professional stigma (Schulze, 2007).

Factors leading to stigma amongst professionals

Social Stigma

Recently, Major and O'Brien (2005, p. 395) stated that the stigma that stems from mental health problems could be defined as, "relationship- and context-specific and that it does not reside in the person but in the social context". Social stigma is the dimension that attracts the most attention. Thornicroft, Brohan, Kassam, and Lewis-Holmes (2008), therefore, believe that encounters with those who experience mental health problems are the best way to challenge stigma and prevailing negative attitudes.

The general outlook of the population in the UK towards those with mental health problems seems to be more positive, as they become less afraid of and more congenial to those with mental health problems. Nevertheless, surveys polling the general population in England on their attitudes to those with mental health problems found that one person in every eight would not wish to reside next to someone with a history of mental health problems (Doherty, Moran, & Kartalova-O'Doherty, 2008). In addition, research by Moffitt *et al.* (2014) revealed that one fifth of the population thinks those with a background of mental health problems should not occupy public office - down 2% from 2009 - although 36% feel that those with mental health problems may be more disposed to violence - up 7% from 2003. Furthermore, 57% feel that those with mental health problems should be in psychiatric institutions (up 5% from 2009);

while 48% feel that they are not accountable for their behaviour (up 3% from 2009). 34% of people disagree with the statement that people 'have nothing to fear' from those accessing mental health services near to their home, but 84% believe those experiencing mental health problems should not be forcefully removed from their local community. In addition, more striking figures are that 74% of people believe that women who have been hospitalised for mental health problems cannot be trusted to perform child-minding duties, while 66% disagree with the idea that there should be a decrease in emphasis on shielding the general population from those with mental health problems. Furthermore, 41% of people still believe that those with mental health problems are as dangerous as people think them to be, while only 75% believe they should have equal job opportunities compared with others, although this figure is up by 9% since 2008. Additionally, only 15% think that mental health problems are the result of low willpower or self-discipline, which is statistically down 3% from 2009. On the other hand, the public in Eastern countries, such as in Egypt, Turkey, Syria, Palestine, and Lebanon, appear to uphold the stigma toward people living with mental health problems (Ciftci *et al*., 2013). Indeed, the background of culture, society and family setup can lead to different stigma related to mental health problems. In the Arabic culture, the family is the key social unit in relation to the impact on mental advancement, illness behaviour or patterns, and health management for members of that family (Okasha, 2003). Furthermore, a typical Arab family controls the lives of healthy individuals, as well as those living with mental health problems.

In most Arab countries, looking after people with mental health problems is primarily the family's duty (Okasha, 2003). Research findings indicate that stigma towards people with mental health problems is prevalent among most people in the US (Corrigan *et al.,* 2006), as well as in other countries in Western Europe (Ng, 1997). What is more, it is not only nascent people who have stigmatising attitudes towards people with mental health problems but also knowledgeable professionals working in much of mental health areas (Keane, 1990). By contrast, countries in Asia and Africa do not display such strong stigmatising attitudes toward people with mental health problems (Ng, 1997). These disparate results clearly call for more in-depth analyses of mental health problems concepts, experiences and attitudes across cultures. In some cultures, mental health problems are viewed as an obstacle or retribution from heaven, due to Rassool (2000). Despite the view that there are currently social changes happening to outlooks and behaviour towards people with mental health problems, many Arab families remain affected by stringent cultural beliefs and social norms. Most often, stigma due to mental health problems can have a significant effect on a woman's ability to find a partner and get married.

Thus, professional help is not always sought, even though mental health issues exist and can get worse without assistance (Okasha, 2003). Families are concerned that women with mental health problems (whether daughter, wife or sister) will bring 'a stain' upon their family name (Okasha, 2003), and this represents a major reason why women have more stigma attached to seeking a mental health professional's help, compared to men, and why more men are signed into the hospital (Dalky, 2012). There is often the social stigma attached to members of Arab families who go into hospital for mental health problems and can lead to rejection, non-marriage, or divorce (Dalky, 2012). In Great Britain, females are significant more likely 29% to have received treatment for mental health problems than males 17% (Leslie & Cerin, 2008).

A study by Marrow and Luhrmann (2012), where the psychiatric care provided by mental health professionals in America and India were considered, highlighted this well. The results showed major similarities with diverse outcomes. In both cases, the importance placed on the family and its acceptance within society, matched with ethical considerations, ease of approaches to health care, and social acquiescence of care institutions, led American families to simply throw their people with mental health problems out of the house or, if they were lucky, send them to a care home, while Indian families concealed them at home and cared for them personally.

Moreover, this is a factor that appears prevalent in Turkish care homes. Gary (2005) noted that, whilst working in psychiatric services in Turkey, one family felt so ashamed to have family members with mental health problems, it led them to refuse to bring the child outside of their house, with the father blaming his partner for their child's illness; this was not an isolated incident. However, there was a more positive response from people in such instances when they involved their extended families and spiritual leaders. Furthermore, discriminatory behaviour can permeate public opinion regarding the treatment of individuals with people with mental health problems (Gary, 2005). Hence, individuals living with mental health problems can attract stigma due to behaviour that accompanies illness, such as anxiety and tension, or impaired social skills (Socall & Holtgraves, 1992). What is more, individuals exhibiting irregular or aberrant behaviour are typically more stigmatised than those who do not display such behaviour (Corrigan & Penn, 1999).

Self- Stigma

Crocker (1999) explained how individuals might internalise their perceptions and opinions of their characteristics, often being influenced by the views of society, thus resulting in a self-stigma. This continuous cycle links self-stigma with social stigma, which creates personal feelings of guilt, inadequacy and embarrassment of one's mental health problems (Corrigan, 2004). Consequently, reduced self-esteem, social isolation and anguish are the direct outcomes of stigma. Additionally, a close correlation was found between stigma-related low self-esteem and social inadequacy (Sirey *et al.,* 2001). However, personal self-esteem is not always affected by such stigma, if the individual has suitable coping mechanisms in place (Vogel, Wade, & Haake, 2006). This can be seen in the study by Vauth, Kleim, Wirtz and Corrigan (2007), which found that one's susceptibility to depression when dealing with stress, was lesser in participants with more complex personalities. This is supported by Vogel *et al.* (2006, p.325) who stated, "Since people's self-conceptions are closely connected to their psychological states, stress that damages or threaten self-concepts are likely to lead to emotional problems". One paradox of self-stigma is that individuals can experience low self-esteem on the one hand, and righteous anger on the other (Corrigan & Watson, 2002).

Therefore, models of self-stigma will also reflect the impact of social stigma on an individual's self-esteem, as well as the negative reactions of individuals to this. To explain this paradox, a situational model is posited, which maintains that whether a person suffering from mental health problems has a low self-esteem or feels righteous anger or is indifferent, all depends on the context (Ahmedani, 2011). Other theories have advanced the understanding of self-stigma. For instance, the modified labelling theory holds that the factors affecting psychosocial well-being include the expectations of becoming stigmatised and being stigmatised (Corrigan, 2004). Consequently, the primary factor resulting in the feeling of being discriminated against is a person's alarm that they may be labelled as something that society does not think to be acceptable. A person's emotions are likely to be evoked when stigmatised against; this can result in feelings of anguish, loneliness and even rage (Corrigan *et al*., 2006).

Health Professional Stigma

As was noted in the previous section, there has not been an extensive amount of research on the topic of stigma demonstrated by professionals of mental health care toward people with mental health problems (Ahmedani, 2011). However, there is some recent literature that suggests there is a growing trend of discrimination from mental health care workers towards

people with mental health problems. For example, such individuals could apply their own personal experiences or upbringings to their work, which are reflected in how they perceive and behave towards people with mental health problems (Acker & Lawrence, 2009). Thus, mental health professionals can personally influence their own behaviour and thoughts in terms of stigma towards people living with mental health problems in a professional capacity.

Due to Ahmedani (2011) noted the way a person is raised will greatly determine their prejudices and whether he or she goes on to be a social worker or to pursue some other profession; furthermore, it is suggested that such a person may even develop these prejudices through working with extreme cases of people with mental health problems, this can serve to increase the stigma held by professionals attached to people with these issues. For example, almost three-quarters of UK doctors 73% wouldn't look for professional help for mental health problems, with 33% citing the possible effect it might have on career prospects; 30% referring to the effect on their professional standing; and 20% relating it to the stigma attached to those with mental health problems (Hassan, Ahmed, White, & Galbraith, 2009). The likelihood that social workers and health professionals may hold a stigmatising attitude against their patients, particularly those who are confronted with significant barriers to treatment, appears to be low (Lyons, Hopley, & Horrocks, 2009).

Ultimately, the way an individual response to a person with mental health problems is what determines the existence or absence of stigma (Siebert, 2004). As stated by Wahl and Aroesty (2010), there are many of the reasons why acquiring an understanding of how health professionals perceive the person is significant. The negative attitude held by some mental health professionals, and their associated behaviour towards people living with mental health problems, can be portrayed as stigmatisation on the part of the mental health profession. Hence, several studies have shown there is minimal difference between the behaviour of psychiatrists and members of the public regarding these matters (Ruiz & Miller, 2004; Lauber *et al.,* 2006). It has been suggested that it is common for health care experts to hold prejudiced opinions on those with mental health problems, and to act on them after they find out that a patient is a part of this category (Thornicroft *et al*., 2008).

It could be suggested that, if patients encounter stigma within their communications with experts (who have a duty to be supportive, and sensitive), they are then at risk of experiencing increased stigma from the general community, which does not have the same duty of care. The actions of health care experts are very important because most literature points to the notion that treating those people with mental health problems sensitively and listening to their opinions plays a huge part in their prompt recovery (Lyons *et al.,* 2009).

Diagnosis

Individuals suffering from mental health problems often choose not to seek treatment, as they are afraid of the ramifications of a diagnosis (Corrigan *et al*., 2006). Not only do Jackson and Heatherington (2006) write that people with schizophrenia experience more stigma than those diagnosed with depression, but individuals with mental health problems, particularly schizophrenia, have access to a fewer work, housing, or socialising opportunities due to stigma (Corrigan & Pen, 1999). In addition, researchers have shown how damaging labels of people with mental health problems can be as, even in the absence of abnormal behaviour, they undoubtedly lead to stigmatisation (Yang *et al*., 2007). The concept of label avoidance is defined as the active evasion of mental health provisions, on the part of patients, not to get labelled or stereotyped in a negative manner (Corrigan, 2011). Thus, to evade negative stereotypes, people with mental health problems often decide not to seek the necessary mental health care; this can lead to people with mental health problems not being diagnosed in a safe and medically acceptable way (Erickson & Al-Timimi, 2001).

Barriers to Help-Seeking Behaviours

Awareness of the problems surrounding stigma associated with mental health problems is crucial in the prevention, early diagnosis and effective treatment of mental health problems (Angermeyer & Matschinger, 2003; Gostin & Gable, 2004). The stigma and discrimination experienced by individuals who have mental health problems and their families are intense and pervasive (Corrigan *et al.,* 2000). The World Health Organization (2001, p. 12) emphasises the negative effects of stigmatisation on family life, social networks and employment, which creates "a vicious cycle of alienation and discrimination which can lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalisation". People living with mental health problems are one of the most excluded groups in society often suffering rejection, isolation and depression (Schomerus & Angermeyer, 2008). The issues of stigma prevent many people from living normal lives and deter them from seeking help when they need it, reducing the chances of recovery (Angermeyer & Matschinger, 2003). In fact, the problem of stigma is felt very acutely across the entire mental health system (Gostin & Gable, 2004).

This is particularly felt by patients of the services, who see stigma as an obstacle to their requesting support in the first place (Schomerus & Angermeyer, 2008). In the USA, almost two-thirds of individuals living with mental health problems avoid seeking treatment (Corrigan

& Penn, 1999). It can be argued that one reason that individuals choose not to apply for treatment is the socially- and professionally- held stigma associated with people who are receiving such treatment (Cooper *et al.,* 1997). In addition to this, another reason why individuals avoid specialist care is poor knowledge of the symptoms of mental health problems (Corrigan & Penn, 1999).

Barriers to Work Opportunities

Due to Angermeyer and Matschinger (2003), stigmatised individuals usually have access to fewer work opportunities. In addition, due to World Health Organization (2001), a national survey was carried out to investigate the obstacles to employment faced by individuals with serious mental health problems. The results indicated that such individuals were the target of discrimination and prejudice in the workplace, and thus they could not advance professionally or personally. Furthermore, seven out of ten declared that awareness of their mental health problems made others downgrade their competency. Due to the problems confronting them, three out of four respondents admitted to keeping their mental health problems secret from anyone not in their immediate family. For example, in New York City, three-quarters did not disclose their psychiatric history in job applications (Wahl, 1999).

The experience of individuals with serious mental health problems who constituted the focus of the survey is shared to a certain extent by individuals with less serious mental problems, who are also apprehensive about making their problems known to people in the workplace. For example, due to Wright, Gronfein and Owens (2000) and Kessler *et al*. (2001) and the WHO (2001), African Americans in many societies make up less than 40% of those people living with mental health problems overall, yet these individuals often experience conflict with employers or landlords, and often become distant or hostile towards friends. Another piece of research in London by Shepherd, Boardman and Slade (2008) also revealed that employment levels for those with mental health problems are lower than for those with other disabilities, despite being more desirous of having paid employment. Almost 90% of people with mental health problems state they want employment, which contrasts with just over half 52% of those with other disabilities. Additionally, only 21% of those with mental health problems are employed versus 47% of those, not with mentally health problems. Moreover, research in the UK by Clayton *et al.* (2011) found that those with extensive mental health conditions are even less likely to be employed and that this figure has dropped over the last 40 years. Fewer than 40% of employers would entertain the idea of employing those with

mental health problems or background of these, as opposed to 60% for those with physical disabilities (Morgan *et al.,* 2007).

Separately, a study by Adbowale *et al.* (2014) found that 59% of workers in the UK reported that they would find it disagreeable to have to discuss their mental health problems with a supervisor, with only 9% feeling comfortable with this, and only 24% feeling tolerably comfortable about it. The primary reasons for their reticence were consequences for their employment 26%, 19% citing the attitudes of co-workers, 18% that the supervisor might think them 'mad' or a negative impact on job prospects, such as promotion 16%. The study by Adbowale *et al.* (2014) also revealed that 92% of the UK population think that knowledge of a person's mental health problems could have a negative effect on job prospects. Those believed to be impacted the most were: doctors 56%; members of the emergency services 54%; while 48% named teachers. Meanwhile, only 21% thought that these circumstances would affect the job of a Member of Parliament. In addition, due to Glenn and Coleman (2009) and Adbowale *et al.* (2014), perhaps revealingly, 56% of the general population would be put off hiring someone if they revealed a background of depression even if they were best suited to the role. The reasons cited include potential unreliability 17%, the negative reaction of co-workers or incapability of the staff member 15%, or that they might be found responsible if the person was off work 10%. Moreover, as asserted by Ahmedani (2011), these individuals often neglect their personal care and physical health. The cause of such trends is possibly related to the social stereotypes associated with mental health problems and by challenging these stereotypes (Kessler *et al.,* 2001).

Families

Alongside individuals with mental health problems, their families can also suffer from stigmatisation. Due to Angermeyer and Matschinger (2003), the negative attitudes held toward people with mental health problems also affects their family, friends and the mental health care professionals who must endure this stigma. Mental Health is one of the most pervasive challenges to the development of effective and comprehensive health care in modern-day society (Dinos, Stevens, Serfaty, Weich, & King, 2004). Dalky (2012) found that the average Arab family unit believed that looking after a family member with mental health problems could potentially bring about disgrace for their family name, as well as inspire fear, embarrassment and another social stigma. In addition, it was found that loneliness; shame and a feeling of seclusion were commonly found throughout Jordan and Morocco.

It is important to note that culture and associated outlooks impact how family members handle these situations and their capacity to look after family members with mental health problems. When mental health problems are uncovered, there is a related stigma, which impacts all family members. In particular, the stigma of being found to have mental health problems impacts the person's recovery through their hospital care system (Veltman *et al.,* 2002), as well as the quality of life for those with mental health problems and their families, within their own communities (Shibre *et al.,* 2001; Ostman & Kjellin, 2002; Yang *et al.,* 2007; Dalky, 2012).

Furthermore, Goffman (1963, p. 248) has stated that this effect is "courtesy stigma" or "stigma-by-association," as it impacts all areas have that person's life and all people somehow related to them. For the families of people with mental health problems, courtesy stigma can bring about anxiety, poor family esteem, humiliation, shame, seclusion, bitterness, doubt, and hopelessness (Ostman & Kjellin, 2002; Veltman *et al*., 2002). In addition, families are sometimes held at fault for their members' mental health problems and are chastised for harbouring individuals who could be unstable or uncontrollable (Okasha, 2003; Corrigan *et al.,* 2006). Nonetheless, there are limited research papers that have investigated the outlooks of families looking after people with mental health problems in Saudi Arabia. Whereas a descriptive, epidemiologic study by Kadri, Manoudi, Berrada and Moussaoui (2004) was conducted on Moroccan families and examined 100 family members of relatives living with schizophrenia issue. It was shown that 86.7% of family members stated that their lives were difficult, and 72% said they had psychological trauma and low quality of life (Kadri *et al.,* 2004). It was also shown that male relatives were inducted into hospital more often than females (Dalky, 2012). The possibility of being rejected (in or out of marriage conditions) was a key worry for families and a major reason why they attempted to hide female family members' mental health problems and not look for outside care (Dalky, 2012). In line with other cultures, Moroccan families try to find assistance from spiritual or homoeopathic healers, based on the idea that evil spirits were somehow bringing about the mental health problems. Indeed, this idea is widespread in most of the Arab world (Okasha, 2003).

In addition, there have been minimal efforts in Arab nations to define the stigma of mental health problems and there appear to be no research papers that investigate this phenomenon and its effects on the people with mental health problems and those close to them. The stigma associated with looking for health care and professional assistance is such that families avoid the issue to lower the possibility of being disgraced (Franz *et al.,* 2010) or seen as not being respectable, which can mean they have cast aside (Chang & Horrocks, 2006).

Many families examined felt disgrace and humiliation due to their members' unsociable actions (Chang & Horrocks, 2006); felt lonely in their position as careers, and described feeling responsible for their relative's mental ailments (Veltman *et al.,* 2002). It was a rare occurrence that families felt the positive sides of caring for their relatives, such as love, empathy and undergoing personal development (Veltman *et al.,* 2002; Chang & Horrocks, 2006).

Religion

Many studies focus on the relationship between the cultural stigma and people with mental health problems (Stolley & Koenig, 1997; Lopez, 2005; Padela *et al.,* 2012). A dissension has arisen between the cultural and religious aspects of society in Saudi Arabia. As demonstrated by the attitudes of certain Muslims with respect to people living with mental health problems, the viewpoints of some members of Saudi Arabian society reveal the influence of Islam in generating stigma. This stigma, however, cannot be attributed entirely to the influence of Islam, but also arises from the upbringing and cultural environment in which members of Saudi society are positioned. Cultural and religious beliefs can frequently be influential in relation to the conceptualisation of mental health problems, and consequently inform attitudes towards people with mental health problems (Hogg & Holland, 2010).

As well as being influential with respect to the extent to which individuals living with mental health problems experience social stigma, beliefs about mental health problems can be of influence in determining such individuals' attitudes towards seeking help and complying with prescribed remedial therapies and medication (Nieuwsma, Pepper, Maack, & Birgenheir, 2011). In consequence of this, it is important that personal and cultural attitudes to mental health problems are fully understood if approaches to mental health care are to be beneficial (Hogg & Holland, 2010). In the context of how health professionals treat people with mental health problems, this study evaluates the degree to which the mental health care team are either distinct from society or an integral part of it. Hence, given that Islam underpins all cultural, legal, and religious aspects of its society, Saudi Arabia was selected as the country of interest for the study. The Islamic faith, with its prevalent influence on the lives of Saudi citizens, affects the associations that health care professionals have with the patients in their care. For example, within Islam and Islamic cultures, the concept and belief in 'kader'—that is; fate—is great (Nabolsi & Carson, 2011). Though 'kadar' can result in a fatalistic conviction in some people, it may also constitute a useful, optimistic recognition and submission to the will of Allah (God), as well as more transcendent and positively-oriented perspectives regarding

convalescence (Nabolsi & Carson, 2011). For instance, the issue of people with mental health problems is an opportunity to address or alleviate broken dialogue and reconnect with Allah (God), as well as remedy an absence of belief with frequent praying and self-accountability (Padela *et al.,* 2012).

The historical spiritualistic leaders of the Islamic community, the Imams, are perceived to be circumlocutory representatives of the will of God, as well as actors within convalescence (Abu-Ras, Gheith, & Cournos, 2008). These men may also form a vital part in determining familial and community opinions and attitudes regarding ailments and sickness (Padela *et al.,* 2012). Apart from people with mental health problems, other conditions attract stigma; however, no physical condition elicits such strong attitudes as mental health problems (Corrigan *et al*., 2000; Nabolsi & Carson, 2011). The reason for this attitude is that people believe that those with mental health problems, unlike individuals with disabilities, have control over their condition, and thus, they are to blame for its occurrence (Corrigan, 2000). In addition, some people do not feel sorry for individuals with mental health problems in Islamic countries, but instead, they are indignant deeming these individuals as not being worthy of help (Nabolsi & Carson, 2011). Stigma engenders discriminatory behaviour, which can manifest as a refusal to help, shunning, intimidation, or isolation in psychiatric institutions. Research revealed that stigma stops people from helping individuals with mental health problems (Martin, Pescosolido, & Tuch, 2000; Nabolsi & Carson, 2011). What is interesting is that in the UK, the Department of Health has facilitated sensitivity to the religious and cultural beliefs of people with mental health problems and their families, and have taken care to ensure that relevant procedures are established that apply at all levels and within all functions throughout the NHS and its ancillary community-based services (Department of Health, 1996; Hogg & Holland, 2010).

Media

Pirkis and Francis (2012) note that the stigma experienced by people with mental health problems results from many of different factors, including inappropriate information (ignorance), attitudes (prejudice) and behaviour (discrimination). Hence, stigma can be defined as an attitude, which is reflected in discriminatory behaviour. Consequently, the conclusion reached by a range of studies is that the public derives most of their information on people with mental health problems from the media (Coverdale *et al.,* 2002). In New Zealand, stigma can also arise from the media's portrayal of individuals living with mental health problems.

The representation of people with mental health problems in print media reveals significantly high levels of negative portrayal, particularly in terms of danger to others 61.3% and criminality 47.3%. By contrast, the proportion of positive representations, such as human rights themes, leadership, and academic achievements, was much lower 27% (Coverdale *et al*., 2002). Due to Parle (2011), however, findings suggest that public opinion of mental health services differs from the experiences of those who have experienced them. In studies analysing the subject, service users reported that they had encountered several stigmatising opinions and actions across several elements of their lives. Several individuals in England thought they were stigmatised from the moment that they had been diagnosed with mental illness, and subsequently put this down to the media's portrayal of their illness (Dinos *et al.,* 2004). Read, Haslam, Sayce, and Davies (2006) found that 77% of UK adults do not think that the media sufficiently informs the population about mental health problems. Almost 40% of those reading mainstream papers state that these are responsible for their ideas regarding a correlation between violence and mental health, while one in six experiencing mental health problems stated that the media had deterred them or others around them from approaching professionals for treatment (Henderson & Thornicroft, 2009).

Additionally, in the UK, research by Irvine (2011) revealed that those with mental health problems are often not consulted directly in regards to articles on mental health issues, with one project on the subject only finding quotations in 6% of media pieces. Irvine also determined that the most information about mental health came from the criminal justice domain, while 15% of articles referenced the risk of violence from those with mental health problems and indicated that these levels were significant. It was evident that the greatest acceptance of mental health was from people that had met someone with these issues, and that these people were less inclined to trust the media and its portrayal of mental health and violence (Irvine, 2011).

Conclusion

This chapter has provided an overview of some studies relevant to the proposed research that are discussed above and clearly point to the stigma toward people living with mental health problems with respect to the subjectivisms of professional experience of a mental health team. Thus, the competence of health professionals to manage individuals living with mental health problems should be assessed, not only in terms of their skills and training but also in terms of other factors that may not be so apparent.

Therefore, this study has considered that nationality, religion, and cultural values are factors affecting stigma towards people with mental health problems as well as the relationships between health professionals and patients. In addition, this chapter has provided an overview of the professional attitudes, opinions, and beliefs that influence and impact levels of stigma throughout wider communities and toward people living with mental health problems. Stuart (2005) points out that the professional stigma created towards people living with mental health problems not only directly affects them through the way others interact with them but also influences their lives indirectly, causing certain discrimination. These studies can be viewed as a starting point for future research in this area in Saudi Arabia, as it was conducted in different countries, where this study also took place. This study's methodologies, which also include the research design, study settings and participant recruitment, will be discussed in the following chapter.

CHAPTER 3: METHODOLOGY AND RESEARCH DESIGN

Overview

This chapter will discuss both the methodological and research approaches employed within the present study. The discussion will begin by considering the research paradigms, and their influence upon both the quantitative and qualitative methodologies used. It also delineates the theoretical paradigms. This will be followed by a justification of the utilisation of the 'phenomenological' approach and its place within the research paradigms and methodologies. Finally, the research processes used in the study will be reviewed, focusing on the application of 'phenomenology' for data collection. Data analysis and a detailed discussion of the components of the research processes are outlined, which include: research procedures, study design, the sampling plan chosen with ethical considerations. Emphasis was placed on the design of the scales, with the pilot study testing its reliability and validity. The following processes were employed to facilitate mix-method data collection: recruitment of participants, data collection tools, demographic data, rationale and strategies for analysing the data and data protection issues.

Methodology and Design

Research paradigms and philosophy

Research paradigms and philosophies are significant influences upon research methodologies. Indeed, it is important to explore them to select and use the appropriate research design and data collection strategies. Due to Clark, Huddleston-Casas, Churchill, Green and Garrett (2008, p. 1543), "a research paradigm is a perspective based on a set of shared assumptions, values, concepts, and practices". Furthermore, Clark *et al.* (2008) defined a paradigm as the function of how the researcher considers the development and nature of knowledge. Additionally, a research paradigm is a combination of two ideas that are related to the nature of the world, as well as to the function of the research (Clark *et al.,* 2008). Willis, Jost and Nilakanta (2007, p. 110) explain that the term 'research paradigm' refers to an overall perception regarding the intricacies of the real world. In research, interpretivism and positivism represent the two main opposing paradigms in regards to the real world, which are used by researchers to gather proof for their hypotheses (Clark *et al.,* 2008). In addition, both the qualitative and the quantitative methodological approaches are said to be complimentary (Jack & Raturi, 2006).

The predominant focus of this study is the quantitative and qualitative frameworks, which are both vital for the capture of data on the topic of professional stigma. This dual approach means that perspectives on clinical insight and scientific investigation are covered (Guba & Lincoln, 1994). Due to Bryman (2006), a mixed-method approach involves the combination of quantitative and qualitative data being collected and analysed accordingly. This approach was adopted, as the researcher believes that using the techniques and methods from both approaches would most appropriately facilitate the investigation of my original research aims and objectives. In addition, checks on scientific investigation should always be evaluated in terms of their practicality and validity, because clinical models can be sensitive (Link *et al.,* 2004; Lucas, 2014). "Selecting the correct methodological techniques plays a crucial role in the research, as the methodologies define the type of data collected, which in turn influences the results and the interpretation of the nature of the research problem" (Johnson & Onwuegbuzie, 2004, p. 26).

There are different methods for obtaining data under quantitative and qualitative research. Quantitative research involves an objective formal approach, with numerical data findings, and the most common methods of data collection being questionnaire-based surveys, observation, documentary methods, and experiments (Johnson & Onwuegbuzie, 2004). Notwithstanding, the quantitative and qualitative models are differentiated by separate philosophies, and the findings suggest that the data elicited by the qualitative approach involved more proximity between subject and researcher mediated by observation and interviewing techniques, while the quantitative researchers may have relied on more remote, indirect methods of arriving at data (Morrow, 2007).

In a quantitative approach, quantitative methods involve the collection of impartial measurable data through assessments, polls or questionnaires followed by its numerical or statistical analysis, or the reanalysis of already obtainable data by computational techniques. Quantitative research focuses on gathering statistical data and on examining its pattern across groups of people or other variables, with the goal of exploring the specific phenomena and understanding observed events and trends (Rubin & Babbie, 2016). In quantitative approaches, the positivism paradigm necessarily implies a numerical paradigm (Jack & Raturi, 2006). Positivism is predicated on the notion that societal actors respond to exogenous triggers and motivators, and social phenomena must necessarily be observed and interpreted based on the empirical enquiry by applying the deductive method (Johnson & Onwuegbuzie, 2004). Positivism posits that reality is natural, objective, recordable and capable of being reduced to testable propositions (Johnson & Onwuegbuzie, 2004).

In this perspective, the purpose of an analytical enquiry is to understand events, and their interrelatedness, so that societal law may be discerned and recorded and converted to tools for forecasting future probabilities (Morrow, 2007). Positivism is a whole and indivisible reality, which is apprehended and recorded through the filter of sensory perception (Jack & Raturi, 2006). Through this process, the observations recorded by social scientists were deemed 'things', equated to concrete phenomena, which separated the observer from the object the subject of the observation, a technique which facilitates the preservation of impartiality (Johnson & Onwuegbuzie, 2004) Likewise, quantitative researchers apply deductive reasoning to observed phenomena, and through objectivity the researcher can substantiate causality of events commensurate to the theory and produce predictive data related to the research study objectives (Johnson & Onwuegbuzie, 2004).

In a qualitative approach, the interpretivism paradigm necessarily implies a non-numerical narratives paradigm (Jack & Raturi, 2006). It is in direct opposition to positivism and provides a tool for criticism of positivist ideology (Jack & Raturi, 2006). Exponents of interpretivism, by contrast to positivists, do not adhere to the idea of one reality that is both real and recordable. Instead, interpretivism believes in the existence of multiple realities, which may not only be dissimilar but may change per time and location (McEvoy & Richards, 2003). To identify the goal of research methodology from the interpretive perspective, one must go beyond the interpretive approach by developing "explanations of why things happen in a specific way in phenomena" (Jack & Raturi, 2006, p. 345). This is attributable to the fact that reality is a matter of subjective experience and perception, which is also subjectively interpreted by such a society. As a subjective interpretation, reality is nothing more than how people interpret it. From the perspective of interpretivism, it is human beings who are best placed to interpret their social world, since reality is a mere subjective projection, which colours how such human beings perceive and interpret the social interactions taking place (Jack & Raturi, 2006).

Therefore, interpretivism emphasises that the aim of social studies is not to study supposed inherent laws of society, but rather to understand the frameworks of meanings that members of society use to understand the society in which they live. Qualitative research examines the subject's experiences of phenomena, and the role of the researcher in a qualitative study highlights the collaborative process of knowledge production within the research field. The qualitative researcher acknowledges their own position as part of the research, eliciting knowledge of lived phenomena through experience and meaning making attributed by their participants. Qualitative researchers seek to negate the limitations of experimenter bias through

reporting the participant's experience from their individual understanding (Bradley, Curry, & Devers, 2007).

Relationship between paradigms and methodology

The mixed method approach, together with the qualitative and quantitative approaches, is a key research methodology. Andrew and Halcomb (2009) believe "mixed method" is a third major methodological approach, offering something other than entirely quantitative or qualitative practices. Tashakkori and Creswell (2007, p. 303) have stated that mixed methods are "research in which the investigator collects data and integrates the findings and draws inferences using both qualitative and quantitative approaches or methods in a single study of inquiry". Mixed methods research combines elements of qualitative and quantitative research approaches for the broad purpose of increasing the depth of understanding. The definition of mixed methods, from the first issue of the Journal of Mixed Methods Research, is "research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry" (Tashakkori & Creswell, 2007, p. 303). Mixed method research started in anthropologist and sociologist circles from the 1960s, and in the next two decades, "triangulation" started to be mentioned in methodology discussions (Morse, 1991).

Triangulation refers to the combination of methodologies used in a study of the same phenomenon to reduce the level of inherent bias presented using a single method (Morse, 199; Creswell, 2013). In addition, this allows for both the common elements and the differences to be found, triangulated and theories created thus (Creswell, 2013). Wahab *et al.* (2012, p. 617) state "that triangulation, under the context of social science, consists of two or more theories or approaches in one research study of a specific phenomenon to help reach the desired construct". This way, research questions can be addressed, establishing trustworthiness and wider applicability to the research (Wahab *et al.,* 2012).

Another possible benefit of using mixed methods is that the research can gain credibility since the qualitative approach offers detailed reasoning compared to a quantitative study through the depth of meaning to numbers with the use of narrative and dialogue (Mackenzie & Knipe, 2006). It has been mentioned already that 'paradigm' in this paper is used for the philosophical aim or foundational theoretical framework and reason for the researcher to undertake the study at hand. Data collection methods can be used in conjunction, and a researcher most often falls in line, philosophically, with an existing paradigm, which is built

from different aspects, and aim to create unique results (Wiersma, 2000). Due to Mackenzie and Knipe (2006, p. 193), a "researcher's theoretical orientation has implications for every decision made in the research process, including the choice of method". This philosophical debate "left educational research divided between two competing methods: the empirical scientific tradition, and the naturalistic phenomenological mode" (Mackenzie & Knipe, 2006, p. 205).

In modern times, research methodologies are more complicated from a design aspect and can be more openly involve the necessary methods, with mixed-methods becoming more widely used. The mixed-methods approach allows for numeric as well as text data to be collected, and so the end database includes both quantitative and qualitative findings (Creswell, 2003, p. 20). Symonds and Gorard (2010, p. 121), stated that combined or mixed-methods research are found to be a "key element in the improvement of social science, including education research" (p.7) with research strengthened using a variety of methods. Symonds and Gorard (2010) argues that mixed method research "requires a greater level of skill" (p. 7), "can lead to less waste of potentially useful information" (p. 7), "creates researchers with an increased ability to make appropriate criticisms of all types of research" (p. 7) and often has greater impact, because figures can be very persuasive to policy-makers, while stories can be recalled easily and repeated when trying to illustrate a point (p. 7). Numerous experts, such as Creswell *et al*. (2003), and Thomas (2003) consider qualitative and quantitative approaches to be mutually beneficial when selecting suitable investigation approaches. Paradigms, which are largely in favour of mixed methods approaches, give an opportunity for the question to establish the data collection and analysis methods used, gathering quantitative as well as qualitative data and integrating the data at various parts of the inquiry (Creswell, 2003; 2013).

Philosophical underpinning for the mixed methods approach

Mixed methods research methodologies are growing in popularity for nursing research aiming to increase understanding of nursing phenomena (Polit & Beck, 2008). In this regard, the quantitative and qualitative paradigms represent different philosophical approaches to, and views on, scientific investigation (Morrow, 2007). "A quantitative study is based on the concepts of manipulation and control of phenomenon and the verification of results, using empirical data gathered through the sense; conversely, qualitative research is concerned with gaining insight and understanding into an individual's perception of events" (Nieswiadomy *et al.,* 2012, p. 1959).

In logical investigations into the phenomenology, Kafle (2013) points out that, in the context of research, phenomenology describes the study of phenomena: their structure and meanings. Methodologies of a phenomenological nature are especially efficacious in highlighting people's experiences, sentiments and viewpoints, and thus, bring into question extant normative presumptions and commonly held opinions. They are primarily concerned with how reality is viewed through the prism of experience or how it is altered in consciousness, as the aim of the phenomenological researcher is to provide a vivid rendition of lived experience. Dowling (2004) and Langdridge (2007, p. 4) refer to phenomenology as a branch of philosophy that seeks to concentrate on individuals' perceptions of the world and what they represent to them; a focus on people's "lived experience".

Describing it as a qualitative method; Langdridge notes that "phenomenology focuses on human consciousness", as it relates to the meaning and the way meaning is mediated through experience. Even though phenomenology can be defined as the philosophical study of the structures of experience and consciousness, the movement's thoughts have relevance beyond philosophy and have made a valuable contribution to other academic fields: phenomenological traditions can be found in the disciplines of psychology and psychiatry for example (Cohen, Kahn, & Steeves, 2000). Indeed, within the nursing research field, phenomenology and phenomenological practice are becoming increasingly common (Annells, 1996). Nevertheless, nursing literature is starting to mirror concerns regarding researchers' use of phenomenological approaches, while simultaneously neglecting the philosophical foundations of phenomenology itself (Cohen *et al., 2000*). When phenomenological research is augmented with an interpretive element, it may then be employed as a foundation for practical theory, thereby allowing its utilisation in education, substantiation or the questioning of existing activities or policies in the future (Stanley & Wise, 2002).

Throughout this study, the idea that lies at the foundation of Heidegger's philosophy, which relates to interpretive phenomenology "Hermeneutic phenomenology", shall be expounded and assessed regarding the methodological understandings they facilitate in the process of being employed for phenomenological research (Heidegger 1992, p. 15-16). Heidegger (1889-1976) has reinvigorated the concept of phenomenology by shifting the emphasis away from consciousness and essence to a new accent on its existential and hermeneutic (interpretive) facets (Kafle, 2013). Moreover, other explanations of hermeneutic philosophy are provided by Zahavi (1996, p. 245), and the emphasis on interpretation is based on the traditional hermeneutic philosophy that unifies understanding by "language-critical thinking", within

"textual meaning," "dialogue," "preunderstanding," and "tradition"; an approach that determines that any objective experience involves some degree of interpretation. It is significant that the methodological process chosen for development of the nursing field is defendable, and that it is seen to be in line with the philosophical timbre of the research in question, as well as the research aim (Annells, 1996; Dowling, 2004). Martin Heidegger claims that human beings cannot be understood except as existing within the day-to-day physical world in which we are empirically and pragmatically embedded (Heidegger 1988, p. 18). Heidegger refers to this as 'Dasein' that is 'Being-in-the-world' (Tracy, 2010, p. 837-838; Kafle, 2013). Heidegger's view makes the key point that the relationship between people and their environment is essentially active; he claims that we are not passive spectators of our surroundings and that the environment is not merely a collection of objects surrounding us; both these elements are defined by their relationship to each other, creating thus a web of functionality (Heidegger 1988; Willis *et al.,* 2007).

Furthermore, Heidegger (1992) argues that the way humans interpret experiences is affected by five key elements, including how we exist as part of a social reality – 'life world'; the objects that are of value to us and how our ability to self-interpret allows us to realise that we physically exist at specific points in time (Kafle, 2013). When conducting interpretive phenomenological analysis, one begins by examining every transcript and identifying a specific unit of meaning, while maintaining the autonomy or uniqueness of individual experiences. The next step is to identify any correlations between the independent units of meaning that could potentially characterise the experiences of the collective group (Willis *et al.,* 2007, p. 100).

Willis *et al.* (2007, p. 110) noted, for a preliminary introduction to the method, that it is necessary to identify a few steps. The first step in carrying out a phenomenological research project is through "selecting the phenomenon that will represent the shared experience" (Tracy, 2010, p. 837). Following the process of choosing a suitable phenomenon, the researcher may then proceed to the interview stage, and in this instance, this relates to the professional mental health team. Due to Tracy, the researchers must produce appropriate questions for the group they are interviewing (2010, p. 840). The following actions will ensure that the study progresses: querying, expanding, developing and confronting answers, as these will result in clearer output (Kapungwe *et al.,* 2010). Finally, the data should be collected (Lester, Hannon & Campbell, 2011). Further details appear in the section 'Phase Two Data Collection'. "The reliability of the research data will relate to the depth and quality of the researchers' understanding of the participants' experience" (Lester *et al*., 2011, p. 1058).

In assessing the data, the researcher must seek to locate the "universal nature of an experience" (Tong, Flemming, McInnes, Oliver, & Craig, 2012, p. 1). Data analysis includes the highlighting of "significant statements, sentences, or quotes that provide an understanding of how the participant experiences the phenomenon" (Tracy, 2010, p. 840). These steps will enable the researcher to achieve "understanding of the participant's experience" (Tong *et al.,* 2012, p. 1). It was previously explained how this study utilises a mixed-methodology design approach as it was suggested that the methodological choice should be dependent upon the nature of the real problem (Tracy, 2010). Using the techniques and methods from both approaches would most appropriately facilitate the investigation of my original research aims and objectives (Creswell, 2009).

Additionally, in this study, a mixed-methodology design was used to collect data regarding mental health professional viewpoints, and these were evaluated using thematic analysis of professional stigma. This permitted a more comprehensive and in-depth deliberation and investigation of a certain phenomenon. Self-reports and a focus group discussion "consider human, experience, preferences and tendencies, in which sentiments and views are connected to services, ideas and products that are devised", (Miles & Humberton, 2002, p. 27). The main role of the researcher within the data collection is, due to Kitzinger (1995), to persuade and motivate participating individuals to be more concerned and become included in the dialogue taking place, thereby motivating them to speak about the subject matter in question. Furthermore, the employment of a focus group within the qualitative approach increases validity, as the concepts and the conversations with participants may be substantiated, verified or disagreed with throughout the discussion stage under the interpretive paradigm (Webb & Kevern, 2001). According to Ricoeur (1991, p. 105) "Hermeneutic phenomenology marked a significant shift away from the ideas expressed by its earlier exponents". Nelson (2000, p. 150) stated, "Proceeding on the acceptability of innumerable interpretations of the phenomenology, which preclude the reduction of this school of thought seeks to penetrate the subjective experience and establish the real, objective nature of the things as sensed by the individual". At the core of Hermeneutic phenomenology is the "subjective experiences of individuals and groups", according to Willis *et al.* (2007, p. 104), while the term has been enlarged beyond the boundaries of its original meaning and now includes "understanding human action in context". It seeks to expose the universe as experienced by individuals, as it is filtered through their own narrative accounts (Collins, 1997, p. 375). Consequently, in this study, the hermeneutic model is suggested for use to interpret the findings of the research (Wilson & Hutchinson, 1991).

Similarly, hermeneutic phenomenology, which has been favoured by analysts in the context of health research, is used as a way of discerning the meaning of lived experiences **(**Heidegger 1988). Moreover, hermeneutic phenomenology is more suitable to this research's aim and objectives of subjective experiences (Willis *et al.,* 2007). In addition, the core of Hermeneutic phenomenology is the interpretive and positivist paradigms in this research philosophy, which is defined as the "subjective experiences of individuals and groups seeking to expose the universe as experienced by individuals, as it is filtered through their own narrative accounts" (Collins, 1997, p. 375; Kafle, 2013).

Moreover, a mix-method phenomenology is particularly suited to the exploration of subjective views on any given issue. With this type of phenomenology, the subject - along with their worldviews - are the primary focus. Mix-method approaches create a directory of "stigma experiences" and these real-life experiences, which are both direct and second-hand accounts, form the foundations of the data analysis (Schulze & Angermeyer, 2003). Furthermore, this approach also explains how the participants perceive these stigmas and as Kelly, Jorm and Wright (2007) further explain, it is necessary to document the differences in stigma perceptions between participants in focus group discussion.

Consequently, this concept formed the foundation of the focus group topic, and thus, stigma experiences were explored through those participants that were in the mental health profession. "A focus group discussion is commonly used as a method of qualitative research in the sociology of health and illness" (Lawton & Parker, 1999, p. 353). Moreover, focus group discussions are preferred over individual interviews, as they offer the opportunity for in-depth individual analysis without the pressure of face-to-face interaction, which some participants may seem intimidating, and in turn feel unable to express their true feelings (Morgan *et al*., 2007).

Morgan *et al.* (2007) report the purpose of a focus group is to allow the researcher to not only obtain collective views, but also the deep-rooted experiences and beliefs that underpin them. Focus group discussion also allow the researcher to obtain information from outside the participants' individual memories, with the additional participants often acting as triggers. However, the increased number of participants can increase group complexity and challenge the group dynamic, due to Kelly *et al.* (2007, p. 26), focus groups "can also provide access to social interactional dynamics that produce memories, ideologies, and practices among the group members".

This study offers the opportunity to individuals that experiencing stigma and discrimination on a regular basis to take the role of experts in the field, with their first-hand knowledge and expertise considered vital to the advancement of the theoretical discussion surrounding the topic. In addition to relieving pressure, focus group offer numerous channels for communication, which in turn provides participants with a comfortable environment in which they can share experiences, ideas and beliefs with other individuals that have experienced something similar in their lives (Schulze & Angermeyer, 2003; Morgan *et al*., 2007). Furthermore, regarding Steward and Shamdasani (2014, p. 16), "the resulting atmosphere of familiarity is beneficial in facilitating statements on difficult and unpleasant subjects such as stigma". Schulze and Angermeyer (2003) also state how group participation mitigates the interaction between the researcher and the individual participants. Due to Madriz (2000, p.835), "in this way, the dynamics within the group decrease the influence of the researcher over the interview process, and hence, provide a more prominent role to the participants' opinions". In addition, the focus group has an adverse effect on the dynamics of the setting, in a way in which makes the participant's contributions interdependent (Madriz, 2000). Schulze and Angermeyer (2003) agrees that this type of group setting is more "subdued" and is likely to incite feedback that is truly representative of the participants.

Morgan *et al*. (2007) also refer to the focus group as "group interviews", in which the mediator will invite the participants to engage one another, and interact accordingly. Nonetheless, the results obtained from the focus group are unlikely to be produced through interview and observation, and instead are more likely to outline the participants' subject knowledge. Despite their obvious similarities to a more informal interview approach, the focus group is more complex than a method of mass data collection. The focus group can be defined as a 'group discussion' on a mutual topic with a view to fulfilling a research proposition (Kelly *et al*., 2007, p. 26). Moreover, within the focus group, the discussion is guided, monitored and recorded by the researcher (Kitzinger, 1995). When considering the research objective - namely to outline real-life stigma experiences and ascertain the existence (and to what extent) of the phenomena of professional stigma - a focus group was the most logical and effective approach.

Moreover, some of the selected studies utilised mixed research methods, producing minimal significant results – providing mental health support to those in need at an early stage is essential, especially those experiencing stigma, with a mix-method approach. For example, in a literature review performed by Nordt *et al.* (2006), mixed method research methods were used including focus groups, semi-structured interviews, and self-reflection reports to determine the concept of a stigma held towards people with mental health problems, which

were measured on an attitude scale and social distance measurements. Moreover, several studies applied a mixed methodology to determine the phenomena of stigma by those who suffer from mental health problems, e.g. some studies have used mixed data collection methods when exploring possible barriers experienced by those accessing mental health support (e.g. Boyd *et al.,* 2007; Barney *et al.,* 2009). Another study carried out by Taskanen *et al.* (2011), focused on mixed method studies for those that previously requested mental health aid and experienced a stigma from mental health service professionals. Some recent studies have attempted to analyse the relationship between self and social stigma of those with mental health problems by using mix-method approach (e.g. Bathje & Prior, 2011; Masuda & Boone, 2011; Belloch *et al.,* 2009; Deen *et al*., 2011). However, these study groups are often a specific cohort rather than people worldwide with social and self-stigma (Isaacs *et al*., 2010), which could limit the findings to the groups involved. Studies that have used a mixed method approach have made it apparent that, to understand the current stigmatic views of health professionals on those with mental health problems, a more holistic approach is required. In this study necessitates a variety of investigation methods.

Research Procedures

Research design

The outline of the data collection and data analysis sections of any research study are determined within the research design. Due to Bryman (2006) a research design is valid if it is developed to create evidence that applies to a group of factors concerning a research question. To address the research questions, a methodological strategy was devised in this study using the application of a few different methods.

In this study a two-phased approach was utilised by employing a mixed-method approach to bring interpretive results together Miles and Huberman (2002) and Creswell (2009), and also use this strategy design "concurrent triangulation mixed methods design" utilized to explore the contradictory and comprehensiveness of the study findings (Miles & Huberman, 2002; Creswell, 2009). "The mixed-method approach ensures that the quantitative and qualitative methodological technique is concurrently assimilated within a single study" (Bryman, 2006, p. 113; Creswell, 2009). Consequently, the study shall capture the various processes within organisational structures, communication, dialogues and reasoning (Miles & Huberman, 2002).

Due to Tracy (2010) and Creswell (2013), a mixed-method design ensures that both the qualitative and quantitative methodological approaches assist one another, thereby creating a more comprehensive analysis regarding the research subject to answer the research questions and achieve the research objectives. There are two mixed method designs put forward, which are simultaneous and sequential. The sequencing type is an important decision for mixed methods study design (Creswell, 2013). Simultaneous sequencing is the concurrent use of qualitative and quantitative methods, and the resulting data is employed during the data interpretation phase to facilitate each method's findings and establish a conclusion.

This research approach comprises the third main research paradigm, generating a different, but relevant approach to that facilitated by the quantitative or qualitative methods (Creswell, 2013). Moreover, in this study, cross-sectional data was collected and used in concurrent mixed methods designs to examine the participants in one direct (Creswell, 2013). Cross-sectional survey not only provides a useful mechanism for evaluating relationships between variables but also highlights differences between sub-groups (Baxter & Jack, 2008; Creswell, 2013). This research shows the benefits of employing a mixed methods approach, due to the greater level of detail in the end results. In this study, the qualitative data from the focus group discussion (Phase Two) revealed some explanations for the quantitative data, which was generated by a cross-sectional survey using self-report questionnaires (Phase One). Additional to the employment of a survey and follow-up with a focus group discussion, this study could assess the conceptual framework more comprehensively, as well as the cultural viewpoint of the university establishment and Saudi Arabian hospitals.

Furthermore, due to Kitchenham *et al.* (2009), a type of non-probabilistic sampling can be used in studies that utilise a homogeneous convenience sample technique, which in this instance relates to mental health professionals' attitudes towards people with mental health issues. Due to McEvoy and Richards (2003) and Creswell (2013), the qualitative research often relies heavily on convenience samples. Moreover, Wiederman (1999), Creswell (2013) and Landers and Behrend (2015) argued that the perspectives, opinions, experiences and attitudes of individuals with regard to specific events and phenomena constitute valuable information that can aid the interpretation of quantitative research. In addition, Small (2009) and Creswell (2013), given that the aim of the in-depth qualitative research is to comprehend complex social phenomena, the use of convenience samples in association with non-probability approaches in such research is appropriate. However, the legitimacy of using only the most convenient information to investigate phenomenon has been called into question. Specifically, Lucas (2014) argued that such an approach could only be justified if certain assumptions regarding

the uniformity of social phenomena are established. According to Etikan, Musa and Alkassim (2016), qualitative research methods make use of non-probability sampling. This method does not endeavour to produce data that can be prescribed a value of statistical inference. A phenomenon may only appear once in a data set, and still, be considered a phenomenon. “Convenience Sampling” (also known as “Haphazard Sampling” or “Accidental Sampling”) is a type of non-probability or non-random sampling in which members of the target population that meet a certain practical criterion are selected (Etikan, Musa, & Alkassim, 2016, p. 4). This criterion ranges from personal conditions - such as availability and willingness to participate - to circumstantial attributes - such as accessibility and geographic location [in relation to the study] (Kim & Given, 2008). A structured approach is provided below, which identifies the research design for this project (See Figure 3.1).

‘Phenomenological’ approach

Methodology
Mixed-Methods approach
Non-experimental research

(Phase One) Quantitative | (Phase Two) Qualitative

Epistemology

Heidegger, “must understand being so that we may be able to be given over to the world that is" (Heidegger 1988, p. 13).

Ontology

Heidegger, "philosophy is the theoretical conceptual interpretation of being, of being's structure and its possibilities" (Heidegger 1999, p. 14).

Axiology

While ontology and epistemology are fields, which considers the nature of truth, axiology is the consideration of values and ethics (Mingers, 2003).

Positivism paradigm	Interpretivism paradigm
Objective	Subjective
(Phase One) Quantitative	(Phase Two) Qualitative

"Middle – Rang theory"

Deductive | Inductive

This study is to be managed by more focusing on the qualitative methodological approach stemming from an interpretivism perspective

Mixed-Methods
Concurrent – (Triangulation Design)

(Creswell, 2013)

Techniques
(Cross-sectional data collected)
Convenience sample technique
(Non-probabilistic sampling)

Surveys; Self-Report Questionnaires	Focus Group; a semi-structured open-ended interview
(Num. =50) Quantitative	(Num. =5) Qualitative

KSA – Riyadh

Setting
Mental health hospital
Public Hospital
University Hospital
Nursing College

Participants
Mental Health Professional

Data analysis approaches

Statistical analysis - SPSS; Parametric test " Independent t- test sample- One-Way ANOVA"	NVivo10.1 "Thematic analysis "

Results

Concurrent – Triangulation Design
"Comprehensive results"
(Creswell, 2013)

Figure 3.1 Map method of research design.

Data Collection

Setting

The study was set up to collect information in regards to mental health professionals' attitudes towards people with mental health problems. The study was conducted in Riyadh city, the capital city of the Kingdom of Saudi Arabia (KSA). The settings encompassed general hospitals, offering inpatient and outpatient mental health services in Riyadh. These represented major health care system sectors in the KSA, such as Mental health hospital, Public Hospital, and University Hospital. Additionally, the nursing college was included to represent academia, and this enabled the possibility to acquire greater knowledge of professional stigma, as it was discovered that the academic nursing mental health department at the college was a significant factor in inciting or reinforcing stigmatising attitudes in mental health professionals is the prevailing attitudes of those who prepare them for practice.

From my own experience, I know that mental health nursing covers all aspects of health within a community and provide solutions and preventable measures regarding health and social issues. In this research study, I chose to include participants from the nursing faculty because these individuals can have an immense influence on improving nursing mental health care for those people with mental health problems. Also, the nurse faculty "As I'm" has experience in practical situations involving those with mental health problems. As outlined by Nordt *et al*. (2006), however, this was not unexpected, with many members of the mental health team having either previously worked as clinicians or worked in a dual role as both clinicians and educators, holding similar educational backgrounds.

Participants

Mental health care professionals working in the settings who provide mental health services for Riyadh city formed the study population for this research. The following categories were included: Psychiatrists, Clinical Psychologists, Clinical Social workers, Mental health nurses, and Faculty of mental health nurses.

Criteria for selection of participants

- **Inclusion criteria**

  Mental health professional (as defined).
  Ability to speak Arabic and/or English.

- **Exclusion criteria**

  Non-Mental health professional.
  Non-Ability to speak Arabic and/or English.

Sample Size

The participants (n=50) were all members of the mental health professional team in Riyadh, with 10 participants from each category as defined above. Of those 50 participants, (n=50) were involved in the quantitative aspect of the study and (n=5) in the qualitative aspect, with one participant from each category. A convenience sampling technique means that the researcher can choose participants for an in-depth and appropriate exploration of the research topic, using their unique characteristics (Taylor *et al*., 2014). In addition, this is a common approach for cases involving a small group who are experts in a specific research topic (Davidson-Hunt *et al.,* 2012). Thus, the sample meets the demands of the research as it involves people who examine a certain experience than those with no experience would (Taylor *et al*., 2014).

This paper uses a convenience sampling technique to pinpoint individuals that met the criteria of being a mental health professional (as defined) and speak Arabic and/or English. “Convenience samples” are often referred to as “accidental samples” as many elements are selected without reason, and are occasionally selected based on circumstance, for example, if they are located close - both spatially and administratively - to the location of the data collection

source (Etikan, Musa, & Alkassim, 2016). On the other hand, Keeney *et al.* (2006) stated that criteria varied when it comes to selecting experts, and there are no guidelines as to sample size in "Convenience samples". In most cases, panels involve 15–30 subjects from the field, or 5–10 from various categories (Linstone & Turoff, 1975; Davidson-Hunt *et al.,* 2012).

Creswell (2013) believes that data collection involves the researcher's preparation and gathering of data from the various sources involves, to make sure there is enough data for appraisal. In addition, when it comes to mix-method research, the aim, resources and level of complexity affect the number of participants involved. When the sample size is greater, then superior results might be found (Linstone & Turoff, 1975). On the other hand, greater samples bring about issues with regards to management and response rate (Davidson-Hunt *et al.,* 2012). In addition, Taylor *et al*. (2014t) state that the population sample should be made up of experts alone for that topic, while Hasson, Keeney, and McKenna (2000) state that experts are a collected of informed people. Bernstein, Hadzilacos, and Goodman (1987) feels that experts are specialists in their industry, or are individuals with certain subject knowledge (Davidson-Hunt *et al.,* 2012).

Sampling Procedure

After recruiting the participants with a mix-method approach for quantitative data collection in Phase One and qualitative data collection in Phase Two, and once consent was agreed, the researcher began recruiting study samples. The permission to collect both quantitative and qualitative information from the samples of professional mental health team workers at the Mental Health Hospital of Psychiatric and Mental Health in Riyadh, as well as data from the Public Hospital and University Hospital, was obtained from the Chair of the Research Centre and Head of the Mental Health department. However, disappointingly, the sample suffered from a lack of specialisation in mental health nursing and social workers within the psychiatric department in the Public hospital and University Hospital, while participants in the Mental Health Hospital, were rejected to join the focus group discussion.

The permission to collect both quantitative and qualitative data from the sample from the Faculty of Mental Health nurses at the University was obtained from the Dean of the College. The participants were well enough to share their views and to undertake the focus group discussion in the qualitative phase, in addition to quantitative questions from the participants. When conducting a qualitative study in the focus group discussion at the University Hospital, the inclusion of only one participant from each speciality was permitted. Any further additions

of participants from outside the University Hospital were rejected, except for one participant from a Nursing College. Furthermore, to preserve the confidentiality of information, each participant was requested to not discuss the study in the workplace near to or with participants from outside the hospital, aside from the university members. Further details surrounding the recruitment of quantitative and qualitative participants will be discussed in the subsequent sections. Furthermore, in this study 50 participants in the quantitative phase and 5 participants in the qualitative phase were considered appropriate for the research to be easily managed in the limited time available for data collection. Participation in this research was voluntary, and there was no pressure on anyone to take part. Moreover, which was chosen due to the limited numbers of professional mental health teams in the KSA, especially in the capital, Riyadh. Due to the representative of the workforce of mental health professional in Saudi Arabia, the study conducted by Qureshi *et al.* (2013, p. 35) "there is a mental health care workforce gap around the world, although it is more obvious in low- and middle-income countries (LAMICs), and Saudi Arabia is no exception". The research sought to undertake an inclusionary approach to the research participants, and the criteria are listed below. According to Ahmedani (2011), there are 1.1 psychiatrists per hundred thousand of the population in the KSA, as well as 6.4 mental health nurse, one psychologist and 2.4 social workers per hundred thousand. This is the lowest rate of psychiatrists in the Arab world and there is an absence of professionals who specialise in mental health. Saudi Arabia, Sudan and Libya were especially low in terms of the presence of psychiatrists, whereas other nations had a higher number. Upon securing official permission, the researcher commenced recruitment of the study samples.

Royster (2005) and Teddlie (2007) state that no guidelines exist for sample size in the mixed method approach, but studies often involved 40–70 subjects for a quantitative and 5-15 for a qualitative study (Suckley *et al*., 2012). For example, Taylor *et al.* (2014) used 22 experts from different areas in their work, through the mixed methods, subjective experience of mental health workers in different specialities was identified, in a continued effort to tackle stigma from health care workers against people with mental health problems. Liggins and Hatcher (2005) in New Zealand used 5 participants in a qualitative study of mental health workers to identify the extent to which mental health professionals experienced stigma towards people with mental health problems. There is a little reliable guidance on what sample size is needed for a thematic analysis. In addition, Onwuegbuzie and Johnson (2006), Emmel (2013) and Leech and Onwuegbuzi (2007) suggestions range from 4 to 400+ in mix-method depending on the type of data collection and the size of the project.

Data Collection Instruments

This study employed a mixed method approach, which uses quantitative (phase one) two tools were used to assess stigma; the Emotional Reaction on People with mental health problems Scale, and the Attitude Scale. Moreover, qualitative (phase two) data collection approaches and analytical techniques, a focus group discussion was the method of data collection. In addition, "the selection of data collection tools depends on whether the tool achieves the objectives of the research, helps the researcher to solve problems, and supports suspicions and hypotheses" (Newsome *et al*., 2008, p. 570). "Time and resource availability have to be considered in the selection of tools" (Krishnaswamy *et al.,* 2009, p. 2).

Research tools development

The research instruments were created and developed by the researcher and supervisors to measure the key objectives of this study, as well as taking the Saudi Arabian culture into consideration. Examples of how the instrument tools were detailed in Appendix V. Emotional Reaction on people with mental health problems Scale, Appendix VI. Attitude Scale Questionnaire – Short Form. The instrument included 29 items measuring the Emotional Reaction on People with mental health problems Scale using a 5-point Likert scale, with the response format ranging from 'strongly agree to strongly disagree'. In addition, the Attitude Scale Questionnaire-Short Form (AQ-SF) contains 27 items, based on a three-point Likert scale containing the values 'rarely', 'sometimes', and 'frequently'. These tools used for individuals that met the criteria of being a mental health professional (as defined) and speak Arabic and/or English.

Jorm *et al.* (2005) also believe that peoples' beliefs and attitudes in regards to mental health problems are also likely to have an adverse effect on whether those individuals disclose their symptoms and seek help for their problem. Having a sound knowledge and understanding of a topic, and in the case, mental health can assist in the recognition, treatment and management of mental health problems. Due to Angermeyer, Holzinger, and Matschinger (2009), population-based studies have typically underestimated the relevance of attitudes and emotional reactions as a contributing factor to mental health stigma.

Data from self-reported questionnaires still constitutes the major source of knowledge surrounding this issue and focus on the mental health professionals' emotional reactions and

attitudes during an interpersonal interaction, on their "perception" of stigma towards people with mental health problems.

Corrigan and Watson (2002) propose that stigma should be considered a multi-layered phenomenon that incorporates undesirable attitudes, negative emotional reactions, and biased actions. Therefore, for these reasons the researcher decided to identify the phenomena of professional stigma by measuring the emotional reaction and attitude of mental health professionals who demonstrated stigma towards people with mental health problems. As a result, the researcher opted to identify the phenomena of professional stigma by measuring the emotional reaction and attitude of mental health professionals, perceiving this to be demonstrative of stigma towards people with mental health problems.

This study used a methodology developed by both the researcher and supervisors (in English, and then translated to Arabic version, furthermore, the questioners made in both languages in Arabic and English), which are following the requirements of this study and the nature of the participants in Saudi society. Due to Nieswiadomy (2011, p. 168), “new instruments could be created and generated from previous researcher’s perspective, however, the information is usually provided freely and developers are typically pleased when other researchers credit them through their creations”.

In this study, necessitates an Emotional Reaction on People with mental health problems Scale in accordance to the AQ-29 as a 29-item scale, which measures emotional responses towards people living with mental health problems. According to Thornicroft *et al*. (2008), emotional reactions could potentially further anticipate discrimination and stereotypes. According to Angermeyer and Matschinger (1996, p. 326) “to assess emotional reactions towards people with mental health problems, most focus on aggressive emotions; pro-social reactions; and feelings of anxiety”. Through these sources are derived from creating a questionnaire of Emotional reaction on People with mental health problems scale, and how the view on people with mental health problems is influenced by general opinion, an experience of prejudice and the influence of the community.

This scale was utilised to measure the emotional reaction of mental health professionals towards people with mental health problems. According to Thornicroft *et al.* (2008) suggest that emotional reactions can further stigmatise mental health and potentially lead to the perpetuation of discrimination. Moreover, Corrigan (2004), provided an important to recognise the public emotional reactions against people with mental illness. This scale was developed by me in conjunction with my supervisor to reflect aspects of common Saudi culture and therefore ensure relevance to the research objective.

In addition, in this study, the Attitude Scale for mental health problem was modified in relation to the AQ-27 in a 27-item, self-administered measure of stigma attitudes and beliefs and a focus on prejudice towards people with mental health problems. This scale was utilised to measure the attitude of mental health professionals towards people with mental health problems. The scale was adapted by me in conjunction with my supervisors to reflect aspects of common Saudi culture and therefore ensure relevance to the research objectives.

According to Corrigan *et al.* (2012, p. 614), "in addressing the attitude demonstrated towards people with mental health problems, the focus should be on nine dimensions: Blame; Anger; Pity; Help; Danger; Fear; Avoidance; Segregation; Coercion". Attitude Scale is a valid and reliable self-report scale that measures respondents' attitude to mental health problems; it was tested in several studies worldwide such as (Hahn, 2002; Pelzang, 2010; Salve *et al*., 2013; Corrigan *et al.,* 2012, p. 614; Poreddi *et al.,* 2014). Hahn's (2002) questionnaire, which investigated the attitude of professional nurses towards their patients with mental health problems, was utilised to ensure the validity of the instrument further. The Attitude Scale for Mental Illness used in Hahn's study (2002, p. 3) yielded a Cronbach's Alpha 0.87, indicating high internal consistency between scale items. The Attitude Scale for Mental Illness is a reliable scale to use in this study.

Translation of questionnaires

The aim was to adapt and progress an expedient measure for those conducting research, to quantify the stigma held towards people with mental health problems, particularly, by those providing the mental health care services. Moreover, the participants were provided with the alternatives of completing their survey - questionnaires either in English or Arabic; their endemic language. Through this method, the questions can be made more comprehensible and straightforward. Therefore, to ensure the results had greater validity, a review phase was implemented whereby a multidisciplinary committee reviewed the adjusted and translated questionnaires following guidelines that were based on Beaton, Bombardier, Guillemin and Ferraz (2000). The author and study-supervisors abide by strict criteria to ensure that the survey study was adapted to the circumstances of Saudi Arabia, and coordinated the research aim and objectives effectively.

Methods

The research presented concerns into the phenomena of stigma among mental health professionals in Saudi Arabia towards people with mental health problems. Meanwhile, existing methodological foundations and guidelines that were based on Beaton *et al*. (2000) were employed in adjusting the study tools towards the target language and culture, which also presented six different stages required by this method.

Stage 1 (forward translation)

The methodology process required the questionnaires to be translated into Arabic in advance from the base language of English. For this purpose, two native speakers of Arabic, who were also proficient in English (bilingual speaking), were selected for the task and were also fully briefed on the aims and tools measurements of the study.

Stage 2 (Synthesis of T1 and T2 into T1, 2)

The next phase involved gaining a consensus from all committee members on the finished translated document, which was approved by a separate committee of experts supervising the study.

Stage 3 (back translation)

This phase involved utilising two individuals who spoke English as their primary language to retrospectively translate (or back-translate) the questionnaire responses. The English speakers in question grew up in countries where English is the first language and had both been residents in England for over two decades, while also speaking Arabic fluently. Additionally, neither of these individuals had access to the original document containing the questions, as it was a 'blind' test, wherein each translated only the answers for the respondents assigned.

Stage 4 (Expert committee)

The expert panel committee, in this case, was made up of professional health workers, as well as translation, linguistics and methodology specialists. The fourth stage involved the development of the penultimate document, with the expert committee having approved the translated forms and a separate comparative analysis of the pre- and post-translated documents.

Stage 5 (Face validity)

A test phase was then delivered using the penultimate document and was tested on twenty participants (Pilot study Test Validity and reliability of the stigma scale). Every participant was required not only to fill in the survey but also to assess each question in terms of its reasoning, arrangement, display, directions and ratings for the response. This stage also involved the compilation of an in-depth report from the accumulated feedback from the respondents,

outlining issues with the format and potential modifications of the penultimate document from findings of the validity test. Subsequently, the expert committee then reviewed this report.

Stage 6 (committee appraisal)

The validation tests and report generated in the previous stage were then developed by the committee to create the finished version of the tools.

Pilot study - Test Validity and reliability of the stigma scale

A small-scale pilot study was undertaken to identify any potential issues with the questionnaire. One of the main advantages of conducting a pilot study is that it can give the warning about where the main research project could fail, or whether proposed questionnaires are inappropriate or too complicated. A pilot study provides an opportunity to resolve possible problems before implementing the full study (Clark *et al.,* 2008). Due to Van-Teijlingen, Rennie, Hundley and Graham (2001), a pilot study can be used to test the feasibility of the study and test the mechanical issues of research instruments.

For this reason, I decided to conduct a small-scale pilot, specifically to evaluate the questionnaire employed in the quantitative survey (English/Arabic version). The methods identified by Sim and Wright (2005) and Westbrook *et al.* (2013), were employed to evaluate the questionnaire. These methods included: testing the duration of the questionnaire, the effectiveness of its layout and presentation, the administering process, the level of question response, the difficulties of understanding questions, the sensitivity of the questions, and the identification and resolution of any other unexpected procedural issues. Selecting a sample size for pilot studies requires small samples, which may be appropriate for pilot-testing a data management system or demonstrating the ability to execute a specific research protocol (Van-Teijlingen *et al.,* 2001). Westbrook *et al.* (2013) cite the indication in the extant literature to the effect that a pilot study sample should be 10% of the sample projected for the larger parent study. On the other hand, Hertzog (2008) warns that one may not be prescriptive or flexible on the issue because different factors influence studies. When it comes to the number of participants, this study included four participants from each discipline of the professional mental health team: four mental health nurses, four psychiatrists, four clinical social workers, four clinical psychologists, and four faculties of mental health nurses. A total of 20 professionals were employed throughout the data assessment. The pilot study participants were excluded from the main study. It is often recommended to not include the pilot study in the main study samples, and this is a widely-held view (Peat & Williams, 2002; Westbrook *et al.*, 2013).

The sample population was composed of predominantly male and female members. In general, the group was of Saudi Arabian origin (n=17) and the remainder of the group was comprised of Egypt (n=1) and several single members from other nations, such as Jordan (n=1); and Lebanon (n=1). The biggest group regarding age was those who were of 30-45 years-of-age, and the Survey Monkey filter was employed for the surveys after their completion to simplify and aid the assessment and analysis phase. Lastly, after receiving approval from the hospital's administration, individuals were sent an email asking them to agree to be included in the study. They were advised that completing the survey would likely take them around three-quarters of an hour.

Table 3.1. *Reliability analysis of Pilot Study*

	Cronbach's Alpha	No of Items	Items Removed
First scale	.715	29	With no items removed here
Second scale	.727	27	With no items removed here

The pilot study found that the reliability of the two scales was assessed by measuring their internal consistency and computing their Cronbach's alpha coefficients. For the first scale of Emotional Reaction on People with mental health problems, the reliability reached the acceptable level of 0.715 (>0.7), for the second scale of an attitude scale, the reliability reached the acceptable level of a reliability level of 0.727.

Validity, Reliability and Trustworthiness of the study

The consistency of validation and content across the various language forms of the questionnaire is a key aim of cross-cultural re-working. The scale was made up of collections of sentences designed to provoke specific stigmatisation responses. The use of multiple sentences was deemed to be more accurate than single ones, as they provided much more comprehensive and reliable outcomes (Boynton & Greenhalgh, 2004).

This is the case, because standalone sentences may mean something slightly different to different people. If a collection of sentences is used – all clearly stating a similar or even identical opinion – it is harder for users or participants to add bias or unwanted personal

interpretations (Graneheim & Lundman, 2004). Hence, the perfect assessment of external accuracy is to study a collection of topics or subjects. The correlations can be predicted to stand at somewhere between 0.75 and 0.89 (Koehn & Lehman, 2008). Consequently, the legitimacy of the stigma measures was evaluated via the use of the internal consistency technique – the strategy is most commonly linked with the Cronbach Alpha coefficient. The technique offers a legitimacy signifier in the shape of a correlation coefficient; and the internal consistency technique is based upon the intricacies of scaling theory (Boynton & Greenhalgh, 2004).

Quantitative approaches were used in the collection of data; in distinguishing between validity and reliability; "validity" concerns the accuracy with which a measurement instrument measures the quantity, concept or effect being measured (Koehn & Lehman, 2008). In particular, Sandelowski (2000) notes that a measurement that is valid is one that accurately represents that being measured. "Reliability", on the other hand, describes the stability and consistency of the measurements obtained (Koehn & Lehman, 2008). In this study, a validated standardised instrument that met the validity and reliability criteria was employed as the tool to collect data. Indeed, in terms of this study, "content validity" refers to the degree by which the validated standardised instrument (the instrument) and its associated components could inclusively encompass the factors that are relevant in respect of the measurement being undertaken (Grove, Gray, & Burns, 2014).

For the purposes of this study, the instrument is conceptualised as the emotional reaction on people with mental health problems and attitudes scales with respect of people with mental health problems. Cronbach's alpha coefficient was used to appraise the consistency of the instrument and to test its reliability concerning an emotional reaction and attitude scales. Due to Angermeyer, Holzinger, and Matschinger (2009), population-based studies have typically underestimated the importance of attitudes and emotional reactions as influential factors upon mental health stigma. The instrument's reliability coefficient is in proportion to its consistency (Koehn & Lehman, 2008). Previous studies have indicated that a reliability coefficient with a minimum value of 0.70 is required (Grove *et al.,* 2014).

In the second phase of this study, qualitative approaches were used in the collection of data; validity and reliability in respect of qualitative data are examined through trustworthiness, which includes credibility, dependability, confirmability and transferability (Graneheim & Lundman, 2004; Koehn & Lehman, 2008). Trustworthiness was established by reviewing a multidisciplinary focus group of researchers with different perspectives (Faculty of mental health nurse, Psychiatrist, Psychologist, Social Worker, and Mental health nurse).

In respect to achieving reliability, the focus group discussions were administered and transcribed by the researcher and supervisors throughout. The discussions were digitally recorded, thereby facilitating authentic and accurate transcription, thereby further enhancing trustworthiness (Patton *et al.,* 2002), endorsed by participants and elucidated in Table 3.2. Issues of credibility concern the focus of the research; namely, the degree of confidence exhibited on how well the data and processes of the analysis address the research objectives (Koehn & Lehman, 2008).

Bitsch (2005) states that dependability refers to "the stability of findings over time" (p. 86). Dependability is where participants appraise the findings, interpretation and recommendations of the study to confirm that the data is in line with the data gathered from the study's sources (Cohen *et al*., 2013; Tobin & Begley, 2004). Dependability comes because of an audit trail, code-recode strategy, stepwise replication and peer examination (Chilisa & Preece, 2005; Schwandt *et al.,* 2007). Confirmability refers to "the degree to which the results of the inquiry could be confirmed or corroborated by other researchers" (Baxter & Eyles, 1997, p. 505). Moreover, confirmability is "concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are clearly derived from the data" (Tobin & Begley, 2004, p. 392). On the other hand, transferability refers to "the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents – it is the interpretive equivalent of generalizability" (Tobin & Begley, 2004, p. 388). According to Bitsch (2005), the "researcher facilitates the transferability judgment by a potential user through 'thick description' and purposeful sampling" (p. 85).

In addition, due to Miles and Huberman (2002), the degree to which research results apply to other contexts or groups is known as the property of transferability. Hence, to enable other researchers to assess the transferability of this study's results by contrasting them with various scenarios and identifying similarities of settings, the research methodology and procedures have been presented in detail. Moreover, given that the discussion data generated sample results, the views of this study's participants can be said to be equivalent to the views of the mental health group. Therefore, the present study meets the condition of transferability. In this study, for reliability and validity of data analysis results in both the researchers and supervisors accordingly.

Process of Data Collection in (Phase one and Phase two)

Phase one of Data Collection

Recruiting Participants

For the quantitative aspect, participants were selected from various study settings, according to eligibility criteria. The first four categories of mental health professionals (excluding academia) were selected from the various clinical sectors, ensuring representation of all categories from all sectors. As for academia, the sample was equal across the Nursing College at the University, and permission was obtained from chairs to perform quantitative data collection. Due to the small number of mental health professionals in Saudi Arabia, the hospitals requested that questionnaires were distributed between 10 to 30 participants, producing a somewhat predictable response rate. 30 copies of the questionnaire were distributed to each hospital and nursing college (120 questionnaires in total).

The final number of returned questionnaires was 50 a total participant involved in each group participated from three hospitals and one nursing college (psychiatric 10, psychology 10, social worker 10, faculty of mental health nurse 10, Mental health nurse 10), which is equivalent to a refuse rate of 58.3% and equivalent to a response rate of 41.7 % ([3.33%]; 4 respondents participated from Public Hospital, [20%]; 24 respondents participated from Mental Hospital, [10%]; 12 respondents participated University Hospital, and [8.3%]; 10 respondents participated Nursing college).(See Appendix VII. Table 4.1: The Characteristics of the participants in the study sample, Self -Report Questioners (n=50)). Additionally, as mentioned above, the “Convenience samples” are often referred to as “accidental samples” as many elements are selected without reason, and are occasionally selected based on circumstance, for example, if they are located close - both spatially and administratively - to the location of the data collection source (Etikan, Musa, & Alkassim, 2016). On the other hand, Keeney *et al.* (2006) stated that criteria varied when it comes to selecting experts, and there are no guidelines as to sample size in “Convenience samples”. The research sought to undertake an inclusionary approach with the research participants and each professional category: Psychiatrists, Clinical Psychologists, Clinical Social workers, Mental health nurses, and Faculty members of mental health nurses had 10 participants. The sample size of participants came to a total of (n=50). This sample group was equally divided into the five categories of mental health professionals.

No proportionate allocation was used, to increase statistical efficiency when comparing various groups enrolled in different hospitals and nursing college in Riyadh. In this study,

information was gathered over the course of two months. Following the completion of these stages, the data collected from all investigations was assessed. This activity took approximately 30 minutes with each participant. After meeting the participants in the hospitals and nursing college, the researcher asked for the participant's consent to take part in the study, and if they agreed, they would complete a consent form. The researcher then explained to the participants the importance and objectives of the research and responded to any of their questions before they began the questionnaires. The participants were given the questionnaire at their department and the researcher would return there if they required any clarifications or simply to collect the data.

Data collection tools

Two tools were used in the present study as Self–Reported Questionnaires.

Demographic questionnaire

The demographic questionnaire created by the researcher and research supervisors allowed the acquisition of demographic data from the participants, including (Group of specialities, Nationality, Gender, Qualification, Post-graduate qualification, Experience years, and Work Setting). Details can be found in **(**Appendix VII. The characteristics of the participants in the study sample of Self–Reported Questionnaires (n=50)).

The Emotional Reaction on People with mental health problems.

This stigma scale was used to measure an individual's emotional reaction towards people with mental health problems and consisted of 29 items. (See Appendix V). Each respondent was prompted to state the degree in which he or she agreed or disagreed with the statements in the Emotional Reaction on People with mental health problems Scale based on a five-point Likert scale, ranging from 1 = strongly agree to 5 = strongly disagree.

Attitude Scale Questionnaire-Short Form (AQ-SF)

The stigma scale was used to assess the attitudes of mental health professionals in relation to the stigmatisation of people with mental health problems and its corresponding effects and consisted of 27 items each scored on a three -point on the Likert scale. **(**See Appendix VI). Each respondent was prompted to state the degree in which he or she agreed or disagreed with the statements in the Attitude Scale based on a three-point Likert scale containing the values 'rarely', 'sometimes', and 'frequently'.

Data analysis

A total of 50 respondents participated in this study. Following the data collection stage, the data entry and analysis was done by using SPSS (version 20) for Windows. Additionally, quality control was undertaken at the stages of coding and data entry, as the University of Salford provided the locked storage space for printed versions of the data documents following data entry and data scrubbing. Data was presented using descriptive statistics in the form of frequencies, percentages, means, and standard deviations for quantitative variables. Together with this, confidence limits were computed at a 95% level of confidence (Martin & Sherington, 1997).

Descriptive statistics were used to guarantee validity through correct formatting the data were entered and accounting for missing data. Descriptive statistics were employed, which also allows for the further assessment of dependent variables in terms of their trends and degree of normality. The final demographic query in the survey involved opinions in decision-making; as such descriptive analysis was also carried out on this query. Multiple analyses were conducted to determine the correlation between the independent variables "demographics", and dependent variables "emotional reaction scale and attitude scale". Analytical methods based on the covariance of a few variables were proven valid by these analysis methods, as they incorporate consideration of dependent variables being impacted by covariates. It follows from this method that a decision can be made on the employment of a multivariate analysis of variance, depending on whether any predictive ability derived from dependent variables emerged from covariates.

(ANOVA) To establish whether a disparity would be recognised between groups of the independent variables, based on a linear combination of the dependent variables, the ANOVA methodology was employed. Witherell and Beineke (2001) identified ANOVA as the method of highest efficiency, which works to the highest standard when measuring data that represents many different factors to be examined in different groups. To determine if independent samples were derived from the same distribution, the parametric method of one-way ANOVA by ranks.

The one-way ANOVA serves to identify and compare any correlation between the mean values of the sets of interest, which establishes whether any are significantly at variance with any other. Additionally, this allows for the identification of any disparities between independent variables within a linear combination of dependent variables, while a comparison of a sample mean values was achieved via the independent samples t-test.

Heeren and D'Agostino (1987) identified that the independent samples t-test might be employed when dealing with measurement of the data were the variables mean values examined between two groups. The independent samples t-test and One-way Analysis of Variance (ANOVA) were employed to determine the differences among study groups, and were used to address the research question: *How* do *mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?* These tools were also used to address the research question: *To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?*

During the analysis, odds ratios with 95% confidence limits were calculated for risk factors. Spearman rank correlation analysis was used for the assessment of the inter-relationships among quantitative variables and utilised for ranked ones. Statistical significance was considered at p-value <0.05. The determination of the relationship between two series of data and the evaluation of its strength was undertaken based on Spearman's rank correlation coefficient. This coefficient served as a statistical technique for research questions validation (Morgan *et al*., 2007).

Data protection issues – Data security for a quantitative questionnaire

All data from the questionnaire was anonymised. The names and contact details of participants were removed from the questionnaires and stored separately in a password-protected computer at the University of Salford. Information was scanned and stored on the secure F drive, and this was accessible from within Saudi Arabia. Once anonymised in this manner, the hard copies of data were scanned onto the same University of Salford F drive and used to enter data on to SPSS. Access was only for the researcher and the supervision team at Salford, as it was not shared elsewhere.

Phase two Data Collection

Recruiting participants (Focus group)

For the qualitative aspect of the study, participants were selected by the head of the mental health department at the University Hospital and by the head of the department in the nursing college, mainly because they were known to have relevant experience, which was particularly applicable to the study. They were also selected based on the principle of maximum variation, to provide a broad range of perspectives on the topic of mental health in the KSA.

The focus group was formed of mixed categories (all five categories) to elicit different experiences and views. Simple discussion schedules with relevant generic areas were prepared for the focus group, and the researcher acted as facilitator, after receiving special training for this activity. Their opinions, attitudes, experiences and interests were ascertained regarding the topic (Srinivasu *et al.,* 2011). When all participants are collected at a given time and place, this is known as 'recruitment' (Rabiee, 2004, p. 655). Such scenarios may be engineered in a variety of ways. One particularly useful method is to make use of membership books. It may also arise because of a personal connection to the group, as noted by Lindlof (2001).

Additionally, it must be determined whether the group to be examined is to be homogeneous or heterogeneous (McLafferty, 2004). Familiarity between subjects is an additional consideration to bear in mind, as they may influence each other, inadvertently or otherwise. In this study, all participants were bound by professional codes of conduct and had an appreciation of the rule that governs patient confidentiality. Participants were emailed initially and telephoned a day in advance to confirm attendance. They were informed of the length of time of the group discussion (one hour) as a volunteer because participants generally become restless (Cizza *et al.,* 2010). Notice often increases the chance of subjects attending and being willing participants. The location for the focus group discussion was in the meeting room at the University Hospital (See Appendix VIII).

For the qualitative section of the research, the sample size of participants was (n=5) who were taken from the 50 who were already involved in the quantitative aspect of the study. Appendix IX. The characteristics of the participants in the study sample of focus group discussion (n=5). The major health care's system sectors in the KSA were represented, such as mental health hospital, Public Hospital, and University Hospital. Additionally, a Nursing College was included to represent academia.

In addition, the focus group discussion was approached by the academic staff of mental health nurse in the Nursing College and mental health professional team from University Hospital, regarding the instructor I had received from the supervisor director of the mental health department in University Hospital to start our focus group discussion. The provision of only one participant for each speciality was agreed for a qualitative aspect of the study and there were no further additions of participants from outside the hospital (from other hospitals; except the participant from Nursing College) to participate in the focus group discussion. To preserve the confidentiality of information, each participant in the workplace was told not to discuss the study with participants from outside the hospital, except with university staff. This activity took approximately one hour (focus group discussion) in a meeting room at the University Hospital.

Following the completion of these stages, the data collected from all investigations was assessed. The permission to collect qualitative information from the sample of professional mental health team workers at Mental Health Hospital was obtained from the chairs of the research centre. Furthermore, permission to collect qualitative information from the sample of the professional mental health team at the Public Hospital was also obtained from the chairs of the research centre. However, the sample suffered from a lack of specialisation in psychiatric and mental health nursing and of social workers within the psychiatric department.

Data collection tools

Data was collected from the focus group discussion. Focus group methodology is considered an effective technique for exploring people's views about issues and the reasons underlying such views (Powell, Single, & Lloyd, 1996). It is superior to individual interviews, as it may generate more diverse responses, as they encourage participants to speak out about sensitive topics (Liamputtong & Ezzy, 2005). Specifically, the focus group is the main source of gaining a view of an experience through the provision and supply of services (Powell *et al.,* 1996).

The Qualitative form can be found in Appendix X. The main advantage of the focus group method was the ability to mobilise participants to generate their own questions in their own vocabulary and to respond to any comment on each other’s contributions on their own terms (Liamputtong & Ezzy, 2005). Statements were challenged, extended, developed, undermined and qualified in a way that generated rich and in-depth data (Kapungwe *et al.,* 2010). This is particularly pertinent for this study, as it deals with a complex and sensitive issue: stigma.

Furthermore, a focus group can shed light on certain shared norms and understandings, as well as discrepant and divergent views (Srinivasu *et al.,* 2011).

Process of data collection in focus group discussion

The researcher guided discussion and questions and ensuring opportunity for all participants to express their views. The audio and video recording were employed. Time was allocated towards the completion for clarifications to be made, which ensured comprehension from the group. Thus, the accurate reflection of gathered information was better ensured.

A qualitative design was employed for the focus group discussion that was attended by participants for a one-hour-long meeting in a chamber in the University Hospital (Psychiatric department). Cooperation of the department was accepted to establish a formal group, as well as to assure those individuals who were participating in the focus-group dialogue: five participants through recruitment (n=3 females, and n=2 males). While considering the availability of the individuals involved (both subjects and researcher) a set of data analysis was undertaken utilising NVivo10.1 (Silver & Lewins, 2014).

All participants at the University Hospital were included, and discussion was carried out in English. The first thematic trends that were created addressed many issues that pervaded within the mental health care sector regarding stigmatisation, and this was inclusive of additional, more comprehensive elements addressed as sub-aspects of this stigma. Deduction and induction were both utilised and adhered to in the analysis of data. In the focus group with mental health professionals, additional information was sought on how these individuals may hold a stigma against people with mental health problems. Mental health professional representing each of the different professional groups were included in the focus group. Overall, the focus group addressed four issues to achieve the research questions: professional stigmatisation experiences, the possible causes of stigmatisation, the impact of professional stigma on mental health services and recommendation and suggestions of possible methods of minimising stigma, particularly of professional stigma. To assist the focus group moderator, a compilation of focus group guidelines was established (See Appendix X).

These guidelines contained keywords and probes, which could be used to refocus the discussion if required. Once the group invitees had consented to participate and being recorded, the group discussion began and took approximately one hour. The researcher, with the assistance of supervising staff, subsequently undertook the role of critical peer-reviewed by reviewing the thematic assessment and the emergent themes.

Why audio - video recorded in focus group discussion

Participant privacy and the confidentiality of the process were of utmost importance, and are a particularly sensitive issue in the case of video recordings (Al-Krenawi & Graham, 2000). An excellent stereo recording and a satisfactory VGA (640X480 pixel) camera were used. Using this device, information was recorded onto an SDHC card via QuickTime h.264. The recordings were easily transferable and encrypted across computers because the video data did not require any compression. It could also be more securely controlled by means of digital security.

The focus group discussion was both tape and video recorded before undergoing audio transcription. In addition, the tape recordings and the video recordings made potentially inconclusive information more accessible, clear and allowed the researcher to confirm any elements of ambiguity (Al-Krenawi & Graham, 2000). The researcher could perform a fully comprehensive analysis by creating many categories and subsequently used these categories to organise the stigma experiences (Schulze & Angermeyer, 2003). In the focus group discussion containing five participants of different specialities, the video recording helped the researcher to be able to analyse the indicated thematic code in detail as it related to each participant interaction and intervention in the focus group discussion. The focus group was recorded in both video and audio format, and the words were verbatim transcribed. Moreover, the researcher used a tape-recording session with video and audio records, because they did not want to miss any comments through the analysis transcript. Thus, they created a thematic code related to each participant in the focus group discussion for the transcription process and analysis to be more accurate (Al-Krenawi & Graham, 2000).

Analysis of this transcription was subsequently iterative in nature and was performed with the help of the research supervisors. The research then examined the transcription multiple time, analysing the reading of the words uttered and ensuring that there was a limited adjustment to the structure of the analysis. Thematic analysis was then undertaken to establish the information; identification and coding of the trends therein, with excerpts taken as 'unitary' informational segments. In this study, group participants were invited to discuss professional views and attitudes of stigmatisation towards people with mental health problems.

Role of the researcher in focus group

Group discussion succeeded with the researcher helping to drive the progression of discussion, as well as maintaining the organisation of the group and managing the closing of the group discussion.

Beginning of the focus group

Participants were thanked on arrival, to generate good will. On arrival, participants were steered towards their nametags and refreshments, and all consent forms were completed. It was explained that the confidential nature of the data recorded and subjects were informed of the maintained anonymity of their identities (See Appendix X).

Moderating the focus group

It is generally accepted that a researcher must be an expert in the subject of inquiry. In particular, Baker and Hinton (1999) noted that if the researcher does possess specialist knowledge in the relevant area, it is imperative that they do not impart any views to the discussion group in this regard. If participants are unresponsive, t they should be prompted using probing inquiries, to sharpen the focus of questions (Rafii *et al.,* 2003). Subsequently, questions were employed once introductory remarks were made and the aim of proceedings was explained, to generate discussion amongst subjects. Following this, terminology was introduced and clarified at necessary intervals and subjects were reminded of the value-free nature of their responses, with the researcher assuring participants of their freedom to speak in favour or opposition to their colleagues would be respected.

The inquiries that were posted were aimed to be general and open-ended at first until subjects came to feel at ease; following which more pointed inquiries were introduced. Towards the completion of the process, the proceedings were brought to a natural close by offering a summation of the preceding events, confirming the contributions made to apply. Lastly, the researcher delivered appropriate closing remarks and offered thanks to all participants for their efforts, reiterating guarantees of confidentiality (Baker & Hinton, 1999) (In Appendix X).

Data analysis

The recorded focus group discussion was transcribed and analysed (Patton *et al*., 2009). The objective was to build and expand, rather than test theory, which allowed for the discovery of new insights and individual experience and enhanced understandings that are derived from the coded categories, themes and patterns (Kapungwe *et al.,* 2010). Consequently, in this study, the hermeneutic model is suggested for use to interpret the findings of the research (Wilson & Hutchinson, 1991). At the core of hermeneutic phenomenology is the "subjective experiences of individuals and groups", according to Willis *et al.* (2007, p. 104), while the term has enlarged beyond the boundaries of its original meaning and now includes "understanding human action in context". It seeks to expose the universe as experienced by individuals, as it is filtered through their own narrative accounts (Collins, 1997, p. 375).

Qualitative research provides a fascinating insight into the real experience of mental health care professionals and patients who have experienced stigma, and although different to the thematic analytical style of quantitative research, these methods can often complement each other (Braun & Clarke, 2014). Phenomenological and hermeneutic approaches, including the recently developed phenomenological analysis in a thematic analysis (Smith, 2015), are becoming more widespread, due to their effectiveness in reflecting the experiential and interpretative realities of test subjects (Braun & Clarke, 2014). Although common, thematic analysis is only now garnering the same degree of recognition traditionally held by methodologies such as grounded theory and phenomenological analysis.

A seminal article by Boyatzis (1998) based on "coding and theme development" shied away from the shift to the phenomenological approach, as they believed that the analysis is essentially a method for addressing and analysing patterns found in qualitative data. Following the creation of the thematic analysis approach in the 1970's (Merton, 1975), many variations have been produced within the psychological field (e.g. Aronson, 1995; Boyatzis, 1998; Attride-Stirling, 2001; Joffe & Yardley, 2004; Tuckett, 2005; Braun & Clarke, 2006). Several authors reject thematic analysis as a phenomenological method (e.g. Guest *et al*., 201; Braun & Clarke, 2014; Smith, 2015). However, the theoretical flexibility of thematic analysis can be utilised and used as an analytical method, in place of a methodology, as per other qualitative approaches.

For this research group, the methodology adopted was both positivism and interpretivism with the realist proviso that the responses of the research group were accepted as truthful expressions of their general opinions and incentives, as well as their reactions to the specific

research experience (Kafle, 2013). What is more, for this study, the data record was played both visually and audibly in the English language through the discussion. The collected information was transcribed in detail, as every word was noted except for those that may have encroached upon participant privacy rights, such as their names. Following this, the researcher became acquainted with the information and trends by intently studying data, and applying categorical labels and descriptions and trend codes. Upon participant's information and discussion, significant data excerpts were utilised to clarify a trend's characteristics.

In the search for a pattern within the group discussion of their experiences of professional stigma, all relevant paragraphs were assigned a code that was representative of the original statement. Each code and sub-theme were effectively paraphrased and then served as a basis for its category creation. The coding system remained fluid throughout the process and was consistently changing to meet the demands of the research questions. Categories with similar content and goals collaborated. At the beginning of the process, the transcripts were coded by all team members - both the researcher and supervisors accordingly for ensuring the reliability of thematic analysis. In assimilation with the argument outlined by Mackenzie and Knipe (2006), coding is the most method for organising and presenting data before to further investigation and analysis. Throughout this part of the research, the supervisors supervised all discussions throughout the qualitative data analysis. It was during this process that the most efficient coding practice was generated and, thus, all similar "professional stigma experience" categories collaborated into a more generic classification. Additional perspectives were obtained from health professionals and cultural background, which provided an alternative viewpoint regarding the stigma of mental health.

Moreover, coding was applied to these transcripts, although it was done so deductively. In conclusion, the research was documented in a detailed report. Regarding this study, Miguel, Ryan, and Amaya-Amaya (2005) suggested that relevant literature was consulted to develop data perceptions, assumptions, and accounts. Documenting a succinct, comprehensive, and coherent report by formulating both data and personal understanding is crucial, and thus, results were discussed considering the relational aspect of stigmatisation, which is one of the specific research trends (Hoover & Koerber, 2011). Consequently, documented data was arranged as follows: The first step listed and described the individual categories. Next, each category's documented evidence was described. Following that, research data was succinctly interpreted. Lastly, analyses and personal perceptions, in accompaniment with details and evidence from the relevant subject literature, were presented.

Fereday and Muir-Cochrane (2006) explained that qualitative analytical process of thematic analysis is a process that is utilised to classify, evaluate, and document various trends by consistently reviewing the collected data. The trends located through this method were those most significant within anonymised portrayal. The NVivo 10.1 program was then used to store and manage the imported, transcribed interviews; and this application also allowed for the development of an audit trail, which elucidated not only the research design but also the results that occurred (Hoover & Koerber, 2011). As highlighted by Beckert (2007), interrelated processes can be distinguished using action codes, allowing for contrast against static isolated topics. This assessment intended to mirror the real story of these people, while noting the wider societal context (inclusive of their connection to the interviewer) and how this affected their experiences (Innes & Murphy, 2008); for example, many factors emerged regarding what may influence the beliefs held by professional mental health teams, such as the social stigma, diagnosis, religion, media, education, and families. A transcription of the group was then thematically analysed (Braun & Clarke, 2006). This was completed with the assistance of the NVivo program (Hoover & Koerber, 2011). The six steps of thematic analysis for qualitative data adopted by Braun and Clarke (2006) can be found in Appendix XI. The analysis was supported by the NVivo 10.1, which was used as a technique to support the qualitative data analysis (Hoover & Koerber, 2011).

In the field of academic psychological research, a qualitative thematic analysis is widely respected as a methodology, which is innately adaptable at both practical and theoretical levels (Braun & Clarke, 2006). Research data examined in this way more readily reveals core themes for further investigation, to fundamentally answer research questions. The main objective of this analysis thematically focused: it was hoped that through the process of an insightful analysis of data supplied by participants in relation to their reasons for taking part in the research and their reactions and assessment of the experience, general themes would emerge (Taylor *et al.,* 2010). The NVivo 10.1 program provides a platform for academics to structure, curate and code qualitative data to a sufficient degree (Graneheim & Lundman, 2004) (See an example Figure 3.2 and Table 3.2).

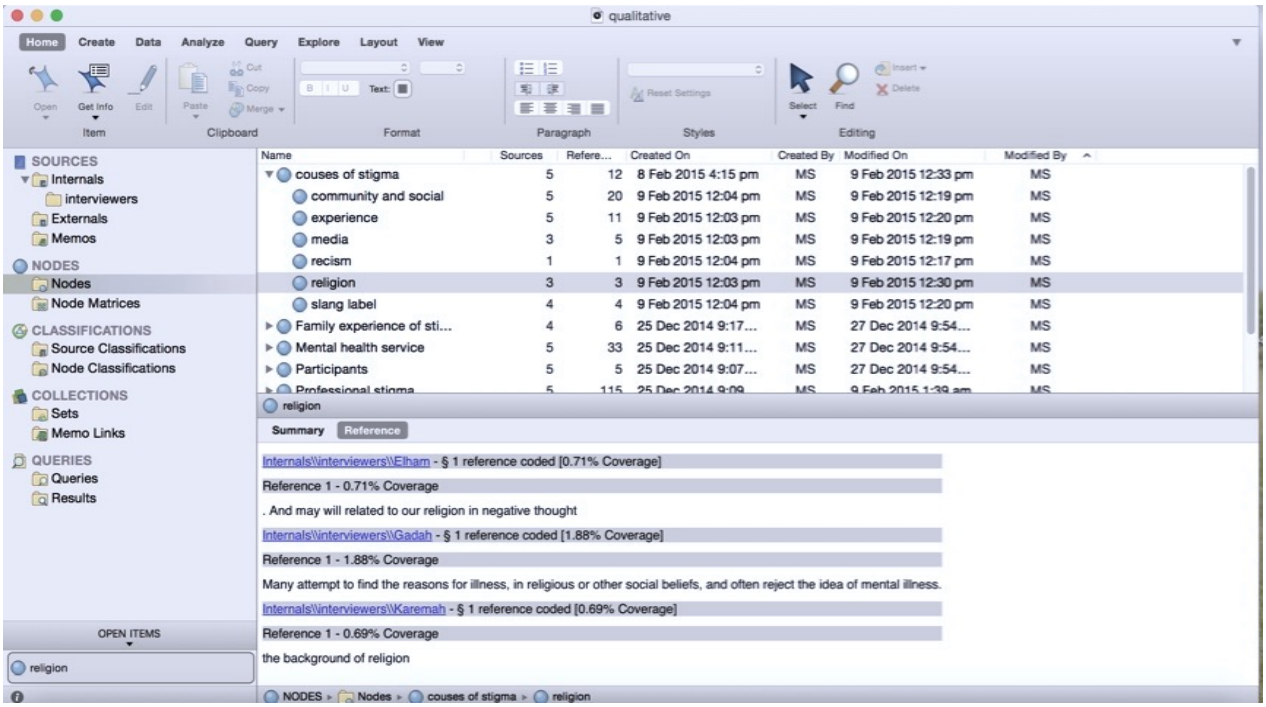

Figure 3.2. "Examples" NVivo10.1 Program data analysis used.

Table 3.2. *"Examples" Documented qualitative data obtained from the focus group discussion*

Listing and describing the individual categories	documented evidence was described	Interpreted		Analyses
Participant	One argument from the participant.	Main Them (Code- node)	Sup them (Sup code- node)	
Psychologist	"*Many attempts to find the reasons for illness, in religious or other social beliefs, and often reject the idea of mental health problems."*	Causes of professionally held stigma	Religion	One Saudi female participant psychologist member noted that some people ignore and refuse to countenance the idea of mental health problems, and view them from the perspective of their social and religious beliefs, rather than trying to understand the mental health problems. As she stated

Data protection issues – Data security for a qualitative questionnaire

It was not possible to fully anonymise data within the discussion, as the participants would see each other and hear the discussion. However, there were guidelines for the group discussion, which related to acknowledgement of differences of opinion and experience within the group discussion, working as a team, and the need not disclose information outside the discussion room. Privacy was a primary concern here, and the additionally sensitive nature of video recording was recognised. The system employed AES-256-bit encryption, which stored password-protected encrypted volumes on the relevant computer; the researcher held the password only. Backup copies were made and encrypted volumes stored securely on DVD-R discs at the University of Salford. Encrypted passages were to be opened only when the thematic analysis was being carried out. Digital security ensured that risks of tampering and unwelcome access were greatly reduced, as encryption serves as a form of protection even where volumes are inserted into laptops (Al-Krenawi & Graham, 2000).

In addition, the research observed all the required legal standards in relation to the meeting of Data Protection issues under the UK Data Protection Act 1998, while the data will be kept for three years following PhD completion, to enable publication and post-doctoral research. Subsequently, following the PhD completion, the anonymised data will be stored at the University of Salford for this period (See Appendix X).

Ethical Considerations

Ethics in research have long been a matter of academic debate, although it is critical for researchers to understand the basics of ethical issues and how these affect a research project (Nelson, Lushkov, Pomerantz, & Weeks, 2006;). Due to Raiborn and Payne (1990, p. 883), ethics can be described as “a system of value, principles or practices and a definition of right and wrong”. McCabe and Rabil (2002) expanded this definition by claiming that ethics refers to what is good and bad, right and wrong, just and unjust. Consequently, first, following the approval from the University of Salford ethics panel, permission from the Ethics Committees to allow this study to be conducted was gained from the administrations of Hospitals and Nursing College in Saudi Arabia, where participants were recruited (See Appendix XII. and XIII). Pertinent authorities approved the study protocol, and the study’s aim and procedures were explained to all potential participants of the research.

The provision of participants from each speciality agreed for quantitative and qualitative aspects of this study. These people also signed an informed consent form before participating in the focus group and data collection instruments. Participants were informed of their right to withdraw from the study at any time without giving any reason. This was written on the data collection instruments for the quantitative part of the research, and was communicated individually to those taking part in the qualitative section. The personal data of individuals taking part in any academic research is protected, as it is subject to the requirements of legislation, including the Data Protection Act (Redsell & Cheater, 2001), and the ethics code of the British Psychological Society, which states that "participants in psychological research have a right to expect that information they provide will be treated confidentially and, if published, will not be identifiable as theirs" (Robson, 1993, p. 593). They were assured about the confidentiality of any obtained information, and if published, it would not be identifiable to a specific participant.

For the quantitative and qualitative parts, since anonymity is impossible, trustworthiness is essential. The researcher's phone number and all possible communication methods were identified for the benefit of the participants to return at any time for any explanation. Moreover, no harmful manoeuvres were performed or used, and no foreseen hazards were anticipated from conducting the study, the information given in the participant information sheet can be found in (Appendix XV). Following the approval from the administrations of Hospitals and Nursing College for access to the hospitals and the nursing college where participants were recruited. Following official approval regarding data collection, the researcher contacted the head manager of the psychiatric and mental health department and the hospital and nursing college's research committee. Overall, it was not difficult to gather data from within the department, as subjects willingly completed questionnaires (invitation letter for head manager of the department, see Appendix XIV).

Informed consent

Participants who consented to take part in the study were afforded the time to read the information given in the Participant Information Sheet (See Appendix XV). The researcher was present during the consent process to answer any questions that the participant may have had. Due to Westbrook *et al.* (2013), the best form of consent is "informed" consent. This aspect was detailed at the beginning of the information sheet; it is essential that people who participate in research fully understand exactly what the research involves for them and freely

agree to participate in it (Steinemann *et al.,* 2006); freely given informed consent is at the heart of ethical research. Obtaining informed consent helped to ensure that participants were not deceived or coerced into participating in the research, and so the offer was open and honest in providing a clear explanation of the scope of consent being sought. To participate effectively in informed consent processes, the researcher had the knowledge, expertise and capability to provide sufficient information and could answer any questions raised by potential research participants. Due to Wellington, Bathmaker, Hunt, McCulloch and Sikes (2005), some participants may consent to involvement in the research without being fully aware of what their involvement entails. There are various methods that researchers can use to obtain consent (Steinemann *et al.,* 2006; Shalowitz & Wendler, 2006), although for this study a written document was chosen, which provided essential information for participants regarding the study's aim, what their participation involved and what would happen after the study, with reference to the use of their responses in publications (Participant Information Sheet and Research Participant Consent Form, See Appendix XV. XVI).

In this study, all participants were bound by professional codes of conduct and had an appreciation of the rule governing patient confidentiality (Steinemann *et al*., 2006). Nevertheless, participants were reminded that they should not disclose information about patients in any way, which could compromise patient confidentiality. The researcher carried out the focus group, as outlined in the Participant Information Sheet (Appendix XV), Qualitative Form (Appendix X) and by the Participants Invitation to focus group discussion (Appendix VIII). Participants were informed in the qualitative form that there would be video and audio recordings, although they could stop the audio and video recording at any time and for any reason, if they felt uncomfortable. During the research, other ethical principles were applied. For instance, during the qualitative aspect of the study, the participants were offered the option of anonymity and advised of the security and privacy of the tape recordings, which would be destroyed after they had been analysed. Participants were made to feel as comfortable as possible during the discussion process, to be able to concentrate and feel confident enough to answer the questions without inhibition. Additionally, a location was chosen that offered privacy and a pleasant and relaxing atmosphere.

In addition, the participants in the focus group were asked not to discuss the past or current patients and were only required to discuss their professional experiences while interacting with people living with mental health problems. This ensured that the confidentiality and privacy of those with mental health problems were protected. The researcher also informed the participants that, if a breach of confidentiality occurred, the discussion would be ended

immediately and it would be requested that the participants stopped talking and respected the privacy of patients if they wished to continue participating in the focus group. The focus group discussion could restart, once patient confidentiality was assured.

Conclusion

This chapter outlined the key principles and concepts of this study, and it provided sound reasoning for the use of a mixed method approach. It clearly outlined the ways in which the chosen approach suits the study. The researcher was responsible for establishing the criteria whereby the mental health experts were recruited. The quantitative and qualitative studies were both carried out in Riyadh city for reasons of legitimacy and fairness. Furthermore, the findings and an evaluation of the outcomes are featured in the following chapters.

CHAPTER 4: FINDINGS

Overview

In this chapter, the findings from the mixed methods research are outlined. Summaries of the demographic features of the participants, for both the quantitative and qualitative studies, are illustrated in Appendix VI and Appendix VIII**.** Participants were sourced from three hospitals and one university in Riyadh city, Saudi Arabia. In this chapter, the investigations and evaluation of the findings of the study will be presented in two parts. The first section will outline the results of the quantitative data analysis (Phase One) with 50 participants, whilst the subsequent section will outline the findings from the analysis of the qualitative data (Phase Two) with 5 participants. The final section will outline the findings from the analysis of the engagement result in the mixed method, and the frequencies of data score measures of five focus group members that participated in (Phase two), with qualitative analysis in (Phase one) of the quantitative analysis data.

Phase One (Quantitative) Data Analysis

In phase one, the sample group is expounded upon and the preparatory assessment (including the description of instruments therein and reliabilities and desirability) is shown, after which the findings of the research questions are presented. The data acquisition involved the creation of two separate data sets; Dependent variables (The Emotional Reaction on People with mental health problems scale and Attitude Scale Questionnaire-Short Form (AQ-SF)); Independent variables (Group of specialities, Nationality, Gender, Qualification, Post-graduate qualification, Experience years, and Work Setting).

Demographic questionnaire

In addition to the completion of the previously stipulated questionnaires, the sample population gave details regarding their demographics and filled in their questionnaires (See Appendix VII. Table 4.1). This questionnaire gave the researcher the data required to complete the study, including the data regarding the sample population's details (including elements such as their nation of birth; gender; grouping of specialists; qualifications owned and experience in field) and aspects regarding their profession (level of degree; connection to their working environment).

Table 4.1. *The Characteristics of the participants' in the study sample, Self -Report Questioners (n=50)*

	Frequency	Per cent
	Group of specialities	
Faculty of mental health nurse	10	20.0
Psychiatrist	10	20.0
Mental health nurse	10	20.0
Psychologist	10	20.0
Social worker	10	20.0
	Nationality	
Saudi	36	72.0
Non-Saudi	14	28.0
	Gender	
Male	23	46.0
Female	27	54.0
	Qualification	
Diploma	6	12.0
Bachelor	19	38.0
Master	14	28.0
Doctorate	11	22.0
	Post-graduate qualification	
No	25	50.0
Yes	25	50.0

	Experience years	
<10	24	48.0
10+	26	52.0
	Setting	
Nursing College	10	20.0
Mental health hospital	21	42.0
Public Hospital	3	6.0
University Hospital	16	32.0

Description of Respondents (Professionals)

After participants completed the demographic questionnaire, 50 participant responses were included in the data analysis. This group included mental health workers (n=50), which consisted of a faculty of mental health nurse 20%, (n=10); psychiatrists 20%, (n=10); psychologists 20%, (n=10); and social workers 20%, (n=10); and mental health nurses 20%, (n=10). Overall, most respondents described themselves as Saudi 72.0% (n= 36) with the remainder of the participants identifying as non-Saudi 28.0% (n = 14). Furthermore, participant gender was noted (male=46.0 %, n=23; female = 54.0%, n=27) with experience years (48.0%; 24<10; 52.0%; 26=10+, SD= 9.5±0.5). Moreover, most respondents' qualifications were shown as: Diploma (12.0%; n=6), Bachelor (38.0%, n=19), Master (28.0%, n=14), Doctorate (22.0%, n=11), with Post-graduate qualification (50.0%, n=25), Non-Post-graduate qualification (50.0%, n=25). The setting for the respondents was in the Nursing College (20.0%, n=10); Mental health hospital (42.0%, n=21), Public Hospital (06.0%, n=3), University Hospital (32.0%, n=16).

Phase One (Quantitative) Data Analysis Results

Validity and Reliability of the Stigma Scale

Reliability of the stigma scale was calculated through use of the internal consistency method (Average inter-item correlation), which is linked with the Cronbach Alpha coefficient. Consequently, this produces a reliability measure known as a correlation coefficient. A key foundation of the internal consistency technique is the scaling theory (Boynton & Greenhalgh, 2004). Initially, the scaling theory was developed to calculate the single factor - stigma. Thus, the items are likely to have strong correlations, not only amongst themselves but also with the factor stigma. The consequent relationship or correlation indicates that the scale items are perhaps a valid measure of stigma. The Cronbach alpha score of 0.83 provides an approximation of the fraction of the total variance, which cannot be attributed to error, and thus, illustrates the reliability of the scale (Boynton & Greenhalgh, 2004).

Reliability Scale: Emotional Reaction on People with mental health problems scale.

Table 4.2. *Reliability Scale: Emotional reaction on people with mental health problems scale*

		N	%	Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	Mean	Variance	Std. Deviation	N of Items
Cases	Valid	50	100.0	.844	.846	77.28	226.573	15.052	29
	Excluded	0	.0						
	Total	50	100.0						

Reliability Statistics - Scale Statistics

Table 4.2. Shows reliability with a Cronbach Alpha score of .844.

Reliability Scale: Attitude scale

Table 4.3. *Reliability Scale: Attitude scale*

		N	%	Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	Mean	Variance	Std. Deviation	N of Items
Cases	Valid	50	100.0	.870	.867	51.240	91.778	9.5801	27
	Excluded	0	.0						
	Total	50	100.0						

Reliability Statistics - Scale Statistics

Table 4.3. Shows reliability with a Cronbach Alpha score of .870

Therefore, along with examining how emotional reactions correlated with attitudes toward people with mental health problems, one purpose of including this instrument in the study was to examine the psychometric properties and provide empirical evidence of the internal consistency of this measure. Indeed, this approach represents a significant correlation between stigma score and coping mechanism on the emotional reaction scale, which provided a Cronbach Alpha score of .844, and a significant correlation between stigma score and coping mechanism on the attitude scale, with a Cronbach Alpha score of .870.

Data Analysis and Findings (Emotional Reaction on People with mental health problems scale)

The Frequency distribution of Emotional Reaction on People with mental health problems score.

Table 4.4. *Analytical results of the raw score frequency of emotional reaction on people with mental health problems: Test Scale*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	46.00	1	2.0	2.0	2.0
	49.00	1	2.0	2.0	4.0
	51.00	1	2.0	2.0	6.0
	53.00	1	2.0	2.0	8.0
	58.00	1	2.0	2.0	10.0
	59.00	1	2.0	2.0	12.0
	61.00	3	6.0	6.0	18.0
	62.00	1	2.0	2.0	20.0
	63.00	1	2.0	2.0	22.0
	66.00	1	2.0	2.0	24.0
	67.00	1	2.0	2.0	26.0
	68.00	2	4.0	4.0	30.0
	70.00	1	2.0	2.0	32.0
	71.00	3	6.0	6.0	38.0
	72.00	1	2.0	2.0	40.0
	73.00	1	2.0	2.0	42.0
	74.00	2	4.0	4.0	46.0
	76.00	3	6.0	6.0	52.0
	79.00	1	2.0	2.0	54.0
	80.00	1	2.0	2.0	56.0
	81.00	1	2.0	2.0	58.0

82.00	1	2.0	2.0	60.0
83.00	1	2.0	2.0	62.0
84.00	2	4.0	4.0	66.0
85.00	1	2.0	2.0	68.0
87.00	1	2.0	2.0	70.0
88.00	1	2.0	2.0	72.0
89.00	2	4.0	4.0	76.0
90.00	2	4.0	4.0	80.0
91.00	2	4.0	4.0	84.0
95.00	4	8.0	8.0	92.0
100.00	1	2.0	2.0	94.0
101.00	1	2.0	2.0	96.0
106.00	1	2.0	2.0	98.0
107.00	1	2.0	2.0	100.0
Total	50	100.0	100.0	

Statistics

		E-High score=high stigma	Raw Score on emotional reaction
N	Valid	50	50
	Missing	0	0
Mean		77.2800	93.32
Median		76.0000	93.50
Std. Deviation		15.05234	14.582

In relation to the 29 items using the Five-Likert scale (agree, strongly agree, neutral, disagree, strongly disagree), the theorising range of distribution is set at 29 to 145 facts scores. The results are presented in Table 4.4 above, which shows that 46 facts scores are the lowest stigma score. Meanwhile, 107 facts scores are the highest stigma score. Additionally, both the Mean score (77.2800) and the Median score (76.0000) are similar in number, which indicates a similarity between the highest and lowest levels of stigma toward people with mental health problems in the Emotional Reaction scale. Finally, the participants show a professional stigma, as demonstrated in the score results in the above Figure (See Figure 4.1) Meanwhile, it is evident that all the participants hold a professional stigma towards people with mental health problems of varying degrees.

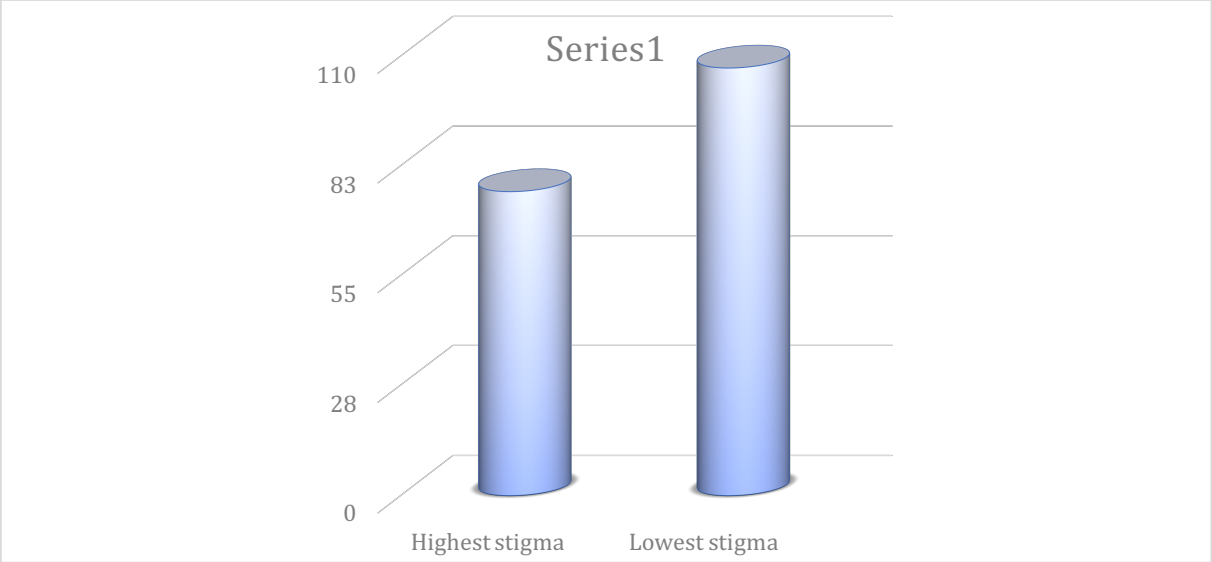

Figure 4.1 Raw score frequency on emotional reaction on people with mental health problems Test Scale.

This study focuses on the following research questions:

How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?

A large amount of variability exists amongst members of a professional mental health team. Details of this can be found in Table 4.5. Below.

Table 4.5. *Summaries relation between participants' emotional Reaction on people with mental health problems scale and participants' characteristics*

	Attribution scores (max=4)		**N**	***F***	***p*-value**
	Mean	**SD**			
			Group		
Faculty of mental health nurse	74.7000	9.40508	10	11.646	.000
Psychiatrist	62.0000	14.77987	10		
Mental health nurse	82.1000	11.52244	10		
Psychology	73.4000	10.15655	10		
Social worker	94.2000	7.95543	10		
Total	77.2800	15.05234	50		
			Nationality		
Saudi	77.1667	16.02409	36	1.687	.200
Non-Saudi	77.5714	12.75035	14		
			Gender		
Male	76.3478	16.38627	23	.761	.387
Female	78.0741	14.08471	27		

		Qualification			
Diploma	78.1667	9.94820	6	1.396	.256
Bachelor	81.2105	16.93641	19		
Master	77.5000	16.14716	14		
Doctorate	69.7273	10.62159	11		
Total	77.2800	15.05234	50		
		Post-graduate qualification			
No	80.4800	15.41136	25	.000	.998
Yes	74.0800	14.27387	25		
		Experience years			
<10	77.3750	15.97501	24	.072	.789
10+	77.1923	14.46657	26		
		Setting			
Nursing College	74.7000	9.40508	10	1.805	.160
Mental health hospital	82.5238	16.60006	21		
Public Hospital	66.3333	2.88675	3		
University Hospital	74.0625	15.51115	16		

Relationship between Emotional Reaction on People with mental health problems scale and profile of the participants

Data methods used to evaluate the data were the independent samples t-test and the One-Way Analysis of Variance (One-Way ANOVA) as given in the Statistical Package for the Emotional Reaction scale. The independent t-test and the One-Way ANOVA methods produce a one-way analysis of variance for a quantitative dependent variable using an independent or single factor variable. The results of the independent samples t-test and the One-Way ANOVA variance are reviewed below considering the relevant research questions.

Group Statistics (Independent samples t-test)

The underpinning research question denotes that factors (i.e. nationality, gender, years of experience and post qualification) relating to respondents would not significantly affect the perception of the professional stigma toward people with mental health problems. When evaluating this research question, data was evaluated using the independent samples t-test, while statistical conclusions were set at an alpha level of 0.05 (See Table 4.5). Both the demographic or control variable were evaluated to examine the connection between the predictor and variables. This enables an evaluation of any initial configuration in the data prior to performing further data evaluation. Consequently, the demographic variables did not significantly account for any variance in the model. The variables included: nationality (F (1.687); p=. 200> 0.05), gender (F (.761); p=. 387>0.05), years of experience (F (.072); p=. 789 >0.05), post-qualification (F (.000); p=. 998 >0.05). Analysis of Between-Subjects Effects was performed, which indicated no significance. Meanwhile, the other respondents showed no significance, as the p-value is always greater than 0.05.

Group Statistics One-Way ANOVA

The research question states that various factors (i.e. group specialist, qualification and work setting) of the respondents would show significant statistical differences between the subcategories of five groups in sub-specialists. This would affect the perception of professional stigma toward people with mental health problems. When evaluating this research question, the data was tested using an analysis of One-Way ANOVA whilst statistical inferences were determined at the alpha level of 0.05. The results can be found above. Indeed, when testing these variables, ANOVA was used, which were performed to detect any differences between the levels and category of each of the variables in the Emotional Reaction scale.

The results are displayed in the tables above. A difference existed between the different specialist groups and between the variables of the subspecialists (See Table 4.5); the results show the relationship between the Emotional Reaction scale and the respondents within the different specialist's groups. Significant statistical differences exist between the five different specialist groups [*F* (11.646); *p*=. 000<0.05]. Meanwhile, in contrast to this, the respondents showed no significance as the *p*-value was always greater than 0.05 (*p*>0.05). The variables of the other demographic variables were: qualifications (*F* (1.396); *p*=. 256>0.05) and work setting (*F* (1.805); *p*=. 160>0.05).

Principal Component Analysis.

When analysing the results of the dimension reduction factors, nine component factors existed regarding the emotional reaction on people with mental health problems scale. The high scores of each component affected the results with stigma analysis. Three main analysis results of principal component factors were selected 'Exclusion',' Rejection', and 'Caution'. See Table 4.6.

Table 4.6. *Factor analysis dimension attribution to emotional reaction on people with mental health problems scale*

Numb	Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
		Total	% Of Variance	Cumulative %	Total	% Of Variance	Cumulative %
A	**Exclusion**	**6.885**	**23.743**	**23.743**	**6.885**	**23.743**	**23.743**
1	The arguments of local employees against the establishment of mental health services in the health care centre are well founded.						
2	An individual should be admitted to hospital at the first sign of mental health problems.						
3	Individuals with a history of mental health problems should not be allowed to hold a job associated with responsibilities.						
4	Negative social factors are at the root of people with mental health problems.						
5	No responsibilities should be assigned to the people with mental health problems.						
6	Isolation of the people with mental health problems from society is necessary.						

7	Keeping the people with mental health problems locked away is the most appropriate way to deal with them.						
8	It is therapeutic for the people with mental health problems to be integrated into healthcare, but disadvantageous to the other patients.						
B	**Rejection**	**3.077**	**10.610**	**34.353**	**3.077**	**10.610**	**34.353**
1	Individuals suffering from mental health issues are considered a burden on others.						
2	Individuals with a history of mental illness should be prohibited from employment in government positions.						
3	Conversing with individuals with mental health problems is difficult.						
C	**Caution**	**1.632**	**5.628**	**60.990**	**1.632**	**5.628**	**60.990**
1	When dealing with people with mental health problems, it is necessary to bear in mind that their behaviour can be unpredictable.						
2	The people with mental health problems may seem to be normal, but one must always remember that they are not.						
3	People with mental health problems and individuals with mental health are two different things.						

Extract the factors

"Extract the factors is a principle component analysis" (Morales, Martı, Llopis, Campos, & Sagrado, 1993, p. 109). This method evaluates the extent that factors account for any dissimilarity. The aim is to pinpoint the linear combination of variables, which contribute to the highest level of common variance. The factors in the principle component analysis indicate connections between individual relationships. Indeed, the factor loadings in this study are the correlations between the factors and their associated variables. The Eigenvalue is used to determine cut-off factors using a worth. In similarity to regression, the Eigenvalue indicates the "power" of each factor (Morales *et al.,* 1993, p. 109). It is evident from the data evaluation that three subscales exist: exclusion, rejection and caution. Due to Morales and his colleagues indicated that every subsequent factor denotes an element of the outstanding variance until a specific juncture is attained, known as an Eigenvalue of 1. When this occurs, it can be determined that any factors are not applicable to the paradigm used. Any factors with an Eigenvalue greater than 1 illustrate the number of factors required to depict the underpinning dimensions of the data (Morales *et al.,* 1993, p. 109).

Table 4.6 illustrates the principle components analysis. The first factor (Exclusion) is the main contributor to the highest level of common variance (23.743), representing an Eigenvalue of 6.885.

Correlation relationship between the existing factors and the profile of the participants.

To indicate any differences between the factors scores and the type of response.

Table 4.7. *Correlation relationship between the existing factors and profile of the participants.*

		N	%	Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	Mean	Variance	Std. Deviation	N of Items
Cases	Valid	50	100.0	.872	.874	41.78	117.644	10.846	14
	Excluded	0	.0						
	Total	50	100.0						

Reliability Statistics - Scale Statistics

Table 4.7. Shows reliability with a Cronbach Alpha score of .872

Table 4.8. *Summaries of relation between participants' emotional reaction extract the factors scale and participant's characteristics.*

	Attribution scores (max=4)		**N**	***F***	***p*-value**
	Mean	**SD**			
		Group			
Faculty of mental health nurse	42.3000	5.83190	10	7.455	.000
Psychiatrist	30.2000	10.92195	10		
Mental health nurse	42.5000	6.85160	10		
Psychology	42.4000	10.30857	10		
Social worker	51.5000	8.87255	10		
Total	41.7800	10.84640	50		

		Nationality			
Saudi	42.0556	11.83203	36	2.417	.127
Non-Saudi	41.0714	8.10948	14		
		Gender			
Male	40.8696	12.32257	23	1.281	.263
Female	42.5556	9.58498	27		
		Qualification			
Diploma	40.3333	6.65332	6	.792	.504
Bachelor	43.9474	12.52763	19		
Master	42.5714	11.70611	14		
Doctorate	37.8182	8.08478	11		
Total	41.7800	10.84640	50		
		Post-graduate qualification			
No	43.0800	11.37585	25	.000	.669
Yes	40.4800	10.35664	25		
		Experience years			
<10	42.2083	11.91630	24	1.221	.275
10+	41.3846	9.98029	26		
		Setting			
Nursing College	42.3000	5.83190	10	1.923	.139
Mental health hospital	45.4286	11.74977	21		
Public Hospital	36.0000	8.71780	3		
University Hospital	37.7500	11.26351	16		

Both the demographic or control variable were analysed to evaluate the connection between predictor and variables. This enabled the evaluation of any initial connection between the data prior to performing further data evaluation. Extract factors were examined in the Emotional Reaction scale. Data methods used to evaluate the data were the Independent samples t-test and the One-Way Analysis of Variance (One-Way ANOVA) as given in the Statistical Package for the Emotional Reaction scale. Moreover, the respondents showed a difference between the variables of subspecialist groups. Table 4.8 shows the relationship between the Emotional Reaction scales in the group to extract the Factors and the subspecialists group. A significant statistical difference exists between the subspecialists of five groups with [F (7.455); p=. 000<0.05]. Meanwhile, the other respondents showed no significance as the p-value is always greater than 0.05 (p >0.05).

Data Analysis and Findings (Attitude scale).

The Frequency Distribution of attitude scores

Table 4.9. *Analytical results of the raw score frequency of the attitude scale*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	27	1	2.0	2.0	2.0
	36	1	2.0	2.0	4.0
	38	2	4.0	4.0	8.0
	40	1	2.0	2.0	10.0
	41	1	2.0	2.0	12.0
	42	2	4.0	4.0	16.0
	43	1	2.0	2.0	18.0
	44	4	8.0	8.0	26.0
	46	5	10.0	10.0	36.0
	47	2	4.0	4.0	40.0
	48	1	2.0	2.0	42.0
	49	2	4.0	4.0	46.0
	50	1	2.0	2.0	48.0
	51	2	4.0	4.0	52.0
	52	2	4.0	4.0	56.0
	53	5	10.0	10.0	66.0
	54	1	2.0	2.0	68.0
	56	1	2.0	2.0	70.0
	57	3	6.0	6.0	76.0
	58	1	2.0	2.0	78.0
	59	3	6.0	6.0	84.0
	61	1	2.0	2.0	86.0
	62	2	4.0	4.0	90.0
	66	2	4.0	4.0	94.0
	67	1	2.0	2.0	96.0

70	1	2.0	2.0	98.0
78	1	2.0	2.0	100.0
Total	50	100	100	

Statistics		
N	Valid	50
	Missing	0
Mean		51.24
Median		51.00
Std. Deviation		9.580

In relation to the 27 items using the three-Likert scale (rarely, sometimes, frequency), the theorising range of distribution was set at 27 to 78 facts scores. The results are presented in Table 4.9**.** The table shows that 27 facts scores are the lowest stigma score. Meanwhile, 78 facts scores are the highest stigma score. Both the Mean score (51.24) and the Median score (51.00) are similar in number, indicating a similarity between the highest and lowest levels of stigma toward people with mental health problems on the attitude scale. Finally, the participants show a professional stigma, as demonstrated in the score results in the above Figure (See Figure 4.2). Meanwhile, it is evident that all the participants hold a professional stigma towards people with mental health problems of varying degrees.

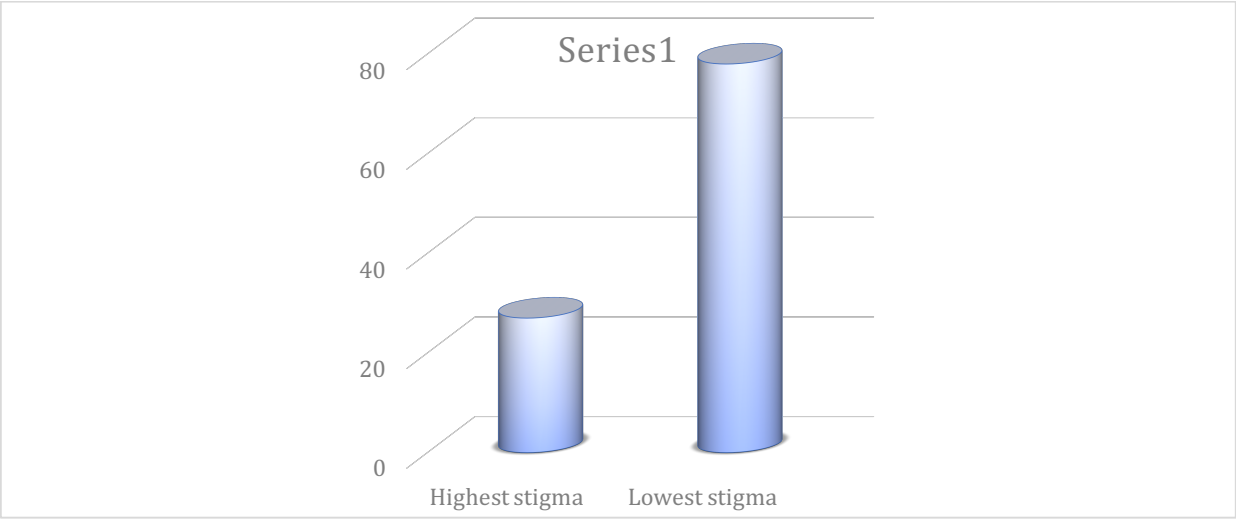

Figure 4.2 Raw score frequency of the attitude scale

This study focuses on the following research questions:

To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?

A large amount of variability exists amongst members of a professional mental health team. Details of this can be found in Table 4.10. Below.

Table 4.10. *Summaries relation between participants' attitude scale and participants' characteristics.*

	Attribution scores (max=4)		**N**	***F***	***p*-value**
	Mean	**SD**			
		Group			
Faculty of mental health nurse	46.40	5.797	10	6.187	.000
Psychiatrist	45.90	7.249	10		
Mental health nurse	53.40	6.883	10		
Psychology	49.30	10.001	10		
Social worker	61.20	9.426	10		
Total	51.24	9.580	50		
		Nationality			
Saudi	51.44	10.112	36	.319	.575
Non-Saudi	50.71	8.380	14		
		Gender			
Male	49.74	9.882	23	.482	.491
Female	52.52	9.308	27		

		Qualification			
Diploma	53.83	5.456	6	4.063	.012
Bachelor	55.42	11.974	19		
Master	50.00	5.602	14		
Doctorate	44.18	6.462	11		
Total	51.24	9.580	50		
		Post-graduate qualification			
No	55.04	55.04	25	3.437	.070
Yes	47.44	47.44	25		
		Experience years			
<10	52.29	9.800	24	.487	.489
10+	50.27	9.460	26		
		Setting			
Nursing College	46.40	5.797	10	2.786	.051
Mental health hospital	54.71	11.163	21		
Public Hospital	43.00	4.583	3		
University Hospital	51.25	8.037	16		

Relationship between Attitude scale and profile of the participants

Data methods used to evaluate the data were the Independent samples t-test and the One-Way Analysis of Variance (One-Way ANOVA), as given in the Statistical Package for the Attitude scale. The independent t-test and the One-Way ANOVA methods produce a one-way analysis of variance for a quantitative dependent variable using an independent or single factor variable. The results of the independent samples t-test and the One-Way ANOVA variance are reviewed following the formation of the relevant research questions.

Group Statistics (Independent samples t-test)

The underpinning research question denotes that factors (i.e. nationality, gender, years of experience and post qualification) relating to respondents would not significantly affect the perception of the professional stigma toward people with mental health problems. When evaluating this research question, data was evaluated using the Independent samples t-test, while statistical conclusions were set at an alpha level of 0.05 (See Table 4.10). Both the demographic or control variable were evaluated to examine the connection between the predictor and variables. This enables the evaluation of any initial configuration in the data prior to performing further data evaluation. The demographic variables did not significantly account for any variance in the model. The variables included: nationality (F (.319); p =. 575> 0.05), gender (F (.482); p=. 491>0.05), years of experience (F (.487); p =. 489>0.05), post-qualification (F (3.437); p =. 070>0.05). An analysis of Between-Subjects Effects was performed and it indicated no significance, as the p-value was always greater than 0.05 (p >0.05).

Group statistics One-away (ANOVA)

The research question states that various factors (i.e. group specialist, qualification and work setting) of the respondents would show significant statistical differences between the subcategories of five groups in sub-specialists. Consequently, this would affect the perception of professional stigma toward people with mental health problems. When evaluating this research question, the data was tested through use of analysis of One-Way ANOVA, whilst statistical inferences were determined at the alpha level of 0.05. One-way ANOVA tests were performed to detect any differences between the levels and category of each of the variables in the attitude scale. The results can be found in Table 4.10.

A difference existed between the different specialist groups and between the variables of the subspecialists. In Table 4.10. The results show the relationship between the Attitude scale and the respondents within the different specialist's groups. Significant statistical differences exist between the five different specialist groups [F (6.187); p =. 000<0.05]. Meanwhile, in contrast to this, the respondents showed no significance, as the p-value was always greater than 0.05 (p >0.05). The variables of the other demographic variables were: qualifications [F (4.063); p =. 012>0.05] and work setting [F (2.786); p =. 051>0.05].

Principal Component Analysis.

When analysing the results of the dimension reduction factors, four component factors existed regarding attitude attribution test. The high scores of each component affected the results with stigma analysis, while two main analysis results of principal component factors were selected: 'Risk', and 'Fear'. See Table 4.11.

Table 4.11. *Factor analysis dimension attribution to attitude scale.*

Numb	Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
		Total	% Of Variance	Cumulative %	Total	% Of Variance	Cumulative %
A	**Risk**	**6.595**	**24.425**	**24.425**	**24.425**	**6.595**	**24.425**
1	When I am around someone with mental health problems, worry that he or she might harm me physically.						
2	I think a person with mental health problems poses a risk to his/her neighbours unless he/she is hospitalised.						
3	I think it would be best for people with mental health problems, and keep them away in a psychiatric hospital.						
4	A person with mental health problems can be isolated from his neighbours						
5	How much do you agree that any person with mental health problems should be forced into treatment with his/her doctor even if he does not want to?						
6	If I oversaw person with mental health problems treatment, I would force him to live in a group home.						
B	**Fear**	**4.815**	**17.832**	**42.257**	**42.257**	**4.815**	**17.832**
1	I would feel anxious or very uneasy in the presence of the person with mental health problems.						
2	I don't think that I can relax and be myself when I'm around someone with mental health problems.						
3	People with mental health problems would terrify me.						
4	How scared of people with mental health problems. Would you feel?						

Extract the factors

It is evident from the data evaluation that two subscales exist: 'Risk' and 'Fear'. In Table 4.11. Above illustrates the principle components analysis, the first factor (Risk) is the main contributor to the highest level of common variance (24.425), which represents an Eigenvalue of 6.595.

Correlation relationship between the existing factors and profile of the participants

To indicate any differences between the factors scores and the type of response.

Table 4.12. *Correlation relationship between the existing factors and profile of the participants.*

		N	%	Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	Mean	Variance	Std. Deviation	N of Items
Cases	Valid	50	100.0	.866	.864	17.84	29.647	5.445	10
	Excluded	0	.0						
	Total	50	100.0						

Reliability Statistics - Scale Statistics

Table 4.12. Shows reliability with a Cronbach Alpha score of .866

Table 4.13. *Summaries of relation between participants' attitudes extract the factors scale and participant's characteristics.*

	Attribution scores (max=4)		**N**	***F***	***p*-value**
	Mean	**SD**			
			Group		
Faculty of mental health nurse	14.90	2.846	10	6.223	.000
Psychiatrist	15.50	5.276	10		
Mental health nurse	19.10	3.281	10		
Psychology	17.40	4.274	10		
Social worker	23.30	5.143	10		
Total	18.04	5.107	50		

		Nationality			
Saudi	17.92	5.347	36	.223	.639
Non-Saudi	18.36	4.601	14		
		Gender			
Male	17.78	5.342	23	.992	.324
Female	18.26	4.989	27		
		Qualification			
Diploma	19.67	2.422	6	3.596	.020
Bachelor	20.37	6.030	19		
Master	16.36	3.388	14		
Doctorate	15.27	4.496	11		
Total	18.04	5.107	50		
		Post-graduate qualification			
No	20.20	5.346	25	2.969	.091
Yes	15.88	3.866	25		
		Experience years			
<10	18.08	4.934	24	.827	.368
10+	18.00	5.359	26		
		Setting			
Nursing College	14.90	2.846	10	3.076	.037
Mental health hospital	19.90	6.016	21		
Public Hospital	14.33	1.528	3		
University Hospital	18.25	4.187	16		

Both the demographic or control variable were analysed to evaluate the connection between predictor and variables. This enabled the evaluation of any initial connections between the data prior to performing further data evaluation. Extract factors were examined in the attitude attribution scale. Data methods used to evaluate the data were the Independent samples t-test and the One-Way Analysis of Variance (One-Way ANOVA), as given in the Statistical Package for the attitude scale. The respondents showed a difference between the variables of subspecialist groups. Table 4.13. Shows the relationship between the attitude attribution scales in the group to Extract the Factors and the subspecialists group.

A significant statistical difference exists between the subspecialists of five groups with [F (6.223); p =. 000<0.05]. Meanwhile, the other respondents showed no significance, as the p-value is always greater than 0.05.

Conclusion

The quantitative outcomes of this study have been explored in this chapter, along with an evaluation of the study population and the preliminary analyses, as well as the methodology and reliability of the work. These results demanded greater attention, and the study proceeded by analysing and presenting the differences that existed between members of the professional mental health team, where the level of revelation within the mental health team presented an interesting find. In general, the survey showed that in Riyadh (KSA) the outlook of stigma demonstrated by mental health professionals toward people with mental health problems during the first two months of 2015, participants appeared to be more appreciative of stigma regarding people with mental health problems by displayed indications a variety of results. A variety of results are seen between the corresponding analysis, based on a five-point Likert scale containing the values ‘strongly agree’ to ‘strongly disagree;’ in terms of perception of stigma amongst mental health professionals; in emotional reaction scale and attitude scale; based on a three-point Likert scale containing the values ‘rarely’, ‘sometimes’, and ’frequently’. Consequently, it is evident that all the participants demonstrated a professional stigma towards people with mental health problems of varying degrees. Because of this study, it is apparent that the extract factors influence and contribute to a higher level of professional stigma regarding mental health problems in Saudi Arabia. The results and an appraisal of these are included in the next section.

Phase Two (Qualitative) Data Analysis

In Phase Two of the study, the sample group is questioned on the potential perspectives and views of professional stigma towards individuals with mental health problems, and how they are compatible or comparable to the conceptual framework. The findings are dependent on the interpretation of perceptions and experiences, can embody multiple themes. This is demonstrated by the findings of the research questions.

Demographic questionnaire

The questionnaire provided the researcher with additional data, such as the characteristic nature of the participant population in Table 4.14; which includes considered variables that might impact on the data: nationality; gender; age; marital status; religiosity; specialisation; qualifications; previous experience; location of workplace; and social and financial level, as well as personalised attributed, qualification level and connection to their place of work; all of which could be considered as part of the Saudi Arabian environment. It is relevant that the sub-specialist may have been of a different nationality; originated from a different background, adhered to a different religion, was of a different gender, or simply [sic] had a different perception, which impacted on the findings (See Appendix IX).

Table 4.14. *The Characteristics of the participants in the study sample, Focus Group Discussion (n=5)*.

Personal characteristics		Participants No.
Group of specific specialists	Psychiatrist	1
	Psychology	1
	Social worker	1
	Mental health nurse	1
	Faculty of mental health nurse	1
Nationality	Saudi	3
	Non- Saudi	2

Gender	Male	2
	Female	3
Religion	Muslim	4
	Non-Muslim	1
Marital status	Married	4
	Non- Married	1
Qualification	Diploma	1
	Postgraduate	1
	PhD	3
Years of professional experience	5-10	2
	26-30	1
	31-35	1
	40+	1
Socio- economic status	Low	0
	Middle	3
	High	2
Setting of workplace	University Hospital	4
	Nursing College	1
Age	25-39	1
	40-59	3
	60+	1

Description of Respondents (Professionals)

After participants in focus group discussion completed the demographic questionnaire, there were 5 participants whose responses were included in the data analysis, 60% (n=3) female, and 40% (n=2) male. This group (n=5), included faculty of mental health nurses 20%, (n=1); psychiatrists 20%, (n=1); psychologists 20%, (n=1); social workers 20%, (n=1); and mental health nurses 20%, (n=1). Most respondents described themselves as Saudi 60.0% (n= 3) with the remainder of the participants identifying as non-Saudi 40.0% (n = 2). Other demographic information includes marital status (married =80 %, n=4; non-married = 20%, n=1) with experience years (<30 years=2, >30 years=3). Most respondents' qualifications were with Post-graduate qualification (80%, n=4), with Non-Post-graduate qualification (20%, n=1). Additionally, the setting for the respondents was in the Nursing College (20.0%, n=1); University Hospital (80%, n=4).

Phase Two (Qualitative) Data Analysis Results

Each statement was regarded as significant and has the possibility of being relevant to the study objective. Every single relevant statement was coded within the NVivo10.1 program as a free node from the start (a node without instruction or meaning). These major themes are presented from the perspectives of the study participants. The four main thematic clusters delineated from the analysis help to identify the phenomenological factors that underlie the existence of a professional stigma towards people with mental health problems, and within each theme, sub-themes were observed. During the focus group discussion, each participant was afforded the time to gather their thoughts and reflect upon or imagine situations and experiences in which they exhibited professional stigma towards people with mental health problems. As mentioned in the literature review, data analysis includes the highlighting of what Tracy (2010, p. 840) described as, "significant statements, sentences, or quotes that provide an understanding of how the participant experiences the phenomenon". Moreover, the analysis of the five participants in the focus group discussion (Faculty of mental health nurse, Psychiatrist, Psychology, Social worker, and Mental health nurse) revealed four main thematic clusters of professional stigma experiences, as endorsed by participants and elucidated in Table 4.15.

Table 4.15. *Major themes and sub-themes of participant's perspectives in focus group discussion.*

Themes	Sub-themes
Experiences of stigma held by professionals (toward people with mental health problems)	Negative feelings
	Positive attitudes
	Diagnosis
	Through the relationship and interaction
	Acceptance
	Stigma experiences within marital relationships
Causes of professionally held stigma	Experience
	Media
	Community
	Racism
	Religion
	Labels
Impact of professional stigma on mental health services	Deficiency
	Immigration
	Policy
Interventions recommended minimising stigma in general, and professional stigma	Community
	Education
	Media
	Mental health care services
	Saudi government Support

The thematic clusters were further analysed for common themes of experience among the participants (See Appendix XVII). To summarise, relevant information to assist in the interpretation of the qualitative data was obtained by carrying out the focus group, which emphasised four key themes of importance for the mental health professionals' team:

- Experiences of stigma held by professionals (toward people with mental health problems).
- Causes of professionally held stigma.
- The impact of professional stigma on mental health services.
- Interventions recommended minimising stigma in general and professional stigma.

The focus group offered possible suggestions of actions that could minimise stigma and professional stigma. Suggestions included ways of improving support to mental health professionals. Aspects concerning the impact of professional stigma on mental health services, suggestions for improvements were also revealed during the qualitative data gathering focus group discussion. It is important to note that the participants raised the cause of professionally held stigma as an area of concern; this was, however, not exposed by the questionnaires. On the following page, quotes can be found from the focus group concerning the main themes. In qualitative data analysis, all participating members undertake some form of group discussion and all participants identified intervention as a key contributor to stigma. Figure 4.3 highlights how participants' code numbers are formulated in qualitative data analysis.

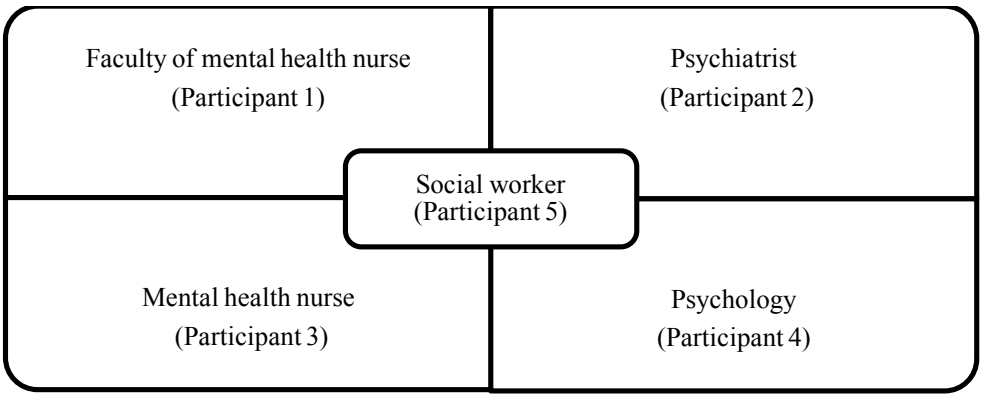

Figure 4.3 Participants' code numbers in qualitative data analysis

The following themes are further explored in the discussion of the results

Theme 1: Experiences of stigma held by professionals (towards people with mental health problems)

The first theme cluster includes the views of professional stigma when health care workers are considered toward people with mental health problems, and where participants would elaborate on their experiences and perceptions. The prominent perceptions were further categorised as: negative feelings, positive attitudes, diagnosis, relationship and interactions, acceptance, and stigma experiences within marital relationships (See Appendix XVIII).

Regarding the above, the participating group dialogue highlighted the following:

Negative feelings

One participant stated that he stigmatised people with mental health problems. Participant 2 described that he holds some negative feelings or attitudes towards people living with mental health problems. The participant stated:

"It denotes the negative feelings and the prejudice that I feel towards the people with mental health problems."

At the same time, the participant would stigmatise other people that they had met based on anger felt towards someone with mental health problems in their workplace. The participant stated:

"That reason could become a source of anger, and would relate to my workplace and lead me to hold a stigma towards people I have encountered socially who are like a patient."

The participant noted the stigma that he held toward those people with mental health problems, and alludes to the negative feelings therein, as well as whether he has it or not within their interactions and dealings with people that have mental health problems.

Positive attitude

Three participants noted that throughout the dialogue of the focus group, the mental healthcare professionals held low levels of stigma against people with mental health problems. This could be due to mental health experts being considered as an important force within wider society. It is believed, by the public too that it is the responsibility of mental health professionals to bring about positive change within the issue of mental health, and eradicate stigma.

Participant 1 noted how she tried to cover her feelings of stigma regarding people who were living with mental health problems and used her positive attitude as a way of getting rid of negative feelings towards those people. The participant stated how she holds stigma toward those people with mental health problems, and she attempts to remove these feelings to establish a good therapeutic relationship with such people when dealing with them. Consequently, this will not affect them negatively and will produce a positive therapeutic relation with them. The participant stated:

"So, I always try to be positive in my attempts as a way of getting rid of negative feelings towards the people with mental health problems, and improve my attitude when dealing with them, we can work on ourselves to reduce our stigma, prejudice and discrimination toward people living with mental health problems, as we can."

Additionally, the participant review highlights the importance of how to cover or dispose of the stigma that participants held toward those people with mental health problems, particularly within mental health care institutions. Hence, in dealing with such individuals, health workers can provide high-quality mental health care services and support those people with mental health problems. The participant stated:

"That they must try to cover their feelings of stigmatisation, especially when in the psychiatric clinic and trying to help people with mental health problems complete their psychotherapy plans, and be supportive."

In addition, Participant 5 finds that focusing on the work experience helped this mental health worker to be more cooperative through the interaction with people living with mental health problems, leading him to greater integration and cooperation with the patient through the workplace. The participant stated:

"I think many professions now have their 'normal' manual workers working together with people with mental health problems, and this integration might help such workers to get more experience with people different to them."

The participant noted, through cooperation, interaction and dealing with those people with mental health problems, that mental health professionals experience this issue that leads them to increase and promote the therapeutic relationships and mental health care plans in a positive way. Consequently, this will result in a decrease in the stigma held it and demonstrated by professional toward those people with mental health problems. Additionally, this will also help to change preconceived ideas through dealing with people with mental health problems.

Participant 4 noted how to conduct oneself when dealing with people living with mental health problems, and how to be tolerant and understand the patient situation and cases. The participant stated:

"I think when dealing with persons with personality disorders, acknowledgement and understanding of their illness will help us to interact with them appropriately, but I don't know. As I'm a psychotherapist, I can understand the people have mental health problems and tolerate them, and this is a key part of psychotherapy."

The participant suggested how to provide therapeutic and mental health care plans to people living with mental health problems, without holding a stigma against such people. In dealing with these people, the provision of a good mental health care therapeutic plan for people with mental health problems is required.

This includes: an understanding of the mental health issue from the beginning, the nature of the mental health problems in question, and accepting those people with mental health problems as a therapist are all required to provide a therapeutic care plan for them. Being a mental health professional also involves trying to understand people with mental health problems and mental conditions, and that this is an integral part of mental health care services. In the same way, as they would speak to anybody else, they spoke without the feeling of prejudice or stigmatisation.

The participant claimed not to feel any stigma towards people with mental health problems. The participant's experience has influenced her work with people who are with mental health problems. The participant stated:

"I don't feel any stigma or discrimination towards those people with mental health problems..."

Here the participant appeared to believe in the therapeutic mental health care plan submitted to those people with mental health problems, without carrying any sense of stigma towards those people with mental health problems, which was true even during their dealings with them both within the mental health care centre and out of the mental health centre.

The participants noted that a positive attitude demonstrated by mental health professionals could help them to decrease the stigma they hold towards people with mental health problems. Through such positive interactions and dealings with people with mental health problems, they can control thought, perception, attitude and behaviour, and thus support the mental health care services they provided to people with mental health problems. This is done through their experienced environment by interacting with people with mental health problems.

Diagnosis

Three members of the participant's group stated that there was a stigma associated with the severity of the diagnosis or the extent of the symptoms the patient was presenting with. The participant 1 stated:

"This depends on the level of people with mental health problems, its diagnosis, and the acceptance and endurance of the other party."

The participant suggested that dealing with people with mental health problems will depend on the type of case, the severity of their diagnosis, and then their ability to deal with such individuals, or not when providing mental health care services in mental health centres, or even in their personal lives outside mental health centre. Participant 4 stated:

"So, the level of stigma I hold towards people with mental health problems depends on their diagnosis."

Here are more statements from two participants in relation to how the diagnosis of people with a borderline problem leads them to hold a stigma against them to the extent that they may prefer not to deal or work with such people with a borderline personality disorder. Participant 4 stated:

"The feel if stigma I hold towards people with mental health problems depends on their diagnosis. For example, I feel a stigma toward bipolar people, but less towards depressed people. I don't like to work with individuals with schizophrenia and with borderline personalities at all."

As is clear, a stigma exists regarding those people with mental health problems, particularly in relation to those people with some specific types of diagnoses. The diagnosis of the situation from the beginning may determine whether the mental health professional would like to deal with them or not and to whether they will provide the mental health care for the person in question or not. The participants noted here that they held the stigma toward people with mental health problems in certain conditions, such as people with bipolar, schizophrenia, and people with borderline personalities. She did not like the concept of dealing with them and would do so as minimal as possible if possible, thereby causing a kind of fear or unwillingness to deal with them and stay away from them. Participant 3 stated:

"I prefer to deal with psychiatric people, rather than borderline people, So, I cannot tolerant to them, because of stigma I feel it towards those people with mental health problems in general."

The participant here noted that she is unable to deal with any people that have a borderline personality, and prefers to stay away from them and deal with other cases or individuals with different diagnoses of mental health problems. As she stated above, she holds a stigma toward those people with mental health problems, and she is not tolerant of them.

Regarding the participants in the focus group discussion, the participants suggested that the diagnosis factor is one of the main causes that results in those mental health professionals' experiences a professional stigma toward those people with mental health problems. Indeed, experiences of stigma held by professionals towards people with mental health problems particularly regarding what the participants have stated within this discussion, the diagnosis plays a role to let the participants of mental health professionals to hold stigmas, depending on the level of the case in question, the diagnosis of people with mental health issues. After explanations from the participants, the main diagnosis such as people with borderline allows the mental health professional to hold that stigma toward people with mental health problems.

Relationship and interaction

Three participants indicated that professional interaction and relationship might be unable to develop with people with mental health problems so that they could not continue their relationship outside of the mental health care service. The participant 2 stated:

"I don't like to have any social life interactions with people with personality disorders."

The participant noted here that he could not forge any relationship or interaction in his life with people with mental health problems such as personality disorders, just like any other person without any mental health issue.

Participant 4 noted that she prefers not to become involved in a relationship with people with mental health problems. Participant stated:

"Negatively. That is why it's better to stay away from people with mental health problems. Really, I cannot tolerate them in my life."

The participant here noted that she cannot tolerate any people with mental health problems or with those personalities, regarding their feelings, and they assume a stereotype and discrimination of stigma toward those people with mental health problems.

Moreover,

".. I'm trying to avoid having relationships with people with mental health problems, but try to accept them when in the clinic, and emphasise the importance of providing good mental health care services – that is what I do"

The participant noted here that she could not deal with any people with mental health problems outside the mental health care centre unless it is in the clinic. This is the case, as this remains the fundamental element of her job, as she does not have to deal with them in another place, especially in her social life because she cannot accept people with mental health problems as normal people without mental health problems.

Likewise, Participant 1 preferred to avoid people who were living with mental health problems as a means of protecting her personal life. Participant stated:

"Yet, sometimes the stigma can happen to me through interactions, So, I think it affects my personal life when I interact deeply with a psychotic patient's condition or a person with mental health problems."

This participant indicated that she felt stigma toward people with mental health problems, particularly when she has a deep relation and interaction with people with mental health problems. This could damage her life when she keeps dealing and forging deep relationships with those people with mental health problems. This could be an issue about the contagion of mental health problems, or fear of fusion with the patient.

The participants appeared to believe how their interactions and social relationships with people living with mental health problems can negatively affect mental health professional's lives and their feelings.

Therefore, the mental health professional prefers to deal in professional relationships only in relation to those people with mental health problems in mental health care centres. In doing this they can provide mental health care services to those people with mental health problems, as otherwise they would not be able to tolerate them in a more social lifestyle and would prefer to keep them away. This is because they still hold a stigma toward such people, and think that having a social relationship with people with mental health problems can damage their lifestyles, thereby leading to increase feelings of stigma toward those people with mental health problems.

Acceptance

Overall, three participants claimed to try and accept people with mental health problems, and develop their own understanding of mental health problems. These participants claimed to be professionally invested in their care and protection. Participant 1 stated:

"They should try to react with understanding and as much caution as possible."

The participant here noted that she could accept people with mental health problems regarding the consideration and be cautious to reactions from people with mental health problems, even if they may be hurtful toward her, which remains a possibility. On the other hand, Participant 4 tried to accept those people with mental health problems by finding a reason to tolerate them. As the participant stated:

"Often with a sense of shock and acceptance, many attempts to find the reasons for illness."

It can be seen here that the participant appeared to believe in their acceptance of those people with mental health problems, stating that it is not easy for anyone, and not easy for her. Consequently, she was sometimes shocked initially when faced people with mental health problems, before trying to find a reason to accept them.

Additionally, Participant 3 noted that she usually attempted to understand the condition of the patient as a means of accepting them; as the participant stated:

"I Attempt to develop an understanding of the case, and be as acceptant as possible."

The participants suggested that understanding people with mental health problems are not easy for those working in mental health care teams, which is why they consider this as an issue in their social lives. Besides, the importance of acceptance by those people with mental health problems can be achieved through interacting with them in the community and clinic.

Stigma experiences within marital relationships

All participants noted in the focus group discussion that it is too difficult to try to accept being married to someone with a mental health problem, or with a diagnosis of mental health problems regarding participants, culture, family, and experience.

Participant 1 noted her opinion regarding the idea of being married to someone living with mental health problems; as the participant stated:

"This depends on the level of mental health problems, its diagnosis, and the acceptance and endurance of the other party."

This participant indicated the acceptance of marrying someone with mental health problems, and whether they, in the beginning, would consider the individual with mental health problems to tolerate the responsibility. Indeed, this would link to questions, such: What is their case or a diagnosis? Is such a person experiencing a dangerous case or severe level of mental health issue?

Participant 2 refused to countenance this idea, as the participant stated:

".. Regarding my opinion, my answer is no, absolutely, not. Especially, for example, regarding my daughter... Would not come to any harm and danger when she married a person with mental health problems."

Participant 2 also contributed in regards to the norms of Saudi Arabian culture; the daughter cannot marry without the approval from her father. Hence, the participant provided the example that he could stop his daughter from marrying someone with a mental health problem because he perceived from his professional experience that people with mental health problems are not qualified enough to have a family responsibility. Additionally, he assumed that his daughter deserves a person without any mental health problems, and he wishes to know that his daughter would not come to any harm when she married a person with mental health problems.

Nevertheless, Participant 4 provided another perspective on this matter, as she noted that it is very difficult to accept this idea, especially in Saudi Arabian society. A relationship of this description would not be accepted, although it should be made clear within the society, where the person living with mental health problems and his family should admit to the fact while concealing no aspect of the matter; as the participant stated:

".. Very difficult in our society – but it should not be done in secret, or hidden..."

Additionally, Participant 5 appeared to be assertive in refusing this idea, particularly regarding the Saudi Arabian culture, which will not accept the marriage of a person living with mental health problem, as the participant stated:

"Absolutely, No! Regarding my opinion and that of the culture surrounding me, I think it will not be easy."

Moreover, Participant 3 considers this type of marriage relationship to be potentially difficult regarding the diagnosis level, as the participant stated:

"The situation will certainly be made more complex, due to the diagnosis of the patient."

The participant demonstrated that the issue of marital status with people with mental health problem could be shown as difficult and mostly unacceptable, regarding the Saudi Arabian culture. This also showed their own view and aspect toward those people with mental health problems, who they viewed to be insufficient and unqualified to tolerate any responsibility compared with other individuals without any signs of mental health problems. And dependency on a degree or level of mental health status to accepted him/his to marital status for them or for those relatives.

The participants who happened to be married to someone with mental health problems showed that it could be very difficult. Their culture and community pressures would mean that those with mental health problems are not acceptable. The participants' own communities and culture can shape their own view and aspect of stereotype. Discrimination can be worse towards those people with mental health problems compared to others without any signs of mental health problems. In fact, the level of acceptance of mental health problems within marital relationships would depend on the degree, level and diagnosis of the mental health of those people affected. To accept your spouses' condition and deal with it depends on their personal view of their marital relationship, as well as their views of a marital relationship, within the context of people within their culture and community.

Theme 2: Causes of professionally held stigma

The six most notable origins of stigma regarding those with mental health problems, as ascertained from the focus group were: experience, media, community, racism, religion, and labels. These were the elements of professional stigma and may indeed exacerbate the professional stigma toward people with mental health problems (See Appendix XIX). Regarding the above, the participating group dialogue highlighted that overall, healthcare professionals were seen to have a negative attitude regarding those with mental health problems. This is indicated in the findings demonstrated in the statements made by those working in the healthcare field.

Experience

Four participants noted in the focus group discussion that these tendencies are generally common in healthcare staff, and these individuals are generally not hopeful regarding the treatment and the outcome of those suffering from these mental health problems. Such viewpoints are likely to be connected to professional experience.

Participant 1 noticed how the background with the experience could lead one to hold a stigma and negative attitude toward those people living with mental health problems. The participant stated:

"Concepts, attitudes, behaviours and experiences can all bring about negative outlooks that directly affect psychiatric patients or people with mental health problems."

Additionally, Participant 3 noted that the experience background pertaining to educational level could influence the stigma held towards people with mental health problems, as the participant stated:

"Due to past experiences and level of education."

What is more, Participant 5 noted that the stigma of mental health problems depends on the mental health team worker experience and his or her behaviour, as the participant stated:

"It depends on person knowledge, experience or the behaviour phenomenon they are exhibiting."

Moreover, Participant 2 noted that a mental health professional could hold a stigma toward those people with mental health problems, in regards to the environment of the workplace, as well as deal and interact with those people who are living with mental health problems, which can lead to a stigma being held against them, as the participant stated:

"The stigma happens when working in an atmosphere with psychiatric patients, and during the attention given when dealing with them."

The participants here noted from the base of a negative background that the concept, the work atmosphere and environmental interactions with mental health problems, as well as the knowledge, and the level of education, could all lead mental health professionals to hold a stigma and negative attitudes toward people living with mental health problems.

Media

Media coverage adds to the poor portrayal of mental health problems. Two participants noted in the focus group discussion that the media remained the primary source of information regarding mental health problems. This was true, even though most participants saw the media's depiction of people with mental health problems as stereotypical.

Participant 4 noted that the media and society could have an influence on the mental health professional holding a stigma on people with mental health problems, as the participant stated:

"Our stigma comes from our culture, our society and from our media in Saudi Arabia."

Similarly,

"The media plays a big role in transferring the image of mental health problems, here in Saudi society."

Moreover, Participant 5 noted that the community experience, in addition to the media, could lead them to hold a stigma against people with mental health problems, as the participant stated:

"The Saudi culture of a community, beliefs, listening to others, the experiences of others, and the media lead us to hold stigma toward people with mental health problems."

The participants appeared to analyse their experience from a negative perception regarding people with mental health problems in Saudi Arabia, which also comes from the media. Consequently, this can play a decisive role in strengthening the stigma toward people living with mental health problems, as well as of mental health professionals' endorsement for holding such a stigma toward people with mental health problems.

Community

All the participants noted in the focus group discussion that the community plays a significant role in creating stigma, especially in relation to how the professional mental health team can be affected by the community and lead to professional stigma toward people with mental health problems.

Participant 1 noted that the culture could lead to a stigma, and thus, those people who were living with mental health problems could not be accepted, and that this would negatively affect their lifestyle. Cultural influences caused those with mental health problems to be regarded as dangerous, which can, in turn, lead to abuse within Saudi society. This participant stated:

"The stigma happens to me, out there in social situations or here at the clinic, and it happens to others through their social life also in our society."

"There is not enough of the strong external support needed to improve the image and desirability of this specialisation negativity of their society."

Also,

"Feelings of incompetence. This causes cluttered thinking, which means healthy people cannot accept them as 'normal'."

"People with a mental health problem in Saudi community are abusive and dangerous and negativity of their society."

In addition, Participant 2 noted that culture plays a role in leading people in Saudi Arabian society to hold stigma regarding people with mental health problems, and there is little support for people who are living with mental health problems, including in the workplace. As the participant stated:

"Society plays its part in stigma."

"Also, our society does not attempt to do much for people with mental health problems."

Likewise,

"There will be a difference in accepting people with mental health working, regarding the place of work they might apply for, for example: in government work or in the private sector."

In addition, Participant 4 suggested how, as a person from this culture, the social stigma also leads her to hold a stigma against people with mental health problems. What is more, the culture has a prevalent idea of stigma through the discrimination and prejudice against those people with mental health problems. Thus, the social stigma will lead the people living with mental health problems to try to hide those problems as a secret issue, without revealing them to others. Indeed, the Saudi culture views those people with mental health problems as inadequate personalities. The participant stated:

"The impact of the negative impressions from the community on me, especially among people with mental health problems. I really cannot tolerate that."

"I do not think so, especially because it is clear that the community holds stigma, with prejudice and discrimination, towards people with mental health problems."

Also,

"Fear in Saudi society, in general, is prevalent – especially when dealing with people with mental health problems, with difficult cases."
"They are trying to keep the issue secret and away from society."

Additionally,

"It is clear that the community holds stigmatisation view on those people with mental health problems."

"Negative thinking, which has a negative impact and fosters inferiority of people with mental health problem."

Additionally, Participant 5 noticed how different cultures create different views toward people with mental health problems. He also related to the level of their mental health situation and diagnosis, and how individuals with mental health problems appear to others through that culture and through the interactions, and relationships. Similarly, the participant noted that the Saudi Arabian culture is the reason that leads the mental health professional to hold the stigma toward the people with mental health problems, as the mental health professionals are a part of that society and culture.

This participant suggested that social stigma could lead one to hold a prejudice toward those people with mental health problems, thereby negatively affecting their lives, as the Saudi Arabian culture tends to be cautious of people with mental health problems. This individual stated it:

"Still, I think that maybe there will be difference opinion coming from culture, regarding the relative level of illness in the individual, their specific diagnosis and how the person appears to others."

"It is why our culture and our society are the main reasons individuals feel stigma towards people with mental health problems, and especially from us toward our patients in the clinic."

Also,

"And may affect a patient's life in giving him a negative view towards others, as others will be cautious of him, so our culture has a prejudice toward people with mental health problem."

Meanwhile, Participant 3 noted that culture is the main reason to lead or hold the stigma toward those people with mental health problems. In addition, the participant explained how the stigma from the cultural influence also had an impact on her regarding the stigma on people with mental health problems, as the participant stated:

"the community is the first reason and motivation us for the emergence of stigmas held against people with mental health problems."

"Personally, I can see that it comes from the community surrounding me and my community's negative opinion of mental health has impacted my outlook."

In general, the participants noted that the Saudi Arabian community could lead the mental health professionals holding a stigma toward people with a mental health issue. Regarding those mental health professionals who are still a part of the Saudi Arabian community and who are integrated into a Saudi culture, they experience negative impressions from the community their attitudes, and these impacts and foster the inferiority of people with mental health problems.

Racism

Participant 3 in the focus group discussion indicated that racism is structural in society and can create barriers for those with mental health problems or behavioural disorders, as it was stated:

"Some of the main causes of stigma toward people with mental health problems in Ethnicity in our racism."

Religion

Participants suggested in their responses that they had a shared sense of the origins of mental health problems with the community: namely, those with mental health issues were “either cursed or lacked religious conviction”. Due to the belief system that was connected to religion, this was difficult to uphold, as there were several members of a family looking to religious and traditional 'healers', rather than going to see certified medical professionals. Consequently, this could result in procrastination in relation to looking for medical assistance, as shown in the subsequent narration from three participants in the focus group discussion.

The participant 1, who was a member of the faculty of mental health nursing noted that religion could have a negative influence regarding the stigma against those people living with mental health problems, as the participant stated:

“Whichever specialist is responsible in their field of illness; it may relate to our religion in negative thought... Such as either cursed or lacked religious conviction.”

Participant 4 noted that some people ignore and refuse to countenance the idea of mental health problems, and view them from the perspective of their social and religious beliefs, rather than trying to understand the mental health problems. This individual stated:

“Many attempts to find the reasons for illness, in religious or other social beliefs, and often reject the idea of mental health problems.”

In addition, Participant 3, who was a member of mental health nursing, noted that stigma could happen due to the religious background and influence of the interpretation, as well as the occurrence of mental health problems; as the participant stated:

“And damage the background of religion.”

The participants in this instance noted how the incorrect religious concept and background could lead to stigma by some people who ignore and refuse the idea of mental health problems as a science and instead view them from the perspective of their social and religious beliefs. Subsequently, this leads them to increasingly aggravate the problem and then to hold a stigma toward those people with mental health problems as inferiors, and qualify these individuals as other people without any mental health problems. Indeed, mental health professionals often emphasise this point to the population who are from the Saudi Arabian culture, as they generally believe that people with mental health issues need a religious therapist instead of a medical therapeutic professional from mental health care.

Labels

As previously stipulated in the literature review, the primary factor that results in the feeling of being discriminated against is a person's alarm that they may be labelled as something that society does not deem to be acceptable. Regarding this opinion, the participating member suggested that there was differentiation in the stigma endured by those with schizophrenia and for those who have issues with their intellect. A key effect regarding the stigmatising reactions stems from how the public perceive and name the issues presented.

In total, three participants suggested that many of terms (in slang language) are employed and applied to persons with mental health problem, or toward the people have 'unaccepted behaviour' within their communities in Saudi Arabian culture.

They were how one participant expounded upon the fact that the stigma, with relation to those with schizophrenia remains significant for the cognitive, emotive and behaviour-related elements of stigma.

Regarding this, Participant 5 stated that these individuals could be labelled:

"Crazy', 'psych people', 'negative person', 'schezo'."

In addition, Participant 4 suggested that any person with different behaviours or attitudes would lead her to create a label for that person, to describe that person as someone exhibiting abnormal behaviour and mental health problems, as the participant stated:

"When I see any person who behaves strangely or with characteristics which diverge from the norms and the attitude typical of Saudi culture, I will look at him as a crazy or a psycho person."

Moreover, Participant 1 also stated:

"'Psycho', 'schezo' or 'crazy'."

The participants noted that the labels of those people with mental health problems remain in common use; forward people have a different or strange attitude, and characteristics than the other, regarding stereotype toward those people with mental health problems.

Theme 3: Impact of professional stigma on mental health services

The participants suggested that there were those with mental health problems, due to views of stigma, who endured two main consequences: the inability to attain treatment and assistance, and that of poor mental healthcare services within the nation in question. This poor situation

of healthcare may be due to the negative attitudes of those in the healthcare sector, as well as the absence of healthcare allocation because of this in Saudi Arabia.

The three most notable origins of stigma regarding those with mental health problems, as ascertained from the focus group, were: Insufficient information; deficiency, immigration, and policy, which are elements of stigma and may indeed exacerbate the stigma toward people with mental health problems (See Appendix XX). Regarding the above, the participating group dialogue highlighted that the frequent thematic trend was seen in the findings of the study that was of the lowly status that mental healthcare services were given, which was in contrast with other elements of healthcare, with the latter generally being more important.

Deficiency

Three participants stated that the government did not fund any training for mental health staff in the nursing faculty or any alternative healthcare professionals who dealt with people with mental health problems, which resulted in the decline in numbers of staff for the role.

Participant 1 noted that the deficiency of the Saudi mental health services is evident, particularly regarding the paucity of psychiatric and mental health nurses in Saudi Arabia. The participant stated:

"I find the paucity of mental health care services in Saudi Arabia shocking - especially concerning psychiatric nurses!"

"I can't understand why there are no psychiatric or mental health nurse specialists in the clinic and working with people with mental health problems."

In addition, Participant 5 mentioned that there are deficiencies in mental health services in Saudi Arabia and inadequate staff. As the participant stated:

"It is because the mental health services in Saudi Arabia are inadequate."

Moreover, the participant 5 indicated that the issue of stigma prevents many people from living normal lives and deters people from seeking help when they require it most. Likewise, the negative attitudes regarding people with mental health problems also affect their family, friends and the mental health care professionals who endure stigma by association with their patients. As the participant stated:

"Not getting all that we hope for from the community support and commission of mental health services in our country, unfortunately, that is what will lead me and for example, others like a patient family and people surrounding them, to move negatively towards those people with mental health problems."

Furthermore, two participants indicated that to be proactive for educational benefits, with regards to mental healthcare, as well as for those that utilise the service, the political agenda needs to be more galvanised to promote the inclusive of mental health.

Participant 1 stated:

"Due to the absence of an available education program."

Moreover, Participant 3 stated:

"They may look to mental health care as good but still need to the helpful services. To reduce the level of stigma."

The participants noted the resulting decline in mental health care services in Saudi Arabia, as well as the numbers of staff in the role. Indeed, there are no psychiatric or mental health nurse specialists in the clinic that indicated that the issue of stigma prevents many people from living normal lives and deters people from seeking help, even when they need it most. Moreover, the negative attitudes' regarding people with mental health problem also affect their family, their friends and mental health care professionals who endure stigma through association with their patients.

Immigration

For other interview subjects with mental health problems, retaining the information concerning it can be deemed to be a deliberate means for the person who has the issue to protect themselves and their family from stigma. All the active participants indicated this. Participant 1 stated:

"It is a sensitive issue, so they stay away from the negativity of their society – and seek out the care of advanced psychiatric help, integrated outside of Saudi society."

Additionally, Participant 4 indicated that those people with mental health problems seek help with mental health therapy outside the country to keep this issue secret. The participant stated:

"They are trying to keep the issue secret and away from society."

As expounded upon above by the statements made, the main sensational elements for those seeking mental healthcare is to look beyond Saudi Arabia to avoid any embarrassment from within the home culture, lead to they stay away from the negativity of their society. Furthermore, the low-level and scarcity of the healthcare services that are available in the

country suggests that they have been given inadequate levels of investment and education regarding their field.

As stated by Participant 4:

"Because the mental health services in some other countries are certainly much better than the services available in Saudi Arabia."

Participant 5 stated:

"Also, regarding my opinion and my perspective, it is because the mental health services in Saudi Arabia are inadequate."

Participant 3 indicated that it might be that the mental health services in Saudi Arabia are good, but that the people who are living with mental health problems prefer to find help from other countries, as they are afraid of the cultural views toward them. As the participant stated:

"Might be afraid of the impact that seeking help might have on their community."

As expounded upon above by the statements made, the main galvanising element for those seeking mental healthcare is to look beyond Saudi Arabia to avoid any embarrassment from within their home, domestic culture that could lead to immigration to seek the mental health care services from outside the country, which could even be true for the mental health professionals.

Policy

Two participants expressed concern about the low levels of community-based healthcare provision regarding mental healthcare, as well as the absence of and intersectional cooperative effort to galvanise the healthcare sector in Saudi Arabia.

The participant 1 indicated that the Ministry of Health and Higher Education should work to apply the policy of knowledge to reduce the stigma as much as possible throughout the culture and enhance the mental health services. The participant stated:

"Moreover, the ministry of health and higher education should start working to disseminate knowledge by policy to reduce the stigma of mental health problems among individuals in the community and enhance the mental health care services, and to stimulate mental health services between professional mental health care teams."

In addition, Participant 4 suggested how the policy should be available to consider this issue of stigma, as the participant stated:

"Policy and legislation procedure should be tolerant, but this needs balance, as not everything can always be tolerated in these situations."

The participants noted that the policy and legislation could play a main role to prevent stigma and improving the mental health care services, particularly the stigma when held by Saudi community.

Theme 4: Interventions recommended minimizing stigma in general and professional stigma in particular

Within this section, the findings taken from the feedback of the participants regarding their thoughts on how to combat psychiatric mental health care stigma are presented. This subject addresses the educational; media; and community; as well as healthcare provided to those with mental health problems in mental health care services, and the Saudi Arabian government support (See Appendix XXX). This demonstrates the results for recommendations from the focus group discussion. The prominent perceptions were further categorised as community, education, media, mental health services, and Saudi government support. Overall, the participating group dialogue highlighted various aspects, as are detailed below. Participants stated that, in assisting others (i.e. members of their family, or members of their community), they need to be accepting of those that have mental health problems, and thus, this would help in the reduction of stigma through developing and progressing media-based means to attain the improvement of mental health care services within the country. To accept this, it needs to be stipulated through the level of care that is provided and then allocated to professional health care teams, as well as those people with mental health problems, to change the impacts of stigma prevalent in the mental healthcare profession.

Community

Participant 1 indicated that the community needs to be more aware of people with mental health issues by changing the attitudes and preconceptions towards them. In addition, the participant noted that the community needs to be more interactive with and accepting of those people with mental health problems, as well as in regards to the career development of mental health professionals. Indeed, this individual stated:

"The society needs to develop their often-biased preconceptions of people with mental health problems."

"Society is heavily involved in working the cultural integration of individuals with a community, and in the development of individuals who specialise in professionalism within a mental health team."

Moreover, the participant 4 noted that the community and mental health care services need to be improved and progressed through the contribution of mental health team professionals, to improve the community awareness and mental health care services. The participant stated:

"Increase the value placed on the improvement and development of mental health care and psychological therapy, through ourselves and through the community."

Also,

"Try to introduce the mental health problem through positive images in our community and society."

Overall, the participants noted that community and mental healthcare services need to be improved and progressed through the contribution of mental health team professionals, along with an improvement in the community awareness and mental health care services.

Education

Participant 5 indicated an additional means of affecting the stigmatisations using educational means by teaching those who work in the field, which may modify their existing attitudes; hence, undertake societal education in practice. The participant stated:

"I think it will come with time, through mental health services', and hard work and learning of mental health workers, people with mental health issue, and community education."

Furthermore, the participant 1 indicated that the development could be undertaken through the health commission via an educational program of mental health aspects, as the participant stated:

"Education programs, specialisation and fiscal stimuli."

In addition, Participant 3 suggested that the participants regarding the methods utilise educational means and that the understanding of mental health problems was to try to reduce the stigma within mental health professional teams. This may be divided into two groups: the individuals that are to be targeted with education (i.e. family members with users of healthcare services were indicated, and mental health workers), and the process of the education itself. This participant stated:

"And educate the affected communities families and people with a mental health issue with providing mental health care services programs for mental health workers."

Participant 1 also noted that the means of education were different and more pertinent in stopping and reversing the stigma within psychiatry. These means included: awareness schemes (dialogue sessions at treatment centres); media campaigns through the community;

and the portrayal in the media (both online and in the press). In addition, to encourage professional mental healthcare schemes for education, the option would be provided to convert professional staff to mental health care workers and educators. It was stated:

"Tutorials and educator. Still, the only things I can change in my own mind involve increasing my familiarity with this approach and the language of people with mental health problems, particularly through the media."

It was indicated that those who facilitated the service required education regarding how they could introduce such schemes across the whole of the nation of Saudi Arabia to better the nation's health care.

Furthermore, Participant 1 indicated that the professional individuals were aware of the lack of professionals, especially specialists, in the field to address the issue, which may facilitate others to look for assistance, as the participant stated:

"In terms of psychiatric and mental health, psychiatric and mental nursing care is often unexpected, but required."

The participants recommended a decrease in the stigma demonstrated by the mental health profession toward people with mental health problems, as an additional means of affecting stigmatisations using educational means. Indeed, by teaching those who work in the field and modifying their existing attitudes (i.e. to undertake social education in practice), while also noting the means of education that were different and more pertinent in stopping and reversing the stigma within psychiatry. In addition, the facilitation of education service required, through how they could introduce such schemes across the whole of Saudi Arabia, to better the nation's health care and decrease the stigma held by mental health professionals regarding those people with mental health problems in the country.

Media

Three participants added the media, community and health care provision were all noted as requiring the necessity of education to progress, which would improve and encourage them to see the mental health problems more accurately and assist those with mental health problems in their path to treatment, advocating their attendance at a clinic and dealing with them with great respect. Participant 4 noted:

"It appears to me that the media needs to improve its views regarding those people with mental health problems."

Furthermore, Participant 1 recommended that the media needs to have more support to improve the educational way of mental health problems and mental health care services, through the community. Indeed, the participant stated:

"The media centre is important in Saudi society and needs to gain support to improve the education on and the image of psychiatric patients, people with mental health problems, and mental health care services that are provided through community health care."

Participant 3 noted that the media plays an important role in improving the attitude towards people with mental health problems, as the participant stated:

"The media it certainly plays a big role in improving attitudes towards people with mental health."

Mental health care services

Four participants indicated that the professional members of mental healthcare teams who were going through the same experiences were perceived to be a way of assisting those with mental health problems to seek and find the help they need. Professional healthcare members of such teams would permit the user of the service they provided to spread the word about their treatment, even beyond the remit of the nation of Saudi Arabia. They would become more educated regarding the required changes and alterations of the care that they deliver, inclusive of the professional stigma within their discipline, and thus, encourage more people to seek out and find help for their mental health problems.

Participant 4 stated:

"I think we need to improve our mental health services provided in our society and in psychiatric clinics."

"Cooperation is the most important, between the community and us as a professional in mental health care services."

Participant 1 recommended that:

"This confirms that psychiatric and mental health nursing care in Saudi Arabia needs to develop and provide support with good ideas and images to reduce negative attitudes towards people with mental health problems. Reducing stigma is key in getting care to people who need mental health and integrated services."

As the results of these study show recommendations made by participants concern the importance of the consideration of the main issues in reducing the professional mental health teams'. For example, the negative attitude towards people with mental health problems throughout social life, as well as the importance of developing the mental health services and

improving professional mental health teams, and can also assist in lowering discriminatory and stigmatising beliefs.

Participant 3 noted:

"Try to merge the mental health care services for psychiatric patients, especially in the in-patient section, with their communities."

In addition, Participant 5 suggested that the mental health services, together with improving professional mental health teams are necessary to advocate a high quality of mental health care services to be delivered to people with mental health problems. Hence, this will help to reduce the stigma that is demonstrated by mental health team professionals towards those people living with mental health problems. This individual stated:

"That we must try to end our stigmatisation, especially when in the psychiatric clinic and trying to help people with mental health problems complete their psychotherapy plans, and be supportive through the mental health care services available in my country."

The participants suggested that the mental health care in Saudi Arabia needs to develop and provide support with good ideas and images to reduce negative attitudes regarding people with mental health problems, particularly those demonstrated by mental health professionals. Reducing stigma is vital in providing care to people who need mental health and integrated services.

Saudi Government Support

As mentioned by the participating members of the focus group, the state of Saudi Arabian mental health care services is presently much better than five years ago, because the mental health care services in Saudi Arabia are starting to be aware that there is a problem by the government. Indeed, they are attempting to support the mental health care services and to accept people with mental health problems, together with mentally healthy people, which indicates the potential to implement a fully supportive mental health care service in the future. As indicated by Participant 5 who noted a variety of statements adhering to this point:

".. Services at this stage of development in Saudi Arabia, are seeking to improve their performance and to improve their mental health care services, to provide better mental health care..."

"Development through the health commission via programs, with a speciality diploma combining social work, psychology and psychotherapy. We can see the development and improvement of mental health care education, which are different than before, here in Saudi Arabia."

"The Saudi health commission actually has a great program, but I don't know if I can say it is an excellent program as its science is from around the 1990s and needs updating, and many Saudi people go abroad to be treated outside of Saudi Arabia."

"Now the mental health work commission has hard work in promoting this program. With the diploma, every year there are new updates, and we get lots of help from social work, psychology and psychotherapy, and this commission is good at supporting us."

In addition,

"Over the five previous years, we can see good promotion from the Saudi health commission and the concepts recorded from the mental health team. I think this is playing with a great multidisciplinary mental health concept."

Furthermore, the participant 1 indicated that the Ministry of Health and Higher Education are now working hard to reduce the stigma and try to improve the mental health care services in Saudi Arabia. The participant stated:

"Moreover, the Saudi government through the ministry of health and higher education are always working to reduce the stigma of mental health problems in the community and mental health teams, and to stimulate mental health services between professional mental health care teams."

The participants noted that the mental health care in Saudi Arabia needs to develop more; services at this stage of development in Saudi Arabia are seeking to improve their performance and to improve their mental health care services, to provide better mental health care. In addition, higher education is always working to disseminate knowledge to reduce the stigma of mental health problems among individuals within the community and mental health workers, and to stimulate mental health services between professional mental health care team.

Results under the Mixed-Method

Frequencies of five focus group members participating in Phase two (Qualitative data analysis) score measures with Phase one (Quantitative data analysis).

Engagement Result Data Analysis and Findings of Emotional Reaction on People with mental health problems scale and Attitude scale.

Table 4.16. *Analytical results of the raw score frequency of respondent specialise in (Emotional Reaction on People with mental health problems and Attitude scales).*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Faculty psychiatric nurse	1	20.0	20.0	20.0
	Psychiatrist	1	20.0	20.0	40.0
	Psychiatric nurse	1	20.0	20.0	60.0
	Psychology	1	20.0	20.0	80.0
	Social worker	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Statistics

		Respondent specialist	Total Attitude	Total Emotional Reaction
N	Valid	5	5	5
	Missing	0	0	0

The Frequency Distribution of Emotional Reaction on People with mental health problems score

To addressed research question; How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?

Table 4.17. *Analytical results of the raw score frequency of emotional reaction on people with mental health problems: Test Scale*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	46.00	1	20.0	20.0	20.0
	61.00	1	20.0	20.0	40.0
	62.00	1	20.0	20.0	60.0
	82.00	1	20.0	20.0	80.0
	87.00	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Statistics

		Respondent specialist	Total Emotional Reaction
N	Valid	5	5
	Missing	0	0
Mean		3.00	67.6000
Median		3.00	62.0000
Std. Deviation		1.581	16.77200

In relation to the 29 items used with the Five-Likert scale (agree, strongly agree, neutral, disagree, strongly disagree), the theorising range of distribution is set at 46 to 87. The results are presented in Table 4.17 above, which shows that 46 is the lowest stigma score. Meanwhile, 87 is the highest stigma score. Additionally, both the Mean score (3.00) and the Median score (3.00) are similar in number indicating that all the participants demonstrated a professional stigma towards people with mental health problems of varying degrees.

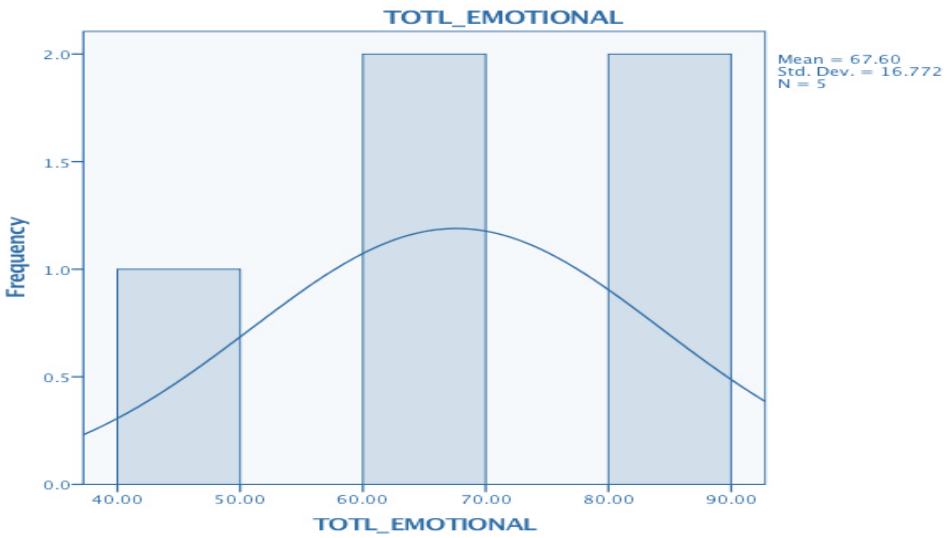

Figure 4.4 Raw score frequency of emotional reaction on people with mental health problems: Test Scale.

Moreover, from the frequency in Table 4.17 and the histogram Figure 4.4, it is shown that all the participants demonstrated a professional stigma towards people with mental health problems of varying degrees.

The Frequency Distribution of attitude score

To addressed research question; To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?

Table 4.18. *Analytical results of the raw score frequency of attitude: Test Scale.*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	36.00	1	20.0	20.0	20.0
	43.00	1	20.0	20.0	40.0
	49.00	1	20.0	20.0	60.0
	52.00	1	20.0	20.0	80.0
	61.00	1	20.0	20.0	100.0
	Total	5	100.0	100.0	

Statistics

		Respondent specialist	TOTAL_ATTITUDE
N	Valid	5	5
	Missing	0	0
Mean		3.00	48.2000
Median		3.00	49.0000
Std. Deviation		1.581	9.41807

In relation to the 27 items employed with the Three-Likert scale (rarely, sometimes, frequency), the theorising range of distribution was set at 36 to 61. The results are presented in Table 4.18**,** which shows that 36 is the lowest stigma score, while 78 is the highest stigma score. Both the Mean score (3.00) and the Median score (3.00) are similar in number, indicating that all the participants demonstrated a professional stigma towards people with mental health problems of varying degrees.

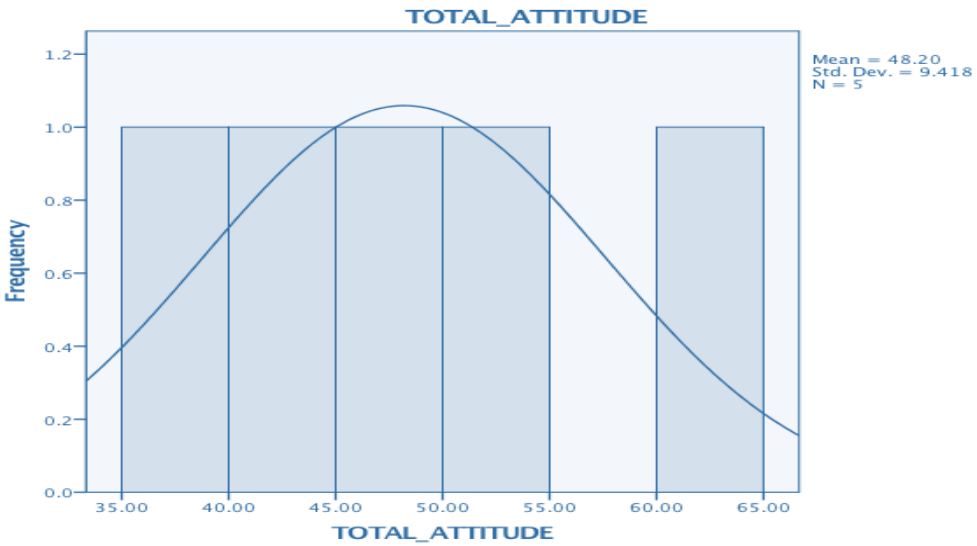

Figure 4.5 Raw score frequency of the attitude test scale.

The frequency in Table 4.18 and Figure 4.5 indicated that all the participants demonstrated a professional stigma towards people with mental health problems of varying degrees. On the other hand, related to the qualitative data analysis in focus group discussion (Phase 2) in Table 4.19 indicated the code numbers of the participants within the Nvivo program for a thematic analysis and participant intervention with the focus group discussion, while coded intervention with a stigma showing that the participants in the focus group and quantitative analysis demonstrated a professional stigma of varying degrees, as described previously in qualitative data analysis results

Table 4.19. *A summary of the frequency of responses is supplied using code number with percentages.*

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Total %	
Professional stigma	6	4	3	8	2	23	25.2 %
Causes stigma	7	4	5	10	6	32	35.1 %
Mental health service	5	1	2	2	3	13	14.2 %
Recommendation	7	1	3	5	7	23	25.2 %
Total number	25	10	13	25	18	91	%
	27.4%	10.9%	14.2%	27.4%	19.7%		

Conclusion

The qualitative outcomes of this study have been explored in this chapter with the thematic framework that appeared after the data was analysed. Due to the research's exploratory position, the results were confined to this study, but many of problems were noted, which require further attention. The findings of this study confirm that professional healthcare providers do hold and demonstrate professional stigma perceptions towards people with mental health problems to varying degrees, which means that professional stigma exists in mental health professionals. The data analysis results indicated that in phase one (quantitative data analysis), phase two (qualitative data analysis), and in the engagement result in the mixed method, the frequencies of five focus group members participated in Phase 2 Qualitative analysis data scores, as measured in Phase 1 quantitative analysis data.

In addition, the quality of mental health care services is still improving within Saudi Arabia. Subsequently, these results will be used to underpin the further development of mental health care services in Saudi Arabia. These issues, together with recommendations for future studies, will be presented in the next chapters and to highlight the importance of MOH within the mental health care services to support the quality of mental health care, through improving the professional mental health team for people living with mental health problems in Saudi Arabia.

CHAPTER 5: DISCUSSION

Overview

In this chapter, the significant findings of this study will be discussed and this will place them within the wider context of other literature and research. The aim of this study was to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in the city of Riyadh, the Kingdom of Saudi Arabia (KSA). Thus, the study identified several findings, which are detailed below; in (Phase One) of quantitative discussion and (Phase Two) of qualitative discussion.

Discussion

The survey questionnaires were designed with input from the supervisors. Factors that needed to be highlighted included how emotional reactions relate to attitudes scales towards people with mental problems. The survey on stigma towards people with mental health problems incorporated the input from 50 participants in phase one, with 5 participants (focus group discussion) in phase two. This survey and focus group discussion were completed in 2015, while the findings of the research questions were first summarised in the first chapter. Subsequently, a critical evaluation then follows. This evaluation is centred on study focus, the survey and measures used for this study, as well as the recruitment. The discussion then probes the theoretical and clinical implications.

Hepworth and Vincent (1999) noted that existing literature contrasts the professionally exhibited stigma associated with mental health intervention as opposed to that concerning professional attitudes in biomedical and clinical situations and that research into professional stigma in mental health should, therefore, employ many quantitative and qualitative approaches. Consequently, it is necessary to employ many different research methodologies in the investigation of professional stigma when dealing with people with mental health problems. Qualitative research characteristically aims not to generate statistically significant findings, but rather to explore themes, patterns and associations within a richer and more diverse data set (Jenkins, Kaim, & Hikida, 2007). Using a combination of methods also strengthens confidence in the validity of the results (Bradbury-Jones & Alcock, 2010). This study identified several findings, which are detailed below. This research study sought to examine professionals who may hold stigmatising views and beliefs towards people with mental health problems and how the existence and extent of these views might impact on the services provided by mental health

professionals and the recovery of people with mental health problems. Therefore, in this research questions and objectives have been achieved in review discussion. This study identified several findings, which are detailed below.

Discussion Phase One

The thematic findings relative to previous research

Each research question is firstly considered in relation to the findings of this study. With respect to these research questions, through the discussion of the findings from the quantitative results, two major themes have been outlined. Theme 1, Emotional reaction on people with mental health problems, addressed research question 3; *How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?* Theme 2, Attitudes towards people with mental health problems, addressed research question 1; *To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?*

The main objective of this surveys was to investigate the attitudes and emotional reactions resulting from the stigma of mental health professionals towards people with mental health problems. Due to Angermeyer, Holzinger, and Matschinger (2009), population-based studies have typically overlooked the importance of emotional reactions as a contributory factor to mental health stigma. Data from self-reported questionnaires still constitute the major source of knowledge regarding this issue and focus on the mental health professionals' emotional reactions and attitude in "perceptions" of stigma towards people with mental health problems during interpersonal interaction.

In this research, results indicated that there was a professional stigma, as well as social (socio-cultural contexts) and self-contribution factors detachment demonstrated by mental health professionals towards people with mental health problems. A finding that is corroborated by Chou *et al.* (1996), which highlighted that mental health professionals in Saudi Arabia are also members of the public, and are thus, also susceptible to the pervading culture that may have internalised some discrimination perceptions about people with mental health problems. Due to Nordt *et al.* (2006) evaluated the outlook of mental health professionals in previous studies and determined that the mental health professionals held stigma towards people with mental health problems. Moreover, some differences were found between the general views of different professionals. In addition, it is evident that all the participants hold a professional stigma towards people with mental health problems of varying degrees.

These findings are consistent with the study by Corrigan (2004, p. 614), perceptions about mental health among the public are reflected in the wide range of perceptions of stigma displayed by mental health professionals, and are therefore frequently noted. The most significant of these challenges was the portrayal of the reactions of the mental health team in a real-life scenario, which clarified the emotional outcomes and perspectives applicable to the expression of professional stigma. Due to Corrigan and Watson (2002), stigma can be considered a multi-layered phenomenon that incorporates undesirable attitudes, negative emotional reactions, and biased actions. Any assessment of a theme, as general as stigma, will certainly be accompanied by conceptual and operational demands (Aloud & Rathur, 2009).

Regarding the quantitative analysis results obtained in the present study, the findings may be categorized into two main themes

Theme 1 showed an emotional reaction on people with mental health problems, addressed research question 3*; How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?* Where there was, a significant effect attributed to status on emotional reactions towards people with mental health problems by subspecialists within the mental health team. The results indicated a significant frequency of professional stigma held towards people living with mental health problems, using the emotional reaction scale. Mental health professionals appeared to exhibit professional stigmatization towards people with mental health problems on all subscales of emotional reaction.

With respect to the differences between the subgroups of specialists in the mental health team, it was found that there were varying degrees of professional stigma between subspecialties, a finding that is corroborated by Lyons *et al.* (2009), the likelihood that health professionals may hold a stigmatizing attitude against their patients, particularly those who are confronted with significant barriers to treatment, appears to be low. As stated by Wahl and Aroesty (2010), there are many reasons why acquiring an understanding of how health professionals perceive the person is significant. The negative emotional held by some mental health professionals, and their associated behavior towards people living with mental health problems, can be portrayed as stigmatization on the part of the mental health profession. Hence, many of studies have shown there is minimal difference between the behavior of psychiatrists and members of the public regarding these matters (Ruiz & Miller, 2004; Lauber *et al*., 2006).

What is more, among the findings were that aspect of professionalism and professional development, such as subspecialist differences, which had not previously been explored empirically in Saudi Arabia. To date, researchers have assumed homogeneity of experience among mental health professionals (Friswell & Penny, 2002). Specifically, given that many of mental health professionals will personally experience stigma in relation to their work with people with mental health problems, many factors in Saudi Arabia may contribute to mental health professionals holding stigmatizing views. The findings in this study are consistent with Holmesland *et al.* (2010) variations among professionals that can be attributed to professional identity can also be observed using this strategy.

The findings of this study suggest that the stigma of mental health problems may be influenced by factors occurring within specific and different socio-cultural contexts, and these should be examined in order that the origins, meanings and consequences of such stigmatization may be fully understood. The study of local conceptualizations, experiences and societal effects concerning mental health and mental health care in relation to stigma may be fruitful (Ahmedani, 2011). In addition, a consideration of the effects of subspecialists' differences, qualifications, cultures, and experiences, together with the availability of mental healthcare services, was a unique contribution to the existing literature. The findings of this study are corroborated by Ng (1997) in respect of the prevalence of mental health problem stigma in Asian cultures, which show some degree of superficial regional correspondence. There are, however, some intercultural differences and it can be discerned that the stigmatization of people with mental health problems across Asian cultures varies in terms of prevalence and severity (Ng, 1997).

On the other hand, the analyses of the data associated with the emotional reaction scales, which have derived from the professional mental health teams, are presented in terms of their key factors that contribute to other aspects of stigma and are related to each other, while the first dimension of (exclusion) highly contributes to the holding of a stigma than the others dimension factors of (rejection and caution). Besides, agreement was reached on the factors that determined stigmatizing reaction, as previous researchers had implied that numerous factors might contribute to the emotional reactions of mental health professionals towards people with mental health problems including contact and experience (Procter & Hafner, 1991; Walach, Buchheld, Buttenmüller, Kleinknecht, & Schmidt, 2006), and education and training (Friswell & Penny, 2002). Hence, these aspects will be examined in depth in the qualitative discussion for Phase two.

In Theme 2, demonstrated attitudes towards people with mental health problems, addressed research question 1; *To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?* An interesting finding that emerged from the analysis was the identification of a significant primary effect whereby a relationship exists between perceptions that a professional mental health team holds in terms of stigma towards people with mental health problems, and the differences observed between subspecialists. The results indicated a significant frequency of professional stigma held towards people living with mental health problems, using the Attitude Scale Questionnaire-Short Form (AQ-SF).

Mental health professionals appeared to exhibit professional stigma towards people with mental health problems in all subscales of attitude. With respect to the differences between the subgroups of specialists in the mental health team, it was found that varying degrees of professional stigma were displayed between subspecialties. This was not unexpected, as many members of the mental health team had either previously worked as clinicians or worked in a dual role as both clinicians and educators, and had similar educational backgrounds (Nordt *et al*., 2006). The findings in this study are consistent with Link *et al.* (2004) analysis that stigma has existed throughout history, and is often explained through the concept of social science; it can cover a wide range of meanings and has been described by experts from many different backgrounds.

Apart from the mental health workers, varying degrees of professional stigma were shown towards people with mental health problems in the research by Holmesland *et al.* (2010), which suggested that this creates the issue of professional identity, and thus, can hinder the progress of cooperation and interdisciplinary action. Previous research, including that of Cohen and Koenig (2004), had evaluated how mental health professionals displayed various perceptions of individuals with mental health conditions, while inconsistent attitudes towards people with mental health problems were found to be present among professionals. Later research has confirmed these findings (Nordt *et al.,* 2006), although no research to date has incorporated the views and attitudes of mental health professional counsellors. In addition, the analyses of attitude scale results for professional mental health teams are presented in terms of their key factors that contribute to other aspects of stigma and are related to each other, while the first dimension (risk) highly contributed to the holding of a stigma in comparison to the other dimension factor (fear). Moreover, the literature review describes how professional stigma can be created through attitudes demonstrated by mental health professionals toward people with mental health problems (Alonso *et al.,* 2009; Thornicroft *et al.,* 2009). As illustrated by the

work of Procter and Hafner (1991) and Walach *et al.* (2006), factors that might contribute to the attitudes of mental health professionals towards people with mental health problems included: inter-contact, educational qualification and subjective experience (Kafle, 2013). Hence, these aspects will be examined in depth in the qualitative discussion for Phase two.

Consequently, what is more interesting, the findings in this study are consistent with the UK-based research conducted by Thornicroft *et al.* (2007) drew together the mainly descriptive findings of 33 national and 29 regional studies, conducted primarily in Europe, which derive findings that accord with those of this study. Besides, the more contemporary literature describes studies that test theory-based paradigms in relation to the stigmatization of people with mental health problems, with time–trends analysis and cross-cultural comparisons, and the appraisal of anti-stigma campaigns, such as that carried out in Switzerland (Lauber *et al.,* 2006). Indeed, the attitude research in psychiatry has achieved significant developments in this respect in the last 10 years; however, further work is necessary if an empirical basis for the efficacy of interventions in relation to the reduction of stigma concerning mental health problems and the improvement of attitudes towards persons with mental health problems are to be achieved.

As well as reported by Gillard *et al.* (2010), in an international comparative study of the perceptions of nursing staff towards individuals with mental health problems, staff in Lithuanian healthcare settings displayed more negativity compared with staff from Finland, Italy, Portugal and Ireland. The researchers proposed that these negative perceptions were the product of social, cultural or institutional factors. Obviously, this study also indicates that mental health workers exhibited varying levels of professional stigma towards people with mental health problems. In this respect, reference to Al-Krenawi and Graham's (2000) *Culturally Sensitive Practice with Arab Clients in Mental Health Settings* was indicated, in order that awareness could be raised in respect of culturally focused social worker, irrespective of whether this concerns Arabic people with mental health problems in Arab regions of the world or in the West. Such concerns include sensitivity to gender, religion, family position, community status, and mental health service usage characteristics in Saudi Arabia. When considered in Western scenarios, acculturation should be added to the preceding sensitivities, as these sensitivities form the cornerstone of mental health worker involving Arab mental health clients. Al-Krenawi and Graham (2000) highlight the importance of short term, directive methods, with communication that is informal and passive, with sensitivity to individuals' concepts of external control loci and their characteristic means of communicating distress. Similarly, traditional approaches may be incorporated into modern ones, where circumstances

indicate this may be beneficial (Al-Krenawi & Graham, 2000).Yusuf, Nuhu and Akinbiyi (2009) noted that mental health professionals need to apply focus to the exigencies of people with mental health problems and their care providers, both in terms of information provision and the definition of correct time in which such care providers can express their concerns and receive counselling. Furthermore, the findings of the present research study corroborate these findings, where the majority of interviewees stated that: "social integration of the people with mental health problems is the optimal therapy for them"; "An individual should be admitted to hospital at the first sign of mental health problems"; "Isolation of the people with mental health problems from society is necessary"; and "When dealing with people with mental health problems, it is necessary to bear in mind that their behavior can be unpredictable".

The findings of the present study point to the significant ambivalent attitudes exhibited regarding people with mental health problems. From this study was shown that participants seemed to believe that treatment for individuals with mental health conditions should be provided at the community level, while it was also the opinion of this group that individuals should be admitted to the hospital upon exhibiting symptoms of mental disturbance. These findings supported by one work that was conducted in German to assess the health workers and social attitude towards people diagnosed with mental health problems by Angermeyer, Matschinger, and Schomerus (2013), however, even though they achieved similar results, which in turn support the general and increasingly prevalent opinion that people with mental health problems should be treated in hospitals with the facilities necessary for their treatment.

Currently, this significant trend of stigma towards people with mental health problems shows no signs of abating. In these study findings, which were consistent with Reavley *et al*. (2012) and Angermeyer *et al.* (2013), similar conclusions concerning attitudes towards people with mental health problems have been drawn in other international contexts, such as in the USA, as well as many countries in Europe and Australasia. On the other hand, very little has been published about emotional reactions to people with mental health problems, except descriptions of the fear of violence. However, one work that was conducted in the south-eastern USA by Acker and Lawrence (2009), that questioned students, asked them to imagine meeting people who may or may not have been diagnosed with schizophrenia. Meanwhile, the three physiological measures of stress, namely brow muscle tension, palm skin conductance and heart rate, were discussed during imaginary meetings. 'Labelled' individuals were compared with 'non-labelled'(Crisp *et al.,* 2005; Thornicroft *et al.,* 2007), self-reported negative attitudes of stigma towards people with schizophrenia is also associated with this tension (Thornicroft *et al.,* 2007), one reason why individuals avoid those with mental health problems is due to

physiological arousal, which manifests itself as unpleasant feelings (Crisp *et al.,* 2005; Thornicroft *et al.,* 2007). Moreover, the findings of the present research study corroborate these findings with most interviewees stated that: “The people with mental health problems may seem to be normal, but one must always remember that they are not”; and “People with mental health problems and individuals with mental health are two different things”. One of the main problems is a lack of real knowledge; although there is an abundance of information in the public domain nowadays (Crisp *et al.,* 2005). However, most of it is inaccurate. Accurate knowledge of mental health problems, sometimes called `mental health literacy,' is insufficient (Crisp *et al.,* 2005). For example, in a survey carried out in England in 2003, it was shown that 55% believed that this statement was correct and accurate; someone who cannot be held responsible for his or her own actions can be assessed as an individual with mental health problems; 63% thought that less than 10% of the population would experience mental health problems at some time in their lives (Department of health, 1996).

Moreover, it has been accepted through evidence that deliberate interventions to improve public knowledge about depression can be successful, which lead to a marked reduction in stereotyping of people with mental health issues (Department of health, 1996). For example, a campaign was conducted in Australia to increase public awareness about depression and its treatment. However, some states and territories received an intensive and coordinated program, whilst others did not (Jorm *et al.,* 2005). In the former states, people became better at recognizing the features of depression, and thus, were more likely to support help for depression, or accept treatment with counselling and medication (Jorm *et al.,* 2005).

Many government surveys were conducted in England between 1993 and 2003, which revealed a mixed picture, as on the one hand there were some clear improvements. For instance, the proportion that thought that people with mental health problems could be easily distinguished from `normal people' fell from 30% to 20% (Schulze & Angermeyer (2003). However, views became significantly less favorable for mental health sufferers over this decade for several reasons (Thornicroft *et al.,* 2007; Hogg & Holland, 2010). For example, the proportion that believed that residents have nothing to fear from people coming into their neighborhood to obtain mental health services decreased from 70% to 55% (Hogg & Holland, 2010). In addition, the findings of the present research study corroborate these findings, where many interviewees stated that: “Individuals suffering from mental health issues are considered a burden on others”. An increase in the spread of knowledge about mental health problems does not necessarily improve either attitudes or behavior towards people with mental health problems (Thornicroft *et al.,* 2007).

Additionally, most interviewees stated that: “I would feel anxious or very uneasy in the presence of the person with mental health problems”, “People with mental health problems would terrify me”,” When I am around someone with mental health problems, worry that he or she might harm me physically”, the findings of the present study point to the significant convergent between emotional reactions with negative attitudes exhibited regarding people with mental health problems. In general, typical negative attitudes with emotional reaction towards people with mental health problems include fear, anxiety and stigmatization; a finding that is corroborated by Angermeyer *et al.* (2013). Furthermore, a cross-sectional analysis of data gathered of public attitude towards people with mental health problems in Germany 2011 has indicated that biogenic beliefs concerning causation are relevant in the desire to separate people with mental health problems from the rest of society (Angermeyer *et al.*, 2013). Angermeyer *et al.* (2013) noted that societal concern regarding people living with mental health problems is also instrumental in the forming of public opinion about the compulsory admission to hospital of such individuals.

Research by Pilgrim and Rogers (2005), concerning the stigmatization of people with mental health problems in Germany, is particularly concerning in view of the stubbornly prevalent negativity towards people with mental health problems in that country, despite many attempts at reforming public opinion over the last decade. Such attempts have, however, been regionally focused, and therefore, unlikely to achieve the scope of national measures, such as the campaign recently implemented in the UK (Cutts, Fieldhouse, & John, 2009). These differences of opinion may potentially be linked to a lack of resources and the existence of a treatment shortfall for mental health conditions. As was discussed in the literature review, the phenomenon of professional stigma exhibited toward people with mental health problems is increasingly evident in Saudi Arabian society, and as such, the impact of stigma toward people with mental health problems may cause a delay in providing mental health care services (Alshareef, 2014).

Moreover, the findings of the present research study corroborate these findings, “Negative social factors are at the root of mental health problems”; “The arguments of local employees against the establishment of mental health services in the health care center are well founded”; and “It is therapeutic for the people with mental health problems to be integrated in health care, but disadvantageous to the other patients”. These findings supported by Qureshi *et al*. (2013), a community mental health service is a complex process that faces several important barriers, while many of these barriers are at the policy level. These may occur when there is a lack of adequate mental health policies and legislation. Meanwhile, there may be insufficient budgets.

Sometimes, there may be procedural discrimination against persons with mental health problems, in terms of limited or lack of health insurance (Corrigan, Druss, & Perlick, 2014). Indeed, some barriers are found within the health care system, which includes disproportionate resources being used up by large institutions. This can lead to a reduction in investments in community-based services. Other barriers include: a lack of integration of mental health care services with the general health system; a lack of integration between mental health care and social care systems, which include poor coordination with housing; welfare and employment services; "lack of coordinated partnerships between statutory and non-statutory mental health services, including the voluntary and independent sectors; inadequate training of staff across all systems" (Taylor *et al.,* 2009, p. 1). In Europe, many of these barriers have been tackled to ensure long-term care for people with mental health problems (Corrigan *et al.,* 2014). Initially, many of these efforts began with the development of new pharmacological treatments for psychoses (Corrigan *et al.,* 2014). Consequently, these have radically changed the prognosis of mental health problems, "especially with the emergence of new psychosocial interventions and new concepts of mental health care organizations that have occurred in several European countries" (Ahmed, Mugen, & Wenbo, 2008, p. 55; Corrigan *et al.,* 2014, p.70).

Overall, a better framework of care has been established; for example, "sector psychiatry in France, social psychiatry and mental health in primary care in the UK, and psychiatric reform and deinstitutionalization in Italy became significant landmarks in this initial evolution" (Corrigan *et al.,* 2014, p. 37). In addition, a multitude of further developments have taken place throughout Europe, following on from these early initiatives, these have helped to advance mental health care in many countries (Corrigan *et al.,* 2014). These have included improvements in the living conditions in psychiatric hospitals, further improvements in community services, the integration of mental health care with primary care, advances in psychosocial care (housing, vocational training), legal protection of the human rights of people with mental health problems, "and increasing participation of users and families in the improvement of policies and services" (Corrigan, 2004, p. 614). Undoubtedly, it was shown that suffering discrimination could lead to personal acceptance of stigma, which can lead to the onset of self-stigma (Goffman, 1963). Hence, people with mental health problems may begin to believe the negativity from others about their condition. They begin to believe that they are unable to recover, undeserving of care, dangerous or to blame for their own mental health problems (Corrigan *et al.,* 2014). This can lead them to feel shame, low self-esteem and create an inability to accomplish their goals (Goffman, 1963). Self-stigma can also lead to the

development of the "why try" effect, whereby people believe that they are unable to recover and live normally so "why try?" (Corrigan *et al.,* 2014, p. 37).

To avoid being discriminated against, some people may try to avoid being labeled as having "mental health problems" or "mentally ill" by denying or hiding their problems and refusing to seek care (Corrigan, 2004). Structural stigma, i.e., a stigma that is part of social and institutional policies and practices, presents additional large-scale barriers to appropriate mental care by undermining opportunities for people to seek help (Ahmed *et al.,* 2008). This lack of equality between resources for mental health and other healthcare, as well as the lack of funding for mental health research and use of mental health history in legal proceedings, such as in legal custody cases, all present structural barriers for those with mental health problems (Corrigan *et al.,* 2014). Barriers may result in individuals not seeking help in the first place, even though they require it. It is thought that knowledge; culture social networks and mental health team can influence the relationship between stigma and access to care (Thornicroft, Rose, & Mehta, 2010). For example, mental health problems and potential treatment can lead to the development of stigma and discriminatory practices, as the cultural factors can also have "an influence on the types of behaviors that are thought to violate social norms and the degree that discrimination against persons who display unorthodox behavior is accepted" (Corrigan *et al.,* 2014, p. 614). For instance, social networks and mental health therapy can also "have a huge impact on people's decisions to pursue treatment, serving either to enhance feelings of stigma or to encourage care seeking" (Corrigan, 2004, p. 614).

The impact of knowledge, culture, networks, and mental health professionals on people's decisions to access care, means that many public-health and policy initiatives, which are meant to encourage seeking help, have focused on educating people about a mental health issue, to combat harmful stereotypes related to mental health problems and treatment. Treatment can also be encouraged by addressing cultural barriers to care that include supportive networks in treatment plans (Ahmed *et al.,* 2008; Corrigan *et al.,* 2014). "Legislation, such as the Americans with Disabilities Act of 1990, the Mental Health Parity Act of 1996, the Medicare Improvements for Patients and Providers Act, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as well as most recently, the Affordable Care Act of 2010, have all served to protect people with mental health issues from all discriminatory practices" (Corrigan *et al.,* 2014, p. 40). In more recent times, there has been a greater focus on discrimination. This is the most obvious consequence of stigma, as it acts as a huge disadvantage to people who are stigmatized (Carter & Golant, 2013). What interesting in USA first Lady, Rosalynn Carter, along with Rebecca Palpant Shimkets and Thomas (Carter &

Golant, 2013, p.6), who founded Bornemann of the Carter Centre Mental Health Program, "describe the challenges faced in trying to reduce the stigma of mental health problems and increasing access to care". Many legislative efforts spearheaded by the Carter Centre have helped create or change a public law, to protect the rights of people with mental health issues and ensure equality for mental health services together with other services. These laws have often served to force structural changes. However, the hope is that legislative efforts will eventually lead to true changes in attitudes towards mental health problems (Corrigan, 2004; Carter & Golant, 2013). Indeed, the Carter Centre has been very successful, even though more work needs to be undertaken. Specifically, integrated research is vital, and thus, this type of research ultimately connects the mental health, public health, education and primary care fields together. The authors of this report and commentary believe that such integrative efforts can help to build a strong network of systems and professionals teams in mental health care services that will encourage access to health care, without the fear of stigma (Thornicroft *et al.,* 2007; Corrigan *et al.,* 2014).

The findings of this study are also shown by Lauber and Rossler (2007), who suggested that in the East countries, it is common to stigmatize and discriminate against people with mental health problems. People with mental health problems are typically regarded as being likely to demonstrate aggression and to be a danger; factors which encourage the maintenance of social distance (Gillard *et al.*, 2010). Lauber and Rossler (2007) additionally noted the prevalence of superstition and the influence of "magic" and religion in relation to mental health problems. What is more, the efficacy of treatment and care provided by mental health services for people with mental health problems is also frequently called into question. Stigma is commonly present within the family, and families themselves may experience stigmatization, disapprobation and social denigration because of a family member having mental health problems. This is frequently manifested in matters pertaining to marriage, marriage breakdown, divorce and exclusion. Moses (2010) noted that psychological disorders attract negative opinions, in contrast to bodily disorders, with the result that psychological disorders are frequently conceptualized in bodily terms in the USA. This phenomenon separates those in need from available help and treatment, and so exacerbates the stigmatization of people with mental health problems. This is particularly felt by patients of the services, who see stigma as an obstacle to their requesting support in the first place (Schomerus & Angermeyer, 2008). Lauber and Rossler (2007) additionally noted that mental health professionals engaged in the case of those with mental health problems are frequent sources of stigmatization.

This review demonstrates that the stigmatization of people with mental health problems by mental health professional, which is especially prevalent in this study. It is also clear that, in the East countries, the elements of stigmatization beliefs concerning the causes of and attitudes towards people with mental health problems and the outcomes of seeking help have more similarities with than differences from those typical of Western counterparts such as in the USA (Moses, 2010). Hence, the cultural aspects noted in the stigmatization of people with mental health problems will be examined in depth in Phase 2 (Qualitative Discussion). The study by Read and Law (1999) suggested that need to evaluated how mental health professionals displayed negative attitudes towards individuals with mental health problems. Later research supports these findings (Nordt *et al.,* 2006), with the research's findings in the West countries providing this study with more clarity in relation to the mental health professional's stigma towards people with mental health problems. This also applies in Saudi Arabia, although it was not possible to find a similar study of professional mental health teams in Saudi Arabia within contemporary literature.

Finally, the quantitative results showed that the professional mental health team held a professional stigma towards people with mental health problems in Saudi Arabia. Nonetheless, as previously mentioned, research has only recently begun to address the issue of stigma displayed by mental health professionals (Schulze & Angermeyer, 2003; Lauber & Rossle, 2007). Hence, various aspects noted in the stigmatization of people with mental health problems will be examined in depth in Phase Two- Qualitative Discussion.

Discussion Phase Two

The thematic findings relative to previous research

To summarise, relevant information to assist in the interpretation of the qualitative data was obtained by carrying out the focus group, which emphasised four key themes of importance to mental health professionals' team. With respect to these research questions, the major themes and sub-themes were explored through discussion of the findings from the qualitative results.

Theme 1: Experiences of stigma possessed by professionals (toward people with mental health problems), addressed research question 1; *To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?* Theme 2; Causes of professionally-held stigma, addressed research question 2; *What are the causes or factors in Saudi Arabia that may lead to mental health professionals holding stigmatizing views towards people living with mental health problems?* Theme 3: Impact of professional stigma on mental health services, addressed research question 3; *How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?* Theme 4: Interventions recommended to minimize stigma in general and professional stigma addressed research question 4; *Explore how Saudi Arabia's mental health care service has enhanced the level of resources and standards of care available to mental health care users, and to what extent can the provision of a mental health care service contribute to the diminishment of the stigma that surrounds people living with such a problem?*

1- Experiences of stigma held by professionals (toward people with mental health problems).

The focus group reported on the theme of "Experiences of stigma from mental health professionals", which was consistent with the themes of: (a) Negative feelings; (b) Positive feelings; (c) Diagnosis; (d) Relationships and interactions; (e) Acceptance; and (f) Stigma experiences within marital relationships (endorsed to some extent by all five participants), addressed research question 1; *To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?*; this corresponded with Corrigan and Watson (2002), who recognised that the actual experiences of people with mental health problems experiencing professional stigma must be taken into account. Therefore, the findings of this study inform the discussion of the theme "Experiences of stigma from mental health professionals". Hence, the phenomena of

professional stigma towards people with mental health problems may be explored. As mentioned in the literature review, research concerning the issue of stigma among mental health professionals towards people with mental health problems is in its nascence (Schulze & Angermeyer, 2003; Lauber & Rossle, 2007). It is evident from the results of this study that the theme of "**Negative feeling**" is significant**,** as endorsed by participants. Similarly, as described in this study, many articles have shown that professional stigma; social stigma and negative attitudes exist towards people living with mental health problems (Schulze & Angermeyer, 2003; Chang & Horrocks, 2006). A strong theme of the focus group discussion provided background information about the stigma that they held toward individuals with mental health problems and alluded to the negative feelings expressed within their interactions and dealings with people that have mental health problems. Likewise, the focus group members also reported stigmatising other people that they had encountered based on anger felt towards someone with mental health problems in their workplace. Corrigan *et al.* (2006) describe how with respect to individual circumstances, various emotional and behavioural responses arise in individuals to whom achievements or failings are attributed. These findings are consistent with those of a study in the USA by Ahmedani (2011), who reported that individuals with mental health problems, who are deemed responsible for their mental health problems, tend to display feelings of heightened anger, which subsequently invoke a discriminatory response from members of the professional mental health team when such individuals seek mental health care.

The findings of this study also corroborate elements of the existing research evaluated in the literature review, including work by Acker and Lawrence (2009) in the USA, which indicates that a growing trend of discrimination by mental health care professionals exists towards people with mental health problems. The suggestion by Link *et al.* (2004) that effective response is influenced by unpleasant generalizations and social isolation reinforced in the existing literature, in concurrence with Ruiz and Miller (2004) and Lauber *et al.* (2006) in Swaziland. They noted that the negative attitudes exhibited by some mental health professionals, and their associated behavior towards people living with mental health problems, can be portrayed as stigmatization on the part of the mental health profession. However, such stigmatization exhibits markedly little difference to that exhibited by members of the public. Indeed, those focus group members who divulged their stigmatizing behavior reflected the findings of this study. These findings are consistent with the study by Corrigan (2004, p. 614), perceptions about mental health among the public are reflected in the wide range of perceptions of stigma displayed by mental health professionals, and are therefore frequently noted. Furthermore, the work of Thornicroft *et al.* (2007) in the UK found that stigma could have a

negative impact on the lives and well-being of people who experience mental health problems. These findings are consistent with those of a study conducted in Switzerland by Nordt *et al.* (2006) in which psychiatrists were shown to have preconceived negative opinions of those with mental health problems. With respect to the statements made by the author in the literature review chapter, professional and social stigma may further exacerbate mental health problems due to the negative effects it can exert on an individual's life. Consequently, this may engender feelings of inferiority or inequality in individuals with mental health problems. As a member of the focus group, who was a psychiatrist posted, it is difficult not to develop negative opinions and attitudes towards people living with mental health problems which, due to (Goffman, 1963; Crocker, 1999), can make the mental health professional's role as a career even more challenging. It is, therefore, important to understand the extent to which mental health professionals are influenced by holding such views when relating to people with mental health problems (Chou *et al.,* 1996), particularly with respect to mental health professionals in Saudi Arabia.

These study findings are also consistent with some aspects of the study by Chou *et al*., (1996) and Wahl and Aroesty (2010), whereby attitudinal surveys found that people living with mental health problems would prefer not to be seen by a psychiatrist, but would prefer to be treated by other health care specialists in order to avoid the stigmatizing attitudes believed to be inherent in interactions with mental health professionals (Corbiere *et al.,* 2012). At the same time, the focus group participants noted the significance of a "**Positive attitude**" as a theme that alleviates negative feelings, as endorsed by participants. Based on focus group participants' responses, suggestions were offered concerning the delivery of therapeutic and mental health care plans to people living with mental health problems, without exhibiting stigma against such individuals. As stated by Wahl and Aroesty (2010), many reasons exist which explain the significance of acquiring an understanding of how health professionals perceive the individual.

This discussion establishes the contributions made to existing knowledge through this study, concerning the importance of eliminating the stigma held by those participants in respect of people with mental health problems, particularly those situated within mental health care institutions. Indeed, participants reported using a positive attitude as a way of avoiding negative feelings towards those individuals. It has been suggested that health care experts frequently hold prejudiced opinions in relation to those with mental health problems, and subsequently act on these after determining that a patient belongs to this category (Thornicroft *et al.,* 2008).

It can be suggested that, if patients encounter stigma within their communications with experts (who have a duty to be supportive and sensitive), participants stated how they would hold a stigma toward people with mental health problems, although they would try to eliminate these feelings to establish good therapeutic relationships with these individuals. The provision of a good mental health care plan for people with mental health problems is therefore required, encompassing an initial understanding of the mental health problems, the nature of the condition in question, and acceptance of people with mental health problems from a therapist perspective. Consequently, the implementation of such a care plan would result in decreased stigma held within and demonstrated by professionals toward people with mental health problems.

The role of a mental health professional also involves attempts to understand people with mental health problems and mental conditions, by exercising tolerance and understanding of the individual situation, a function that lies within mental healthcare services**.** These findings are consistent with the study by Sévigny *et al*. (1999), which revealed that, while mental health nurses in China tended to justify negative perceptions towards people with mental health problems, psychiatrists had greater optimism regarding the possibility to reintegrate people with mental health problems into society. The focus group participants felt that it was important to demonstrate positive attitudes, which they thought could help them alleviate the stigma they exhibit towards people with mental health problems. For instance, mental health workers should they succeed in modifying their perceptions, thoughts, attitudes and behaviours, they believed they could enhance the services they provide to people with mental health problems. There has not been much research regarding stigma, which has been on an international scale (Corrigan *et al.,* 2014). However, evidence on effective as well as cost-effective interventions remains highly limited. Steps to redefine this gap in knowledge through careful evaluation of different interventions are vital, as interventions should reduce the exclusion, which leads to the stigmatization, prejudice and exclusion of many citizens in the community, as well as the mental health team (Kuoppala *et al.,* 2008).

In truth, reduced mental health has considerable personal and economic impacts across the world (Corrigan *et al.,* 2014), as stigma and discrimination associated with poor mental health aggravate these impacts (Bahora, Hanafi, Chien, & Compton, 2008; Kuoppala *et al.,* 2008). Consistently, evidence points towards societies' strongly negative attitudes towards people with mental health problems (Corrigan *et al.,* 2014). There is an accurate view that they represent a danger to the community; a view strongly reinforced in the media (Compton, Bahora, Watson, & Oliva, 2008).

What is more surprising relates to the fact that negative attitudes are not only found among the public but even among mental healthcare professionals. Consequently, these negative attitudes invariably contribute to social exclusion (Corrigan *et al.,* 2014). For instance, this reduces the likelihood of an individual becoming employed or accessing healthcare services (Kuoppala *et al.,* 2008). Subsequently, this has resulted in officers feeling increased self-worth regarding working with people in crisis (Bahora *et al.,* 2008; Corrigan *et al.,* 2014), as well as increasing knowledge and more positive attitudes towards people with mental health problems (Compton *et al.,* 2008), together with reducing stigma shown towards people with mental health problems (Bahoraet *et al.,* 2008; Compton *et al.,* 2008; Corrigan *et al.,* 2014).

Internationally, there has been a surge in research conducted into mental health problems, largely in an attempt to remove the negative stigma that is often attached to people with mental health problems (Penn & Martin, 1998; Corrigan & Watson, 2002; Zartaloudi & Madianos, 2010; Parle, 2011). The focus group participants also felt that it was relevant to explain the importance of diagnosis in relation to stigma. Concerning negative feelings' causation and the reasons associated with stigma towards people with mental health problems, the substantial theme in relation to this study of "**Diagnosis**" severity was identified, as endorsed by participants. Additionally, the findings of this study are consistent with some of the literature reviewed, e.g., Nordt *et al*. (2006) research, whereby psychiatrists were shown to have preconceived negative opinions of those with mental health problems.

The participants in the focus group discussion reported that their encounters with stigma were associated with the severity of the diagnosis or the extent of the symptoms of people with mental health problems. Their dealings with people with mental health problems would, therefore, depend on the type of case, the severity of the diagnosis, and their own ability to manage such individuals (or not,) when providing healthcare services in mental health centres or in their private lives. Moreover, the diagnosis factor was shown to be one of the main reasons for a mental health professional to hold a stigma toward individuals with mental health problems. Experiences of stigma held by professionals towards those with mental health problems, particularly with respect to the participants' statements within this discussion, imply that the diagnosis plays a role in stigma held by mental health professionals, depending on the nature of the condition in question. For example, professional mental health providers tend to avoid interactions with individuals with schizophrenia, bipolar or borderline personality disorder. It can be stated that in the context of stigma against mental health problems, impressions of dangerousness have been associated with elevated fear of individuals with schizophrenia and with feelings of anger rather than empathy (Angermeyer & Matschinger,

2003; Angermeyer *et al*., 2004; Emma *et al*., 2010). In taking the stance that pity represents a mundane reaction, individuals with depression are more likely to elicit empathetic responses from society than those with schizophrenia, which Angermeyer and Matschinger (2003) claim to correlate with more fear and anger. The work of Corrigan (2004) may also be of benefit when describing the associations between the understanding, feelings, and responses of society towards these individuals. With respect to the diagnosis of people with mental health problems, these findings in my study are consistent with some of the literature reviewed in this study, including a study by Eker and Arkar (1991), which clearly indicated that many Turkish mental health nurses sought to avoid dealing with cases of paranoid schizophrenia more than cases of both anxiety and depression. Indeed, per the study and the results of Ratner and El-Badwi (2011), the diagnosis and treatment of mental illness in Saudi Arabia are, unsurprisingly, very much influenced by rigid social rules and customs. It is thus essential that mental health care professionals take these issues into consideration when attempting to treat people with mental health problems. Markham (2003) found in the UK context that mental health staff generally were most pessimistic about people with a borderline personality disorder (BPD) diagnosis and were most wary about working with such individuals.

In addition, these mental health professionals were particularly wary concerning individuals with a BPD and schizophrenia, for reasons of dangerousness and social distance. In other UK-based research concerning mental health nursing staff attitudes towards people with a personality disorder (PD), Webb and McMurran (2007) found that mental health nurses expressed concerns relating to feeling insecure, being accepting towards people with a PD, and feeling that their work is useful, as such concerns were more pronounced than those of their counterparts working in other mental health scenarios; they did, however, express opinions which indicated that they enjoyed nursing individuals with a PD. Those mental health nurses who voluntarily took part in an awareness workshop were found to enjoy their work with people with a PD more; be more accepting of them; and felt their work was useful to a higher degree than their counterparts who did not participate. Accordingly, conversations with mental health nursing staff reveal that they need guidance on matters of security and acceptance of people with a PD, and they need to be assured that their work is useful. The focus group's participants' views indicated that the relationships built between mental health professionals and those for whom they care for are substantially contingent upon the themes of positive emotions, negative emotions and the diagnosis severity.

Another significant theme to emerge from the present study concerns "**Relationship and interaction**", as endorsed by participants. The findings of this study demonstrate that the

experience of stigma by an individual had negatively impacted their relationships with others. For example, professional mental health participants noted in the focus group discussion that they prefer not to become involved in a relationship with people with mental health problems, and cannot tolerate any people with mental health problems or with those personalities.

Likewise, previous studies have supported these outcomes (e.g., Wahl, 1999) whereby individuals experiencing fear in the USA were typically more prone to seek separation from people with mental health problems (Angermeyer *et al.,* 2004; Corrigan, 2004; Angermeyer & Matschinger, 2005). Work by Haghighat (2001) has further identified the developmental nature of fear in instigating a desire for separation from individuals of unpredictable behaviour. The outcomes of the present study further revealed that participants struggled to avert dual relationships (relating to the social and professional relationship at the same time), and thus, limits the capacity to understand the negative result of their dealings and relationships with those people with mental health problems on their own personal emotions and wellbeing. This explains why mental health professionals prefer to deal in professional relationships with people with mental health problems within mental health care centres. The participants also reported that, by ensuring this, they could provide mental health care services to people with mental health problems, whom they would otherwise be unable to tolerate in a more social context, and would prefer to avoid, due to their stigma towards such people. Similarly, these findings are consistent with Kua *et al.* (2000), who reported that outpatient mental health practitioners in Singapore showed a higher proportion professionally, held stigma towards individuals with mental health problems, the perceptions of the mental health professionals regarding aspects of patient care and social distance. Moreover, the findings of this study also suggest that social relationships with people living with mental health problems can damage the wellbeing of the participants, thereby and interaction leading to an increased feeling of stigma toward these people with mental health problems.

These findings are consistent with those of Crabtree (2003), in Malaysia, which relate to psychiatrist reports of the likelihood of patients who are psychotic becoming violent during assessment prior to hospitalisation, whereas mental health nurses were more concerned with possible dangers related to the monitoring of non-psychotic patients. In addition, the findings in the literature review related to the term ‘stigma’, which show that it can be described as ‘the circumstances of the mental health patient who is excluded from complete social inclusion’ (Goffman, 1963, p. 248). What is more, other research suggested that hospital staff, particularly women, reported expectant fear of admitting psychiatric patients for therapy in a non-specialist clinical environment (Crabtree, 2003).

The focus group's participants brought useful reflection based on their professional experience, raising issues regarding how to be more accepting of people with mental health problem. The findings from the present study revealed another significant theme of "**Acceptance**", as endorsed by participants. The focus group's participants suggested finding ways to increase the acceptance of people with mental health problems. While the social interaction with those people with mental health problems is not easy for professional mental health teams. Additionally, professional mental health participants noted in focus group discussion, that the importance of accepting those people with mental health problems, and keep interacting with them inside the community, in order to refrain from excluding people with mental health problems from the community which was an observation supported by the work of Corrigan and Miller (2004), together with Kokanovic *et al.* (2006).

Consequently, this situation can further contribute to social rejection by family members, leading to feelings of inferiority or discrimination (Yang *et al.,* 2007). Additional effects related to health, such as social isolation, discrimination, and prejudice, also accompany mental health problems. In agreement with the work of Doody and Doody (2015), the outcomes have indicated that all the negative observations, particularly those expressed by the mental health team, can be prevented with simple modifications to everyday life, better health care provisions, and improved clinical approaches.

Additionally, the participants in this study raised the issue of how the previously considered themes influence their views on marriage with people with mental health problems. This consideration was not diagnosis-specific. In consequence of this, a significant theme emerged concerning "**Stigma experiences within marital relationships**", as endorsed by all five participants. The focus group participants considered that incidents of stigma reported by individuals had an unwanted effect on their personal relationships, particularly with their spouse. Several participants in the study indicated that their own perspective and interactions with people with mental health problems and stigma allowed them to develop empathy for the affected individuals and strengthen their professional outlook, and the intervention suggested by the study's participants concerned the acceptance of those with mental health problems marrying. This consequently raises concerns with respect to the person with mental health problems being able to understand and take up the responsibilities of marriage, which is informed largely by their diagnosis severity. Nevertheless, other participants provided another perspective on this matter, noting that it is very difficult to accept this idea, especially in Saudi Arabian society, which will not accept such a relationship, and that the familial stigma associated with people with mental health problems can be problematic in terms of extension

into community relations and societal relations (Yang *et al.,* 2007). Indeed, this idea can be difficult to accept, especially in Saudi Arabian culture. Similarly, these findings are consistent with the study of Morgan *et al*. (2007), who reported that some mental health professionals in the UK did not consider people with mental health problems to can achieve any real objectives. In addition, these findings support those of Dalky (2012), suggesting that, in general, marriage in the Middle East to an individual with mental health problems is socially difficult to accept, meaning that the family of an individual with mental health problems will disregard his or her issues, as they will shame the family name and decrease the chance of marriage; this scenario is a common occurrence in Saudi society.

Therefore, the three primary social influences in this respect are the Islamic religion, Islamic culture and heritage, as well as the Bedouin culture, all of which have also been significantly influential in forming the distinctive characteristics of Saudi Arabia (Al-Shahri, 2002). Those who marry an individual with mental health problems in an Arab country will, in general, risk being rejected (either before or after the marriage has taken place) – a position that was corroborated by Dalky (2012), who confirmed that the culture of Saudi Arabia and Arab families are inimical to marriage to individuals with mental health problems. Similarly, other work, such as the research by Abdullah and Brown (2011), confirms this view. A more general study that juxtaposes ethnic and cultural beliefs and mental health problem stigmatisation illustrate the diversity of cultural belief with respect to mental health. By way of example, some Native American cultures stigmatise all people with mental health problems, whereas others do not, or only partially do so, which is contingent upon the nature of the mental health problem (Hogg & Holland, 2010; Ahmedani, 2011). In some Asian countries such as Egypt, Jordan, Syria, and Lebanon where conformity, the suppression of emotions and personal achievement according to familiarly and societally accepted criteria are held in high regard, those with mental health problems are typically stigmatised and considered to be causative of family shame (Hogg & Holland, 2010; Abdullah & Brown, 2011; Anderson, 2014). The cause of stigmatisation, however, is not only socially predicated; mental health problems may be seen to be unhealthy or detrimental to physical health. In relation to this, research conducted in 2003 among US citizens of Chinese and European ethnic origin were asked to comment in specific ways on a scenario where a hypothetical individual had been diagnosed with schizophrenia or a major depressive disorder (WonPat-Borja *et al.,* 2012). The research participants were then informed that the hypothetical individual's professional diagnosis stated that the condition was genetically acquired, partly genetically acquired, or had no genetic causation.

Subsequently, the participants were asked for their views on their son or daughter entering a relationship with, marrying or having children with the hypothetical individual. The results showed significant differences in attitudes to genetic factors in respect of mental health problems that divided along the lines that distinguished the participants of Chinese and European ethnic origin, thereby confirming previous research into the cultural influence within mental health problem stigmatisation (WonPat-Borja *et al.,* 2012).

2-Causes of professionally held stigma

The theme reported by the focus group in respect of "Causes of professionally held stigma", was consistent with the theme of (a) Experience (b) Media (c) Community (d) Racism (e) Religion (f) and Labels, as endorsed to some extent by all five participants, addressed research question 2; *What are the causes or factors in Saudi Arabia that may lead to mental health professionals holding stigmatizing views towards people living with mental health problems.* In consequence of the discussions of the focus group, an initial significant theme to emerge was concerned with "Experience", as endorsed by all the members, particularly the psychology participant in the group discussion. The "**Experience**" theme was discussed by the mental health professionals, alongside related concerns, which determined levels of culture, practical experience and education, to explore the phenomena of professional stigma towards people with mental health problems. Furthermore, as mentioned in the literature review, Kitzinger (1995) recommended persuading and motivating participating individuals to be more involved and included in the dialogue taking place, thereby motivating them to speak about the subject matter in question. This aligns with the sentiment that "thought seeks to penetrate the subjective experience and establish the real, objective nature of the things as sensed by the individual" (Wilson & Hutchinson, 1991, p. 263).

In this study, results have provided an overview of research relevant to the proposed study discussed above, which clearly point to stigma towards people living with mental health problems with respect to the subjectivists of the professional experience of a mental health team. This could be attributable to the fact that reality is a matter of subjective experience and perception, and is also subjectively interpreted by such society; these findings are consistent with Kafle (2013). Another view of explaining that phenomenology is an expression of how one aligns oneself with 'lived experiences' and of how one reflects on the way one experiences the world (Dowling, 2004; Langdridge, 2007, p.4).

As the phenomenon in this study of 'lived experiences' of professional stigma toward people with mental health problems, these findings are consistent with Corrigan & Rao (2012), in regards to view, attitudes, causes, and interventions amongst the professional mental health team and effectiveness of mental health care services approved. In the focus group discussions, one participant noticed how one's background, together with experience, could lead one to hold a stigma and negative attitudes towards those people living with mental health problems. The findings of this study are consistent with Okasha (2003), who showed that the background of culture, society and family setup could lead to different stigma related to mental health problems. In the Saudi Arabian and Arabic culture, the family is the key social unit when it comes to impact on mental advancement, illness behaviour or patterns, and health management for members of that family. In fact, there are few research papers investigating the opinions of families caring for people with mental health problems in Middle Est.

The findings of this study are consistent with those of Angermeyer and Matschinger (2003), who note that the negative attitudes held toward people with mental health problems also affect their family, friends and the mental healthcare professionals who must endure this stigma. This is an important consideration, as mental health is one of the most pervasive challenges to the development of effective and comprehensive healthcare in modern-day society in Middle Eastern regions (Dinos *et al.,* 2004). Moreover, this supports the findings by Vancampfort *et al.* (2016), who found that the average Arab family unit believed that looking after a family member living with mental health problems can potentially bring about disgrace for their family name, as well as inspire fear, embarrassment and another social stigma, which may lead to pervasive views reflected on people with mental health problems. In addition, it was found that loneliness; shame and a feeling of seclusion were commonly found throughout different Arab cultural countries.

There have been minimal efforts in Arab nations to define the stigma of mental health problems and there appear to be no research papers investigating this phenomenon and its effects on the people with mental health problems and those close to them. The stigma associated with looking for health care and professional assistance is such that families avoid the issue to lower the possibility of being disgraced (Stengler-Wenzke, Trosbach, Dietrich, & Angermeyer, 2004). Most of the focus group participants noted that professional experience is related to educational attainment, which in turn could be influential in the stigma held regarding people with mental health problems.

Other influential factors in the stigma towards people with mental health problems exhibited by mental health professionals could include; *inter alia*; the working environment;

and day-to-day interactions and interlocutions with people with mental health problems. The literature review indicates that, although mental health professionals interact with people with mental health problems in comparable circumstances, they are likely to adopt different approaches towards their interactions based on their respective training, regulation, job description, legislative constraints and personal opinions (Alshareef, 2014). In addition, the outcomes of this study are consistent with Holmesland *et al.* (2010), who explained how this creates the issue of professional identity, which can hinder the progress of cooperation and interdisciplinary action. Furthermore, Eker and Arkar (1991) suggest the significance of determining whether discrimination and prejudice are prevalent in those who work in the mental healthcare profession. Likewise, the findings of the present research are consistent with Link *et al*. (2004), who suggested that, while stigma has existed throughout history, and is based on social science concepts, it can cover a wide range of meanings, and has been described by experts from many different backgrounds. The outcomes of this study are consistent with Acker and Lawrence (2009), such individuals could apply their own personal experiences or upbringings to their work, which are reflected in how they perceive and behave towards people with mental health problems.

The findings also indicate that most influential factors concerning the stigmatization of people with mental health problems originate from:

- Negative background;
- Negative conceptualization;
- The working environment, and the environmental interactions with those with mental health problems;
- Knowledge and the level of education.

Consequently, any of these could result in mental health professionals to hold a stigma and negative attitudes towards people living with mental health problems. As described by Bonney and Stickley (2008) in England, individuals with mental health problems are distinguished from other health service users, per society, and exhibit profoundly different therapeutic needs. These people are expected to have difficulties with everyday functions and self-care, are not self-reliant, and require assistance in making decisions (Corrigan, 2000). The participants in the focus group discussion also identified negative portrayals in the media as a second reason-informing stigma towards people with mental health problems. Indeed, this was believed to operate at personal, social and professional levels. Hence, it has emerged from this study, the significant theme of "**Media**", as endorsed by participants.

The findings of the present study also indicate that stigma has been found to be linked to the media through unfavorable coverage and poor portrayals of those with mental health problems. The media was held to be a primary source of information regarding mental health problems. Most participants perceived the media as an important tool within Saudi Arabian society, which has a responsibility and potential to improve mental health education, facilitate the improvement of attitudes, as well as enhance the image of psychiatric patients and mental health care services that are provided through community health care. As described by Pirkis and Francis (2012) in Australia, the stigma experienced by individuals struggling with mental health problems results from many of different factors, including inappropriate information (ignorance), attitudes (prejudice), and behaviour (discrimination) through the media. Hence, stigma can be defined as an attitude, which is reflected in stigma with discriminatory behaviour.

The conclusion reached by many studies is that the public derives most of their information on people with mental health problems from the media (Coverdale *et al.,* 2002). Furthermore, stigma can also arise from the media's portrayal of individuals living with mental health problems. The findings of this study are consistent with Dinos *et al.* (2004) in the UK, where several individuals felt stigmatised from the moment that they were diagnosed with mental health problems, and subsequently attributed this to the media's portrayal of their condition. Additionally, Huang and Priebe (2003) have explored the various ways in which the stigmatisation of people with mental health problems is conveyed in comparative international contexts through the media. This examination compared press coverage of professional mental health team activity in the UK, the USA and Australia; in all, 118 items of press coverage concerning mental health workers were reviewed. Consequently, the general tone in the three countries was shown to be significantly negative, particularly in the case of the UK. Comparatively, where the UK media did report positively, the subject-matter mostly concerned research into mental health and the deliberations of conferences, rather than practice-focused scenarios.

These study findings also represent a significant observation, as they indicate the need for the stigma to be addressed societally, as well as to focus on practice. Byrne (2001) noted that the media provides useful insight into the causation of stigmatisation, which is also an important and, in many cases, the sole mediator of fact and opinion concerning mental illness. The media is significantly characterized by stereotypes and form of 'pandering' to the prejudices of the audience, as Byrne (1997) and Wahl (1999) noted that typical stereotypes of mental health problems align with the Community Attitudes Toward Mental Illness (CAMI) scales. In a similar study relating to television coverage of mental health problems, Wilson,

Nairn, Coverdale and Panapa (2000) reviewed 128 programmes – mostly originating from the USA – intended for juvenile audiences, which determined that 46% referenced mental health problems pejoratively through epithets, such as, *inter alia*, bananas, cuckoo, freak, twisted and wacko. Meanwhile, six programmes featured characters that were labelled consistently as being ill and possessing no positive characteristics. Byrne (1997) noted that this labelling theory suggests that children absorb stereotypical assumptions early in life.

Read and Law (1999) noted that journalistic stereotypes and those held by medical health professionals in respect of mental health problems are substantially similar. What is more, Wilson *et al*. (2000) considered partial and stereotypical media representation of mental health problems to be the major and perhaps sole cause of stigmatisation, although this view has been challenged. There has been a call for a far-reaching initiative aimed at preventing stigma, which would counteract typical media representations of people with mental health problems and replace them with more accurate and considered ones (McKeon, 1998). This proposal effectively encouraged the use of the media to accomplish a sharp redress of its shortcomings. Penn, Kommana, Mansfield and Link (1999) have developed an initiative situated in educational scenarios that present case studies for reflection and consideration and, although these could be beneficial, they are unlikely to be as influential as sensationalist press stories or Hollywood representations of psychotic villains. McKeon (1998) noted that even ostensibly positive media coverage of the mental health conditions of famous people, such as depression, and the twinning of mood disorder with creative talent, may not be wholly beneficial and may even be detrimental. Similarly, psychiatrists' admission of mental health problems and vulnerabilities may establish mental health problems in the popular mind as something that may be infectious or contagious (Wilson *et al*., 2000).

Moreover, Salter and Byrne (2000) have suggested that benefit could emerge from cooperation between psychiatry and the television industry, using television's power to engage and react using popular culture with a view to the establishment of people with mental health problems in a positive light. Nevertheless, it remains necessary for mental health professionals to remain vigilant in respect of inaccurate media reporting. An important issue that was raised by the focus group participants concerns the motivating effect of stigmatisation of people with mental health problems engendered by the Saudi Arabian society.

The emergent question in this respect concerns the degree to which Saudi Arabian society is influential. This led to the focus group participants identifying the significant theme of "**Community**", as endorsed by all participants. Accordingly, mental health problems are generally prevalent in societies and cultures of all kinds and in all locations. Mental dislocation,

emotional disturbance, the feeling of anger or unhappy may all be conceptualised as mental health problems, and are commonly felt by all people from time to time (Hogg & Holland, 2010). When trying to comprehend these statistics, family structure, social context, socioeconomic status, the role of religion, and other belief systems must be considered (Karam *et al*., 2006).

The findings of this study indicated that Saudi Arabian culture was indeed a factor that contributed to mental health professionals harboring stigmatizing views of people with mental health problems, as the professionals themselves are a part of that very society and culture. These study findings suggested that of concern is the prevalence of these attitudes among professional mental health workers, which are also embedded in Saudi Arabian culture and the community, as stated in the literature review. Indeed, the World Health Organization (WHO, 2001, p. 6) emphasises the negative effects of stigmatisation on family life, social networks and employment creating "a vicious cycle of alienation and discrimination which can lead to social isolation, inability to work, alcohol or drug abuse, homelessness, or excessive institutionalisation". This supports a finding by Abdul Salam (2013), that determines the significance and influence of social and religious factors on the native Saudi population and the enormous number of migrants and expatriates (almost a third of the population) in the country. Consequently, one participant reported that this culture could lead to stigmatising views that those people who were living with mental health problems could not be accepted and that this would negatively affect their lifestyle.

In regards to the literature review, it was stated that the fear of social stigmatisation means that many individuals living with mental health problems do not receive the correct treatment they require (Coverdale *et al*., 2002). In short, stigma can also give rise to a cycle of social deprivation because of the chronic nature of the illness (Lee *et al.,* 2005). Moreover, the focus group participants suggested that cultural influences lead to those with mental health problems being regarded as dangerous. Thus, this phenomenon can lead to the neglect of individual rights within Saudi Arabian society, which includes the right to marry, work, be supportive, receive support, and become educated and secure health care. This accords with research by Dalky (2012), which found that the average Arab family unit believed that looking after a family member who is living with mental health problems could potentially tarnish their family name with disgrace, as well as inspire fear, embarrassment and another social stigma. In addition, it was found that loneliness; shame and a feeling of seclusion were commonly found throughout Jordan and Morocco (Dalky, 2012).

The stigma of being found to have mental health problems impacts the person's recovery through their hospital care system in the USA (Veltman *et al.,* 2002, p. 114), "as well as the quality of life for those with mental health problems and their families", within their own communities in the Middle East. The focus group participants noted that it is evident from the Saudi Arabian society and culture that they express the idea of stigma through discrimination and prejudice against those with mental health problems. Consequently, social stigma leads to people living with mental health problems, and whilst doing so, they generally attempt to hide these problems and not reveal their situation to others. These findings are consistent with the studies by Corrigan and Miller (2004), as well as Kokanovic *et al*. (2006), which excluded people with mental health problems from social life and can also lead to the social isolation of their families. Moreover, Stuart (2005) points out that the professional stigma demonstrated towards people living with mental health problems not only directly affects them through the way others interact with them, but also influences their lives indirectly, in terms of prejudice and discrimination.

In this study, it was found that those people with mental health problems possessed inadequate personalities, with inferiority to the other normal people in a Saudi Arabian culture. Furthermore, other findings in my research study reported on how different cultures exercise and display contrasting views towards people with mental health problems. This also relates to the status of their mental health and diagnosis, and how individuals with mental health problems appear to others through that culture and the interactions, and relationships. Furthermore, one participant suggested that social stigma could lead to the holding of prejudice toward people with mental health problems, thereby negatively affecting their lives, as Saudi Arabian culture tends to be cautious of people with mental health problems. These findings are consistent with Okasha (2003), whereby the family is the key social unit in Arabic culture when it comes to the impact on mental advancement, illness behaviours or patterns, and health management for members of the family.

Another participant noted, however, that culture was the main reason for initiating or maintaining stigma toward people with mental health problems. In addition, the participant explained how stigma arising from cultural influences also had an impact on her, which related to the stigma against people with mental health problems. The findings in this study are consistent with Link *et al.* (2004) analysis that stigma has existed throughout history, and is often explained through the concept of social science; it can cover a wide range of meanings and has been described by experts from many different backgrounds. This fact accords with the research of Corrigan *et al.* (2000) that found that in the UK, negative opinions that demonise

social ineptitude that, in turn, is frequently associated with mental health problems, are problematic. These effects militate in favour of social isolation; personal disquietude and reduced employment opportunities and in-work troubles frequently faced by those with mental health problems.

The research of Crisp *et al.* (2000) corroborates that of Thornicroft *et al.* (2007), which posits, in the context of the UK, that initiatives that seek to achieve public awareness in respect of mental health problems can be beneficial in ameliorating the effects suffered by those concerned. Looking ahead, a focus must be applied to determine which initiatives will be most effective in moulding the public mind and, thereby, reducing discrimination against people with mental health problems. Lauber *et al.* (2006), however, noted that positive descriptions of people with mental health problems were less concerned with their characterization, whereas those negative descriptions were mainly concerned with their mental health problems. In contrast, compared to the public in Switzerland, mental health professionals do not exhibit relatively negative or positive stereotypes concerning people with mental health problems (Lauber *et al.,* 2006). Also, the Department of Health in the UK has published a *Practical Guide to Ethnic Monitoring in the NHS and Social Care*, which addresses the provision of care to people of all cultures and ethnicities (Hogg & Holland, 2010).

In the present study, it is indicated that the Saudi Arabian community is capable of encouraging mental health professionals' stigmatisation of people with mental health problems. With regards to mental health professionals who are still a part of the Saudi community and are integrated into the Saudi culture, it is shown that they experience negative impressions from the community and the impact of their attitudes fosters a feeling of inferiority among people with mental health problems, as highlighted in the literature review. This situation can result in mental health care becoming limited, and with so many people to provide for; families often decide to keep health issues hidden out of fear of social stigma or of being perceived as unable to care for the family unit.

In general, within Arabic communities (as in Western ones), people with mental conditions are frequently stigmatised, mocked, derided, and disregarded. This is because, for a very long time, mental health presented problems that were linked to evil forces, 'the evil eye', malevolent magic, violence, addiction, suicide, and sin (Pridmore & Pasha, 2004). Additionally, these findings are consistent with Chou *et al.* (1996), in that stigma can lead to social isolation and decreased the quality of life by restricting access to work opportunities, housing and other basic needs.

Consequently, "**Racism**" has been identified in this study as a significant theme, as endorsed by one participant. As indicated in the literature review, the experiences of individuals with serious mental health problems, which constituted the focus of the survey, are shared to a certain extent by individuals with less serious mental problems, who are also apprehensive about making their problems known to people in the workplace. Conflict based on race occurs when individuals are subjected to racism, which may be defined as the agglomeration of prejudice (attitude) and discrimination (behaviour) that is ethnically or racially located (Silton *et al*., 2011). It is worth noting that racism may be either individual or institutional, as mentioned by Gee (2002).

As Saudi Arabian society is significantly predicated upon by the customs and traditions enshrined in the Islamic religion, it was considered that religion should be an important area of discussion in the context of stigma formation and perpetuation. In consequence, "**Religion**" has been identified in the study as a significant theme, which was endorsed by participants. As described in the literature review, the legal system (Sharia law) in the Arab world is founded upon doctrines from the Qur'an and a series of prophetic standards originally offered by the Prophet Muhammad (Peace Be Upon Him) (MPBUH) (Abdul Salam, 2013). Furthermore, the literature review demonstrates that when trying to comprehend these statistics, family structure, social context, socioeconomic status, the role of religion, and other belief systems must be considered (Karam *et al*., 2006). Therefore, these study findings have also considered; nationality, religion, and cultural values as factors that affect stigma towards people with mental health problems, as well as the relationships between health professionals and people with mental health problems. As noted in the literature review, these findings are consistent with the work of Abdul Salam (2013), whereby mental health should be considered in accordance with its diverse cultural makeup. Hence, medical care must be provided in a way, which treats a range of different religious beliefs with the same level of respect.

Cultural and religious beliefs can frequently be influential in relation to the conceptualisation of mental health problems, and consequently inform attitudes towards people with mental health problems (Hogg & Holland, 2010). As well as being influential with respect to the extent to which individuals living with mental health problems experience social stigma, beliefs about mental health problems can be of influence in determining such individuals' attitudes towards seeking help and complying with prescribed remedial therapies and medication (Nieuwsma *et al.,* 2011). In consequence of this, it is important that personal and cultural attitudes to mental health problems are fully understood if approaches to mental healthcare are to be beneficial.

The findings of this study also revealed that there was a shared impact of the origins of mental health problems within the community; namely, that those who are suffering from mental health problems were either cursed or lacking in religious conviction (Al-Shahri, 2002; Ali, 2006). Another observation made by the focus group participants arose that, although the mental health care provisions are improving, a large proportion of the care designed for individuals with mental health problems is still managed by family members. The findings in the present research indicated that in Saudi Arabia, a family is a sacred unit, and protection of that unit is a religious duty.

It is interesting to note that the 'not guilty because of insanity' plea existed in Islamic communities long before any Western nation decided to incorporate it as a legal judgment; if you are 'insane,' you are not held responsible for your actions (even if they are in breach of the law) (Wahass & Kent, 1997). Nonetheless, despite this sophisticated conceptualisation of mental health problems in the Islamic world, a study conducted among US Muslims found that even when they have positive attitudes toward mental healing, social stigma among Muslims remains prevalent (Ciftci *et al.,* 2013). This is largely cantered on concerns regarding family status in the community, in respect of which mental health problems are frequently considered to engender shame (Aloud & Rathur, 2009). In addition, Shibre *et al.* (2001) found that, among their cohort consisting primarily of Ethiopian Muslims, 75% had experienced stigma arising because of familial mental health problems, and 36.5% stated that they believed that familial mental health problems would have negative implications in terms of marriage and seek treatment. In consequence of this, Muslim women with mental health problems are typically reluctant to seek treatment or discuss their problem within their community due to fears for their future or existing marriages (Thornicroft *et al.*, 2007). Thus, in my study of the belief system that relates to the impact and attitude of religion, this is difficult to uphold, with several members of a family looking to religious and traditional 'healers,' rather than attending a certified medical professional, as described by Handzo and Koenig (2004). One of the most important Islamic teachings (and one which informs much of the social and cultural makeup of Saudi Arabia) is the belief that the mental health problems are a result of sin. Additionally, the findings of this study are consistent with the work of Al-Shahri (2002), which describes how the Islamic faith considers sickness, through both its physical and mental forms, to be both a punishment and a method of atonement for immorality.

Furthermore, the findings of the present study identify deferment as a feature with respect to seeking medical assistance. It is worth mentioning, however, that any recourse to faith is the typical and general reaction of the Saudi population in matters of healthcare and wellbeing,

and represents a pervading practice within the sample population, given that it is present both in Arabian and Saudi Arabian cultures. Moreover, the findings are consistent with the study by Jerrell and Wilson (1997), which facilitate a beneficial perception into the impact of and current thinking about mental illness that is upheld by different demographical groupings (both ethnic and religious). Indeed, this perception may be employed in the formulation of better, more accustomed and tentative treatments and approaches within the community.

It is important to note that the socio-economic characteristics of Saudi Arabia have been similarly influenced by the distribution and evolution of Islamic beliefs. Within the current findings, the stigma was found to also arise because of one's religious background and could influence the interpretation and occurrence of mental health problems. Considering the significance and influence of social and religious factors on Saudi population and expatriates (Abdul Salam, 2013), mental health should be considered in accordance with its diverse cultural makeup. Hence, mental health care must be provided in a way, which considers a range of different religious beliefs with the same level of respect (Hogg & Holland, 2010).

The findings are consistent with those of Qureshi *et al.* (2013) in Saudi Arabia, which demonstrates the necessity for healthcare professionals to understand the complex demographic, cultural, social, and behavioral variables which can improve or lower the situation for people with mental health problems. Accordingly, such professionals must remain willing to make compromises, whilst persistently attempting to prescribe treatments applicable to the unique religious and lifestyle-based needs of Saudi citizens. In the UK, the Department of Health has facilitated a growing sensitivity to the religious and cultural beliefs of people with mental health problems and their families, and have taken care to ensure that relevant procedures are established that apply at all levels and within all functions throughout the NHS and its ancillary community-based services (Department of health, 1996). The Department of health (1996) explicitly assures the preservation of patients' dignity and privacy and respect for their culture and religion everywhere and always, and administrative measures are emplaced to ensure these elements of the NHS' mission are met. In response to increasing ethnic and religious diversity within the UK, NHS trusts have implemented staff education programs and procedures to be followed in respect of according with the various cultural sensibilities and requirements of their clientele, particularly in relation to their treatment and care. Comprehensive guidance in respect of patients' beliefs and religious needs, published in 1996, not only offered prescriptive advice to NHS staff, but also presented examples from real-life practice scenarios and provided references to other sources of information (Department of health, 1996).

The findings of this study also indicate that some people have difficulty considering mental health problems from a scientific perspective and adhere to sincerely hold, but ultimately unhelpful religious or social understandings. The focus group participants also noted that mental health problems could be exacerbated or instigated by religious beliefs, with typical problems in this respect being those concerning obsessions, anxiety and depression. This connection between belief and mental health problems was noted by Sigmund Freud, who observed that obsessive behaviour could be manifested in those whose faith demands strict adherence to mechanistic ritual (Blevins, 2005).

This can also be manifested in anxiety that occurs when such rituals are not, or are only, imperfectly observed. Koenig (2008) noted that, although in these instances religion serves to instil guilt in the believer, either through its ritualistic demands or the high standards that believers must meet, it could also be therapeutic in that it enables believers to achieve absolution, and hence, deliver relief through, prayer and charitable works. There has been a lot of interest in the UK, where there have been significant developments in the conceptualization of the historical connection between mental health and religious beliefs (Behere, Das, Yadav, & Behere, 2013).

Throughout the 20th century, mental health professionals relegated religious observance to the point of irrelevance, considering it to be something that was in retreat as a significant feature in human life and ultimately likely to vanish entirely. Epidemiological research has, however, in many instances, demonstrated that religion occupies a central place in many people's lives and that causal connection can be identified to link religious observance with mental healthiness. Indeed, most research in this area has focused on the US Christian experience, although recent studies have extended this to other locations and religious scenarios (Moreira-Almeida, Lotufo Neto, & Koenig, 2006). Religious faith has frequently been co-opted as a means of treating people with mental health problems, which had an effect due to the power, trust and respect accorded to clergy, and due to the mental health expertise, they acquire through pastoral work. Given the centrality of religion in many people's lives, faith is clearly an important aspect of personal psychology and could, in consequence, be harnessed in the service of psychotherapy, although this must necessarily be done with care and sensitivity for ethical reasons. To achieve an understanding of the potential and pitfalls of religiously oriented therapy, psychiatrists should learn about religion in the context of mental health. They should also seek to understand religion as a potential means of introducing psychiatry to a faith-oriented public, as described by Horovitz (2002).

These findings of the links with religion have the potential to be highly influential in psychiatry, particularly in relation to the identification of symptoms, phenomenology, and the explanation of outcomes (Koenig, 2008). Given the importance of religion to many people and its causative power in respect of mental health, it should form part of the considerations applied in respect of mental health research and practice. Koenig (2008) noted that mental health practitioners could enhance their efficacy in achieving resolution for their patients with mental health problems, and fulfil their professional duties and ambitions, by acknowledging and making use of the religiosity of their patients. Practitioners, who seek to understand patients' psychological and social profiles, and to link these to biological presentations, should build patients' religious faith into their considerations, just as they would with other patient exigencies.

In this study, one participant in one focus group noted how incorrect religious concepts and backgrounds could lead to stigma, with respect to individuals who reject the concept of mental health conditions as a science, and instead view these issues from the perspective of their social and religious beliefs. This situation leads to an increased aggravation of the problem and, eventually, to the development of a stigma toward people with mental health problems who are perceived as inferior, and qualify individuals as other people without mental health problems. It is, therefore, important to note that certain mental health professionals emphasise this point within members of the population from a Saudi Arabian culture, who generally believe that people with mental health problems require a religious therapist in addition to a medical clinician for mental health care. The findings are consistent with the study by Al-Krenawi and Graham (2000), which crucially, and in comparison, to ancient Arabic wisdom, described how the modern Islamic faith does not consider all mental disorders as the consequence of supernatural forces. In fact, at least one eminent Muslim academic, Ibn Sina, has challenged the idea that malevolent spirits are to blame for mental health problems. The diagnosis and treatment of mental illness are, unsurprisingly, very much influenced by these rigid social rules and customs. Moreover, in this study, the findings are consistent with Ratner and El-Badwi (2011), who state that it is essential that mental health care professionals take them into consideration when attempting to treat patients.

In addition, in the present findings, the focus group participants considered the terminology they used in thinking and speaking about people with mental health problems, and how such labels informed their opinions. This was related to the significant theme of "**Labels**", as endorsed by participants. Research revealed that labels of mental health problems invariably

lead to cause stigma and led to increasing the negative attitudes toward people with mental health problems (Gabriels *et al.,* 2008).

The findings of my study also indicate that the nature of terminology (slang language) that is employed and applied to persons who present with mental health problems is influential within their communities. The findings are consistent with the study by Goffman (1963, p. 248), stigma is defined as "a collection of negative attitudes or as stereotypes towards individuals whose characteristics are different from one's own, or that differ from society's norms". Also, the focus group participants expanded upon the fact that stigma, in relation to those that had mental health problems, remains significant for their cognitive, emotive and the behavior-related well-being. With respect to labels used in theoretical terms, individuals deemed to be suffering from mental health problems are alternatively understood to have been given this label (that is, having been observed to emerge from a psychiatrist's office), and thus, are the focus of stigmatisation thoughts and comments (Martin *et al.,* 2000). Furthermore, the psychiatric label attributed to those with mental health problems, as well as the temporal range of which they have experienced an illness, are indications of the level of their disease and are used as a methodological filter for their compatibility with society (Knopman *et al.,* 2008). Regarding this fact, the study found that a key driver to invoke stigmatising reactions is how the public sees and names the issue presented. Moreover, one participant noted that the slang labels applied to those people with mental health problems are still used; forward people have a different or unusual attitude and characteristics compared with others, regarding stereotypes toward people with mental health problems. The outcomes of this study are consistent with Crocker (1999, p. 102) noted, "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context".

In this study, the findings are consistent with those of Liggins and Hatcher (2005), who investigated how people with mental health problems and mental health professionals reported stigma, based on a liaison psychiatry service, which identified stereotype and labelled individuals with mental health conditions. In addition, the findings showed that any individual who displays different behaviors or attitudes would receive a slang label, describing him or her as someone who exhibited abnormal behavior or mental illness. The findings are consistent with the work of Byrne (2001) in England, who reported that the stereotyping and labelling of people with mental health problems leads to self and social stigma, regardless of whether abnormal behavior exists. Additionally, an aspect of this field of study involves the methods for assessing response to various mental health problems, while employing categorizations and

labels most applicable to society and thus, not inevitably of a diagnostic nature (Emma *et al.,* 2010).

3- Impact of professional stigma on mental health services

The focus group reported the theme of; "Impact of professional stigma on mental health services", which is consistent with the theme of (a) Deficiency (b) Immigration (c) Policy (endorsed to some extent by all five participants), addressed research question 3; *How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?* As is clear from the results of the present study, the impact of professional stigma is causative in the deficiency of care that is provided for people with mental health problems. This is the significant theme of "**Deficiency**", as endorsed by participants. As noted in the literature review, psychiatric epidemiological research is limited in Arab countries, although evidence exists that suggests that mental health problems in these regions occur to the same degree as in any other developed nation (Karam *et al.,* 2006).

In Saudi Arabia, the system of mental health services has long suffered several deficiencies in infrastructure and logistics, in addition to a lack of epidemiological data in Saudi Arabia (Alshareef, 2014). For example, that Saudi Arabia struggles to compete with Western nations, particularly when it comes to the psychological and behavioral sciences. A number of studies published in the USA and Great Britain, over the course of just a decade (1992-2001) numbered just under 60,000. If we contrast this with the 299 studies published in Saudi Arabia, over the course of a four-decade timeframe (1966-2006), it is clearly exhibited how far behind the nation still is in comparison to Western superpowers (Qureshi *et al*., 2013).

In the present findings, it was reported that a resulting decline in mental health care services in Saudi Arabia existed, as well as reduced numbers of staff in the area, meaning that there are deficiencies in the mental health services in Saudi Arabia and inadequate provision of staff. Moreover, in this study findings, it was indicated that a significant amount of development is required, which needs to take place if medical care is to be provided to the whole country (inclusive of expatriates). These findings are consistent with the research by Pinto *et al*. (2012), which suggests that a need for sophisticated medical training resources remains in Saudi health care structures and centres of learning, especially in the form of psychiatry provisions and research that is designed to modernise and streamline the wider health care sector. A sizeable and expertly trained mental health workforce is still required, across all sectors of the health care system, to fulfil the demands of an increasingly complex Saudi population (Pinto *et al.,*

2012). As stated by the participants in the focus group, with respect to the current findings, it was indicated that no psychiatric and mental health nurse specialists were available at the clinic. Accordingly, these findings in are consistent with those of Qureshi *et al.* (2013), who explained how Saudi mental health teams are progressively developing the number of team members, but that the shortage of subspecialists in Saudi Arabia negatively affect the provision of mental health care services to people with mental health problems. Additionally, the focus group participants in my study highlighted the importance of accounting for the deficiencies in mental health teams in Saudi Arabia. To ensure optimum performance, productivity and working environment, health care providers should communicate with one another within an integrated community (Ferreira, Giacomelli, Giacomelli, & Spinelli, 2004) using training and education to provide the basis of the required knowledge (Lincoln, Lynham, & Guba, 2011). Moreover, Corrigan and Watson (2002) proposed three methods for lowering the levels of stigma: protest, educate and contact. Meanwhile, the focus group participants noted that Saudi Arabian mental healthcare services are insufficient to meet the requirements, and the alleged limitations and pitfalls inherent in the existing service, thereby assisting the system by employing innovative schedules or progressing sub-disciplines in the field.

The findings of this study describe how stigma prevents many of those suffering from living normal lives and deters them from seeking help when they need it most. These findings are consistent with the study by Corrigan and Miller (2004) at the *University of Chicago,* in that they have been shown to reduce the chance of recovery; this scenario may lead to the onset of depression or exacerbation of an existing condition. Furthermore, stigma can lead to social isolation, and a decrease in the quality of life by restricting access to work opportunities, housing and other basic needs (Chou *et al.,* 1996). Yet, as psychological disciplines progress and develop rapidly in this part of the world, it becomes harder to disregard the towering impact of culture, relationships, and faith on the awareness, identification, treatment, and care of mental health disorders in Saudi Arabia in the current day (Littlewood & Yousef, 2000; Pinto *et al.,* 2012). In addition, research by the *National Institution for Mental Health* in England (Sharan *et al.,* 2009) considered the matter of discrimination in mental health services and its elimination, with the aim of concentrating health organisations efforts towards providing services that are characterised by cultural and ethnic flexibility and non-discriminatory practice.

In this study findings, which were presented in a final report, a need was identified for a mental health workforce that can provide services to a diverse populace. A workforce that is

capable of expansion, both within the public sector and voluntary organizations, to enable the effective treatment and care of people with mental health problems (Hogg & Holland, 2010).

In the review of the findings in the present study, the highest level of significance assigned to significant themes by the focus group participants concerned migration and its effects on migrants themselves, as well as the way in which mental health services are provided for them. Given the diversity of migrants within given communities, a personalisation of services is indicated. The significant theme of "**Immigration**", as endorsed by all the participants, in respect of poor mental health care services within communities was identified.

Participants indicated that people with mental health problems seek mental health therapy outside of the country to keep their issues private. Stigma engenders discriminatory behaviour, which can manifest as a refusal to help, shunning, intimidation, or isolation in psychiatric institutions. Likewise, these present findings in my study also, are consistent with the study by Martin *et al.* (2000), which revealed that stigma prevents people from helping individuals with mental health problems. In the UK, a study conducted by Schomerus and Angermeyer (2008) suggested seeking assistance can be stymied because of stigmatisation elements that are connected to assistance-seeking (treatment-based stigma), and the expected effects of a stigma that may arise thus. The main galvanising element for those seeking mental health care is to look beyond Saudi Arabia to avoid any embarrassment from within the home culture. Additionally, the low quality and scarcity of available health care services further suggest that they have received inadequate levels of investment and education, while people with mental health problems seek help from outside Saudi Arabia, to avoid any stereotype and prejudice from Saudi Arabian culture. Indeed, this study found that people with mental health problems often assumed stereotypes and experienced discrimination through stigma. The global consensus is increasing regarding individuals with mental health problems that experience stigma (Alonso *et al*., 2009; Thornicroft *et al.,* 2009). As indicated in the literature review, an example of one such culture is the situation in Kuwait, where many individuals choose not to seek help at the Psychological Medicine Hospital (the national institution for mental health), due to the stigma attached to mental health problems (Thornicroft *et al.,* 2007). Instead, individuals with mental health problems seek help at local primary care clinics, which are more socially accepted (Almazeedi & Alsuwaidan, 2014).

As the policy in respect of mental healthcare services was identified in this study as being significant in the formation of stigma among mental health professionals, the significant theme of "**Policy**"**,** as endorsed by participants was demonstrated. Public policy-makers may also be reluctant to allocate funding to mental health due to the same stigma, meaning that the

provision of mental healthcare does not figure prominently in the process of allocation of health system budgets (Schomerus *et al.,* 2006). Indeed, the present research found that the Ministry of Health in Saudi Arabian has not done enough. These findings supported by Qureshi *et al*. (2013), a community mental health service is a complex process that faces several important barriers, while many of these barriers are at a policy level. Coker *et al.* (2002) reported that persons with mental health problems did not receive an equivalent standard of care to those with other types of conditions; observation, which appeared to be supportive of the outcomes, related to participants in this study.

The Ministry of Health must address discrimination suffered by people with mental health problems; the ministry has not enacted legislation to address professional stigmatization of such people. Similarly, awareness-raising of concerns surrounding people in Saudi Arabia with mental health problems is lacking (Alsughayir, 1996). Nevertheless, the focus group participants noted that there are many professionals whose duties involve interactions with people with mental health problems, for example, psychiatrists, mental health nurses, social workers and psychological researchers, all of whom would benefit from statutory regulation.

Furthermore, many other individuals within the wider community may work with people with mental health problems. Even though these individuals interact with patients, they are all likely to adopt different approaches towards their interactions, based on their respective training, regulations, job descriptions, legislative constraints, or personal preferences (Holmesland *et al.,* 2010). Additionally, the findings in the present research support the findings of Alshareef (2014) in Saudi Arabia, which reported on the Saudi Arabian system of mental health services, which has long suffered several deficiencies in infrastructure and logistics, in addition to a lack of epidemiological data. In the UK, however, because of diversity within communities and a perceived need to meet their diverse needs efficiently and humanely, NHS trusts have ensured that suitable guidance exists to address the cultural and religious needs of patients appropriately and with respect and sensitivity. Thus, the UK government has produced a guide for use in the NHS entitled Religion or Belief (Department of health, 1996), which, in addition to providing the guidance, offers practical examples taken from real-life scenarios and provides references to further relevant sources of information.

4- Interventions recommended minimising stigma in general and professional stigma in particular

The focus group participants noted that the theme; "Interventions recommended minimising stigma in general and professional stigma in particular", is consistent with the theme of (a) Community (b) Education (c) Media (d) Mental health care services (e) Saudi government support, as endorsed to some extent by all five participants, addressed research question 4; *Explore how Saudi Arabia's mental health care service has enhanced the level of resources and standards of care available to mental health care users, and to what extent can the provision of a mental health care service contribute to the diminishment of the stigma that surrounds people living with such a problem?.* Within this section, the findings taken from the feedback of participants regarding their thoughts on how to combat professional mental health care are stigma are presented. This subject addresses the educational, familial, media, and community-related aspects, mental health care services, and Saudi government support, as well as the health care provisions to those with mental health problems.

The focus group participants' first recommendation, as mental health professionals, concerned the importance of the community focus and increased efforts to reduce stigmatization. Hence, they identified the significant theme of "**Community**", as endorsed by participants. This was regarding community engagement and family acceptance, and of concern is the prevalence of these attitudes among professional mental health workers, which are also embedded in Saudi Arabian culture and community. The findings of this study show that one of the most important Islamic teachings, which informs much of the social and cultural makeup of Saudi Arabia, holds that mental health problems are a result of sin. This is consistent with Al-Shahri (2002), which determines that in Saudi Arabia the Islamic faith considers sickness to be both a punishment and a method of atonement for immorality. Moreover, the guilt and embarrassment of with a family member with mental health problems often cause people to ignore these issues and refuse to discuss them, especially with non-family members (Farooqi, 2006).

These findings in the present research suggested that the community and mental healthcare services need to be improved and further developed through the contribution of mental health team professionals, to improve community awareness and mental health care services. As noted in the literature review chapter, limited research to date has investigated the outlook of families that care for people with mental health problems in the KSA.

However, a descriptive, epidemiologic study by Kadri *et al*. (2004), in addition to work by Pinto *et al.* (2012), reported that there had been huge improvements in the awareness and treatment of mental health conditions in Saudi Arabia over the last two decades. This development has been primarily concentrated in the past twenty years. At present, the mental health care system is making significant progress in relation to providing for the needs of citizens (Qureshi, 2010). The present findings also demonstrate that it is important to understand the extent to which mental health professionals are predisposed by holding such views when relating to people with mental health problems. This is also consistent with the findings of Chou *et al.* (1996), as of concern is the fact that mental health professionals in Saudi Arabia are also members of the public and can, therefore, be influenced by the pervading culture and may have internalised some of these stigmatising views about individuals with mental health problems.

The findings of this study indicate that the community needs to be more engaged with and accepting of those people with mental health problems. This is also important regarding the career development of mental health professionals. This is not to say that the work is over, as a significant amount of development remains outstanding and must occur if mental healthcare is to be made available to the entire country, which is consistent with findings by Pinto *et al*. (2012). Therefore, this calls for the introduction of more advanced resources of medical training in Saudi healthcare structures and learning centres. Such resources could especially take the form of psychiatry provision and research designed to modernise and streamline the wider healthcare sector.

What is more, these study findings also indicate that families in Saudi Arabia tend to be quite large, with many individuals residing together. Consequently, this can mean that mental healthcare becomes limited; with so many people to provide for, families and the community often decide to keep health issues concealed for fear of social stigma or of being perceived as unable to care for the family unit (Leff & Warner, 2006). Looking at Arabic communities, the present findings are consistent with those of Pridmore and Pasha (2004) in Australia, who reported that people with mental conditions are frequently stigmatised, mocked, derided, and disregarded. This is because, for a very long time, mental health problems were attributed to evil forces, the ‘evil eye’, malevolent magic, violence, addiction, or suicide. As reported by Lee *et al*. (2005), mental health conditions are frequently associated with other health-related outcomes, including social rejection, bias, and prejudice. The second commendation made by the focus group participants concerns education. This point arose following the discussion of the community theme, in respect of the efficiency and potential roles of education in achieving

an amelioration of stigma. In consequence, "**Education**" has been noted in the present study as a significant theme, as endorsed by participants. Regarding the training of mental health professionals', the role of family and the public, concerning the stigmatization of people with mental health problems, the focus group participants developed a recommendation based on the findings of this study. This recommendation suggests that to reduce the stigma demonstrated by the mental health profession toward people with mental health problems, education must be an effective tool. Indeed, by educating those who work in the field and by modifying their existing attitudes (that is, to undertake social education in practice), the means of education regarded as different and more pertinent in stopping and reversing the stigma within mental health field can be observed.

In addition, per the findings, the assistance of the education service is required, along with how it could introduce such schemes across the whole of Saudi Arabia's education system, to better the nation's health care and decrease the stigma held by mental health professionals for people with mental health problems in Saudi Arabia. The findings of the study also, are supported by the research of Angermeyer and Matschinger (2003), as well as Gostin and Gable (2004), in that awareness of the problems surrounding stigma associated with mental health problems is crucial in the prevention, early diagnosis and effective treatment of mental health conditions. Moreover, the outcomes of this study suggest utilizing educational strategies and furthering the understanding of mental health issues. Consequently, this may reduce stigma among mental health professionals, while stigmatization attitudes may be modified using education. Besides, by teaching those who work in the field, it may be possible to alter extent beliefs, which is consistent with findings by Corrigan *et al* (2006) and Cahal (2007). As stated in the literature review, a requirement remains for sophisticated medical training resources in Saudi healthcare structures and centres of learning, especially in the form of psychiatry provisions (Pinto *et al*., 2012). For example, in the case of a person who has made a connection with those that have such a condition, stigmatisation attitudes can be lessened (Corrigan *et al*., 2006).

The focus group participants also noted that how education may be implemented is pertinent in preventing and reversing existing stigma among mental health professionals. These included: awareness schemes (dialogue sessions at treatment centres); media campaigns throughout the community; and the portrayal in the media, both online and in the press, which is consistent with findings by Kirmayer, Simpson, and Cargo (2003). Indeed, the findings of this study support the results by Al-Shahri (2002), as a range of additional factors (health, education, culture, media, the spread of wealth, etc.) has also greatly influenced the distinct

characteristics of Saudi Arabia. This recommendation was also made by Al-Yousuf *et al*. (2002), which investigated the Saudi healthcare sector, and focused on the importance of examining all areas of the sector, with the goal of improving the provision of medical resources and health-based education.

One of the most important recommendations to emerge from the focus group participants concerns the role of the media in reducing stigma towards people with mental health problems. Hence, the significant theme of "**Media**", as endorsed by participants, emerged. It is, therefore, recommended that more support should be provided through the media. Accordingly, as discussed in the literature review, several individuals reported feeling stigmatised from the moment that they were diagnosed with mental health problems, and they subsequently attributed this to the media's portrayal of their condition (Dinos *et al.,* 2004). Thus, the findings of the present study indicate that members of the family or community need to be accepting of those that have mental health problems, as this would help to reduce stigma through developing and progressing media-based means to improve mental healthcare services within Saudi Arabia. These findings are corroborated by the findings of Coverdale *et al.* (2002), as the conclusive opinion of several research studies is that the public sphere needs to extrapolate most their data from media sources about mental health. The present findings are in accordance with the all-encompassing health advocacy media program, which has introduced a range of elements. These include educational programs geared towards changing perceptions of people with mental health problems, as well as addressing those factors that complicate the process. These findings are corroborated by the findings of Salter and Byrne (2000) have suggested that benefit could emerge from cooperation between psychiatry and the television industry, using television's power to engage and react using popular culture with a view to the establishment of people with mental health problems in a positive light.

An important recommendation to emerge from the focus group participants concerned the improvement of healthcare and psychological service provision. Hence, the significant theme of "**Mental health care services**", as endorsed by participants, emerged. There is also a need for connection and co-operation between mental healthcare provision and the community in Saudi Arabia. In fact, it was revealed in the literature review (Zaini *et al*. 2011; Qureshi *et al.,* 2013) that existing research indicates that the health care system in Saudi Arabia needs further research, particularly if individuals with mental health problems are to be diagnosed and treated as efficiently as possible. As the findings of the present study indicate, it is essential that healthcare professionals understand the complex demographic, cultural, social and behavioral variables, which can raise or lower the incidence of mental health problems.

This study's findings are consistent with the work of Tamim *et al*. (2010), these professionals must also be willing to make compromises, whilst continuously seeking to prescribe treatments, which complement the unique religious and lifestyle-based needs of Saudi citizens.

The focus group participants indicated that mental healthcare in Saudi Arabia needs to develop and to provide support with positive strategies and representations to reduce negative attitudes towards people with mental health problems, particularly those attitudes demonstrated by mental health professionals. As a matter of fact, the reduction of discrimination is vital to providing care to people who need mental health and integrated services (Alsughayir, 1996). A significant amount of development, therefore, needs to take place if medical care is to be made available to the entire country. These study findings are consistent with the work of Pinto *et al*. (2012), in that a need remains for sophisticated medical training resources in Saudi healthcare structures and centres of learning, especially in the form of psychiatry provisions and research designed to modernise and streamline the wider healthcare sector. By way of contrast, mental healthcare in the UK was revolutionised in 2010 by far-reaching change that set out to radically enhance care quality through, *inter alia*, the use of benign therapy while simultaneously reducing the occurrence of solitary confinement and deprivation of liberty in respect of people with mental health problems (Hogg & Holland, 2010).

The findings of the present study also indicate that within Saudi Arabia, there are some remarkable opportunities for the methodical investigation of the diagnosis, assessment, treatment and care of mental health issues. Yet, as psychological disciplines rapidly progress and develop in this part of the world, it becomes harder to disregard the towering impact of culture, relationships, and faith on the awareness, identification, treatment, and care of mental health problems in Saudi Arabia of the present day (Littlewood & Yousef, 2000; Pinto *et al.*, 2012). As detailed in the literature review, this scheme aims to systematically define, describe, and recommend solutions for the diverse mental health requirements of the Saudi population (Qureshi *et al*., 2013). Nonetheless, many individuals resisted the option of receiving mental healthcare in specialised centres, as detailed in the literature review, which is why the WHO recommended in 2000 that these centres be promoted as the first port of call for individuals with mental health problems (Pinto *et al.,* 2012).

Hence, the purpose of this initiative was to improve the diagnostic and treatment options available to those with mental health problems. However, in regards to instances where mental health professionals were insufficiently trained to manage specific cases, the recommendation was to refer these cases to more experienced psychiatrists in general hospitals for secondary

care. A recommendation was also made by Farooqi (2006), which suggests that, if these psychiatrists were not capable of treating these individuals, further referral to specialized psychiatric centers or teaching hospitals should be mandated.

There was an additional recommendation emerging from the focus group participants with respect to the findings of this study, which concerned the need for support by the Saudi Arabian government, with contribution required from the Ministry of Health. Hence, they identified the significant theme of "**Saudi government Support**", as endorsed by participants. Therefore, government support is recommended to improve the mental healthcare services in Saudi Arabia.

The focus group participants, however, noted that Saudi Arabian mental health care services have been improving over the last five years. The reason for this improvement is that mental healthcare services in Saudi Arabia have become aware of limitations on the part of the government, who are striving to support mental healthcare services and accept people with mental health problems with mentally healthy people, by indicating full support for mental healthcare services in the future. The findings of the present study are consistent with those of Pinto *et al.* (2012), which indicated substantial improvements in mental health care services in Saudi Arabia over the past two decades. Indeed, these study findings indicate that the mental healthcare system is making significant progress when it comes to providing for the needs of citizens. Furthermore, the General Administration of Mental Health and Social Services department of the Ministry of Health has attempted to enhance the provision of mental health care services to the citizens of Saudi Arabia over the past six years (Qureshi *et al*., 2013). Consequently, as part of this objective, many significant healthcare achievements have been fulfilled, including the delivery of inpatient mental health care, which has been reinforced and assisted by an improved and government-endorsed Mental Health Act. Unfortunately, mental healthcare provisions at a local level are not yet as advanced, and require additional work before they can meet the quality of resources available in other developed economies (Mobaraki & Soderfeldt, 2010).

A recommendation, which was also made by Pinto *et al*. (2012), relates to a vast and expertly trained mental health workforce that remains necessary across all sectors of the healthcare system, to fulfil the demands of an increasingly complex Saudi population. The findings of that study also indicated that further development of Saudi Arabian mental healthcare is necessary; a view that was supported by the focus group participants in this study. Besides, there is evidence that attempts are being made in this regard (Alsughayir, 1996; Qureshi *et al*., 2013).

In addition, higher education continuously strives to disseminate knowledge with the aim of reducing the stigma of mental health problems among individuals within the community and to support the mental health services that provide professional mental health care teams. As stipulated in the literature review chapter, many undergraduate and post-graduate training courses in psychology and counselling are now offered by learning institutions across Saudi Arabia. These courses are available at the following locations: The University of Tabuk, King Khaled University in Abha, King Saud University in Riyadh, the University of Dammam in the Eastern province, the and Princess Noura Bent Abdurrahman University in Riyadh. Additionally, a total of thirteen (out of 21) Saudi Arabian medical schools now provide post-graduate training for combined health disciplines, such as nursing, psychology, social work, and counselling. These improvements in mental healthcare within Saudi Arabia may lead to an improvement in the perception and concept of mental health problems, and may, therefore, help to prevent stigma. Stigma among mental healthcare professionals towards people with mental health problems, by improving education, mental health services, and care provided to people with mental health problems.

A summary of findings

The outcomes of the research have been discussed throughout this chapter in relation to the initial aims of the study and associated literature. To portray the features associated with stigma towards individuals living with mental health problems, a conceptual framework was developed. It is also necessary to acknowledge that research into these phenomena and the findings of this study may differ somewhat from the outcomes of other previous studies. This arises as most responsibility lies with public perceptions, as studies attempt to compare public opinion with that of mental health professionals.

The research highlights the elements of stigma that are rooted in the mental healthcare professions. Future work needs to focus on how the existence and extent of these views might impact on the services provided by these people and the associated recovery of people with mental health problems.

Model of Findings

Goffman (1963), Corrigan (2004; 2007) and Ahmedani (2011), explaining the constructs that underlie the concept of stigma include: a) social stigma, and b) self-stigma (Table 1.1). It is paramount to note that the findings in this study indicated how the professional

stigma could be integrated within self and social stigma as demonstrated and discussed in the study findings, to deepen our understanding of stigma in general and among mental health professionals. In this study, professional stigma refers to how the mental health care professionals view individuals with such mental health disorders and illnesses. Even though these professional individuals form a part of the public, and could, therefore, contribute to social stigma, their role as healthcare professionals makes them distinct, due to their more comprehensive understanding of and involvement with those who have mental health issues. Additionally, Stuart (2005) detailed how stigma demonstrated towards people living with mental health problems by professionals not only directly affects them through their interactions with others, but also influences their lives indirectly, in terms of stereotype, prejudice, and discrimination (Table 5.1, Figure 5.1).

Table 5.1. *Components of professional stigma.*

Professional stigma
Stereotype: Negative belief about a group of people with mental health problems, such as incompetence, character weakness, dangerousness, and struggle.
Prejudice: Agreement with a negative emotional reaction such as anger or feeling that the treatment of the mental health problem was no need.
Discrimination: Behaviour response to prejudice, such as: not seeking appropriate therapies.

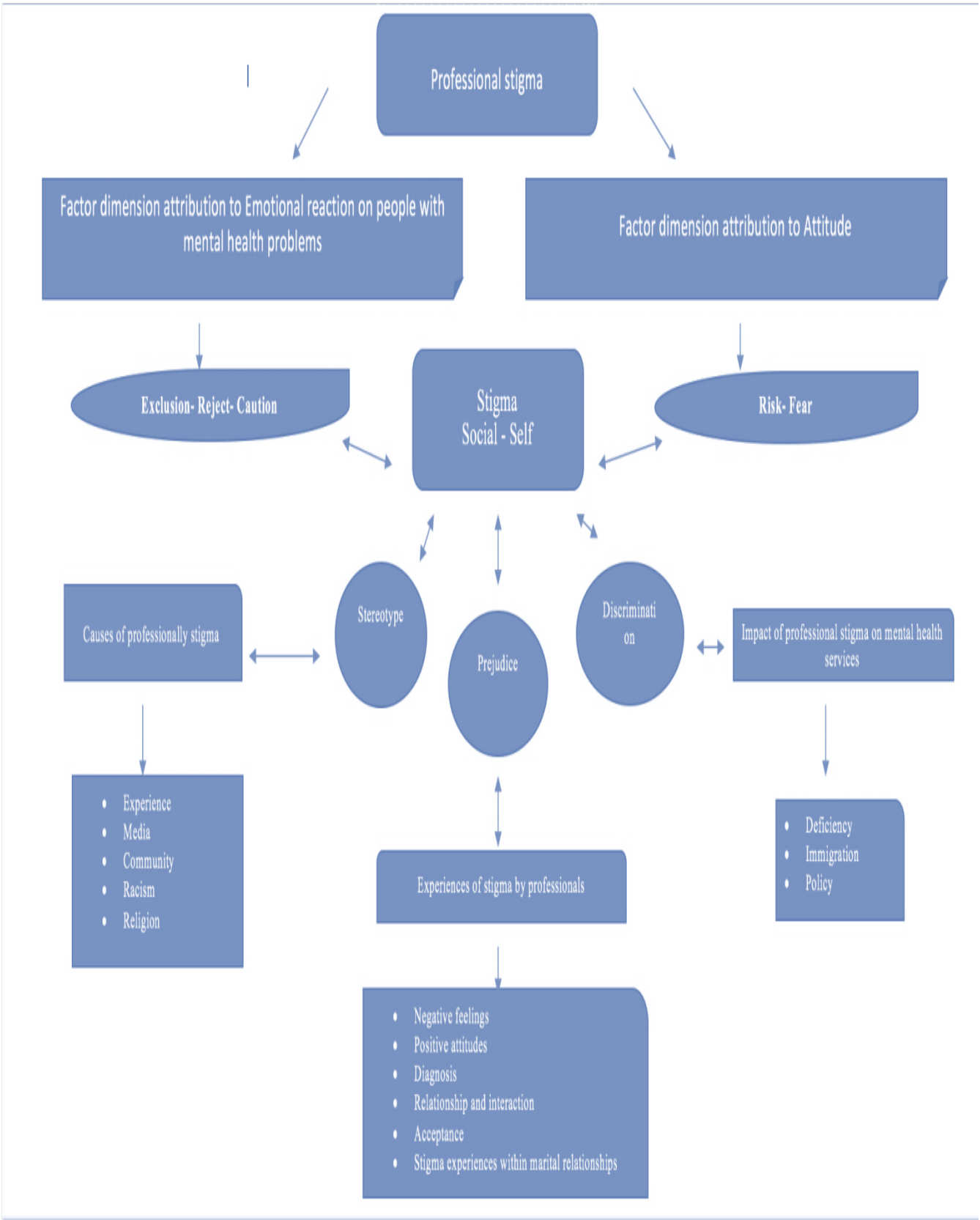

Figure 5.1 A summary model of professional-stigma finding.

Conclusion

This chapter reflected the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems, while the results of this study were discussed. Moreover, the existence of how these views might impact upon the services provided by mental health professionals was also detailed. Unfortunately, it has been shown that insufficient knowledge and undesirable perceptions of people with mental health problems remain apparent, both in Saudi Arabian society and in the mental health profession. In addition, stigma was determined to can form an endless loop, in which professional attitudes remained unchecked, thus raising the possibility of individuals with mental health problems being detained against their will and taking longer times to recover.

It was also found that interactions with people with mental health problems contributed to an increase in incidences of stigma by professional mental healthcare staff. Moreover, there exists a requirement for further education of mental healthcare professionals and the local community, with the purpose of increasing the information available and perceptions of the public towards mental health problems. What is more, a gap was observed in the degree of optimism displayed by the professional mental health team and their opinion of stigma within the team. Subsequently, the next step is to take appropriate measures to deal with these phenomena and resolve them, regarding the context of Saudi Arabia focused upon.

CHAPTER 6: CONCLUSION

Overview

In this chapter an overview of the relevance of these observations will be presented, alongside specific reflection on what I have learned during this Ph.D. journey, as well as the strengths and limitations of the research. Subsequently, recommendations will be made with a view to improving mental health care services by reducing professional stigma against people with mental health problems in Saudi Arabia. The implications of the study will be considered regarding mental health education and clinical practice, community, and organization of mental health care services, and future research. Finally, a thesis dissemination plan will be devised.

A reflective account of learning through this study

The effects of the involvement in this study, in addition to the learning experienced, were important considerations in the research. In a process that commenced in the early stages of the research, during which the proposal was prepared and ethical approval sought, the planning and accumulation of participant data were also accomplished. Due to Devers and Frankel (2000), the researcher must be self-cognizant when conducting a study. This is particularly applicable where the researcher represents the primary research device, as in this study, with respect to this involvement in the self-report questionnaires -survey and focus group discussion. At the starting point, there was limited knowledge or background on stigma, despite some professional exposure to individuals affected by it. This strength was this extensive prior experience of challenging positions in the educational, clinical and administrative sectors of mental health in-patient and community services. This enabled the possibility to highlight the limitations of the current thinking on stigma, and allowed the conclusion that the contribution of service users to the existing policies and directives was negligible. Therefore, it was deemed that by integrating the researcher's background in clinical and educational management with this study, it would be possible to create a positive effect with respect to stigma.

Given that research is frequently performed to validate pre-existing theories, the issue of subjectivity was also given a degree of consideration, as I was mindful of its connection to the existence of prior information and predisposed assumptions of the study outcomes. The emotional reaction scale, attitude scale and additional research strategies were therefore carefully developed to avoid this, and subjected to peer review to identify any inclination towards subjectivity in the study.

Furthermore, I deliberately refrained from placing excess emphasis on my background and prior knowledge of the viewpoint of mental health professionals. Consultations with my supervisor regarding the avoidance of bias were undertaken, and my desire to remain impartial further benefited from my obligation to integrate the mental health professional perspective. Like many people I, as the researcher in this project was vulnerable to embodying some of the beliefs and feelings that are causative in the development of personal stigma towards people with mental health problems. It was with some reflective trepidation that I realised that I had not fully grasped what this means. This may be manifested as apprehension in psychiatric practice, particularly at the beginning of each day, although this apprehension subsides as the day goes on. My research study was, at times, overwhelming and stressful, but it was also always inspiring. The work accomplished here is, I believe, important for the future of mental health and for all those who suffer from mental health problems and experience the accompanying stigma.

I personally concur with many of the themes expressed by the participants in my study. As a researcher in this study, it is very important to remain aware of my privileged insider status. Specifically, in respect of the subject-matter of the study, this concerns the phenomena of stigma and professional stigma towards people with mental health problems, and thus, this has the potential to inform the interpretation of very sensitive data that the study has produced. Burton *et al*. (2007) considers the implications of insider status, noting that while there may be the superficial appearance of peer equality between, in this instance, researcher and participants, this is in fact not to be taken for granted as doing so results in the embedding of personal assumptions that are not justifiable. The gathering of research data for my study and its subsequent analysis required careful attention to be paid to ethical considerations, as well as the potential harm that could arise from insider-contingent bias, which could attempt to suppress the voices of the participants, or allowing the meaning to being corrupted or assigned incorrect levels of relevance. These, if not addressed, could have profound and undesirable implications for the subsequent analysis.

In my recording of findings and their analysis I sought to be the mouthpiece of the participants and, through the application of LeVasseur's (2003) modified framework for bracketing within phenomenology in the research process, I believe this has been accomplished. The issue of power relations between researcher and participant is an important ethical consideration and one that must be considered if the voices of the research participants are not to be drowned out by that of the researcher. In respect of this close attention was paid to the trustworthiness of the results. This was achieved by constant reference being made to the

original source material; that is, the recorded voices of the participants and their transcripts. By these means, the voices of the participants in my research were preserved. A subsequent review of the recordings and transcripts, and reflective practice in respect of them on my part, has revealed a possibility that my influence may have emerged in the research data. During the voice recording sessions I would only express my opinion through concurrence with those expressed by participants; however, I noticed an inclination on my part to enter conversations with participants that may have placed undue concentration on themes, although I do not believe that the actual opinions of the research participants have been misrepresented in any way.

The background and purpose for implementing the theory related to stigma and mixed methods approach owed much to the literature review, which was initially performed. Given the wide sphere encompassed by the term, the potential existed for the concept of stigma to overwhelm the primary objective of the study during the process of determining its components and how they contribute to existing findings on stigma against individuals with mental health problems by professionals. A large body of previous literature was found, although much of it was not strictly applicable to the goals of this study. However, the review process remained targeted towards evaluating the subject of stigmatisation by professionals, enabled by the specific research questions. Consequently, the literature review and the discovery of new concepts and beliefs concerning the stigmatisation of people with mental health problems, whether they emerge from culture, religion, communities, society or the mental health profession, have led to a greater and more sophisticated understanding of stigma and the issues surrounding it.

Human understanding of the world, and the way in which humans engage with and behave towards the world and each other is mediated and informed by culture (Kosslyn, Thompson, & Ganis, 2006). Additionally, the ways in which humans approach the world and each other are fundamentally subjective and, as humans, mental health and social care professionals are influenced by prejudicial ideas, attitudes and behaviours in the same ways that apply to others. These emotional reactions that people exhibit towards those with mental health problems are very common. Certainly, in this study they have been found to be characteristically phenomenological, which raises an issue that commonly arises in phenomenological qualitative research concerning the advisability of conducting the literature review before data collection. In fact, in terms of this study, it was determined that the literature review was a prerequisite for the subject-matter to be adequately delineated beyond the researcher's personal

experience, and the contribution that the research sought to make to knowledge could be adequately established.

The literature review was undertaken in support of this study also served to outline the conceptual framework that forms the research structure. This has established the need for action in relation to the phenomenon of stigma towards people with mental health problems. The literature review constituted a review that was informed by my practical experience and has also provided the rationale behind the research objectives. When conducting the search for literature on professional stigma, the PsycINFO, and other relevant databases were examined for published material that contains the terms 'mental illness', 'exclusion' and 'inclusion'. The key search terms used to describe the experience of the study's subjects included: 'mental health problem* and stigma*'; along with 'stigma*'; 'prejudice and stigma*'; 'stereotype and stigma*'; 'mental health professional* and stigma*'; 'discrimination and stigma*. Phenomenology may, however, despite the methodological issues noted above, be used as a means not only by which research may be undertaken, but also as a means by which a literature review may be performed (Trusov, Bucklin, & Pauwels, 2009).

In conducting the literature review from a phenomenological standpoint, the process incorporates assigning depth and meaning to research data, thereby producing rich and depth-laden descriptions in respect of the phenomenon that is represented in the literature. Indeed, that what was hoping to be accomplished through the literature review. Therefore, in the review, the context of professional stigma and the factors that contribute to professional stigma were described that are shown towards people with mental health problems. The literature reviewed stigma relevant to mental health professionals, and provided a rationale for a shift in perspective in the stigma that takes a more holistic view in terms of the stigma exhibited by mental health professionals.

At the outset, it proved particularly demanding to obtain ethical approval, which required all applicable documentation to be submitted upfront and could not be granted while any questions remained outstanding. The benefit of this experience, however, was that it became possible to understand how participant safety is formulated at the centre of the ethical approval process, as well as the intention to ensure that the research design has been carefully constructed by the investigator. Ultimately, additional knowledge of research methodology and the protection of study participants increased because of this process. What is more, prior to, and especially during, the completion of the research study, the subject-matter was of deep personal importance to the researcher, as it was felt that the study would be incomplete without any personal reflection in this regard.

The accomplishment of the study has been both exhilarating and mentally draining, with concomitant feelings of euphoria and emotional anguish. It goes without saying that the final year of study has been a particularly emotional one, with ramifications pertinent to my own mental health. This has, however, been effective in enhancing my perceptions of stigma.

I identified very strongly with research participants who expressed their struggles with professional stigmatisation of those with mental health problems. Participant narratives in relation to stigma, which at times discouraged my ambition to achieve systemic resolution in relation to this issue, often disheartened me. My strong sense of identification with the participants assisted me in developing empathy with their situations and understanding the changes they feel driven to accomplish. A significant number of participants were highly motivated in respect of resolving the issue of mental health stigma, which they sought to carry forward through voluntary work, engagement in their communities or by political means. While the narratives of the participants were deeply affecting, the solidarity I experienced with them in the pursuit of the resolution was yet more influential.

The most significant effect for me the resulting from working with such people was an enhanced level of passion for the people stigmatised by their mental health, and an increased desire to seek amelioration of stigma. In the same way that participants found motivation from championing those with mental health problems, the completion of my study has further encouraged mine. Working with such people has been invigorating for me in pursuing the elimination of stigma in respect of those with mental health problems, and has established in me a deep awareness of being responsible for those in the mental health community. My ambition has been, following completion of my study, to relocate to Saudi Arabia to continue the work of de-stigmatization of those with mental health problems in that country. Saudi Arabia is a country with which I feel a deep affinity, and I am keen to live there and continue with my professional stigma prevention work.

The accomplishment of my study has endowed me with enthusiasm and a profound sense of duty in this respect, as well as feelings of responsibility towards those with whom I have come into contact during its progress. I am now keen to take up every opportunity to put what I have learned to practical use and to pursue its continuation, perhaps through involvement in large-scale studies located in the community. During the initial process of data collection, it appeared that the study might be quite brief, but it soon emerged that this would not be the case. Following visits to several clinical locations affiliated to the trust, it became clear that a prolonged period (in the region of months) would be required to recruit the required 50 participants, and additional time after that to instigate and evaluate the focus group discussion.

Ultimately, the data collection phase was completed in a few months, at speed determined by the participating individuals. In parallel, it was essential to observed consistency in adherence to the study protocol to demonstrate professionalism and to reassure the participants. From the outset, it was clear that a degree of perseverance was required to repeatedly deliver background information about the study and obtain signed consent from candidate subjects.

The process of accomplishing my study has, for me, been something of an awakening to the real-world demands of academic research. It has not been an easy process; participants were difficult to locate and their recruitment took a few months – much longer than expected – and not all interactions with them were as straightforward or successful as I would have liked. Also, some of the hospitals were uncooperative with me due to the sensitive issues I proposed discussing with the participants. Added to this dilemma, at first, I thought these participants were not appropriate individuals to use in my study. I wanted to interview a wider range of staff from each of the hospitals in Riyadh to develop a complex understanding of stigma towards people with mental health problems, but in the end, I was satisfied with the participants, because through them I obtained valuable information and insights throughout the course of my data collection journey. From the outset, it is important to acknowledge and reflect upon my own feelings, attitudes and understanding of mental health problems. It is important to note that mental health professionals cannot use professionalism to defend morality or to rise above political concerns (Kosslyn *et al.,* 2006).

My inherent professional suppositions were especially tested by several of the recorded instances of stigma by mental health care workers, actual cases that I found compelling despite my previously-held and somewhat speculative understanding of the issue. That professional of mental health care workers display stigma through the delivery of care became apparent to me. Especially insightful were the outcomes of interviews with the mental health professionals who were willing to participate, as they voluntarily shared their experiences and opinions on stigma during the focus group session. Although some may have had earlier reservations about their participation in the study, they could subsequently relate to its overall objectives. The refusal of service users to engage in discussions with participants from other hospitals was somewhat unexpected, and possibly a further manifestation of stigmatization itself. The University Hospital, for instance, did not authorize the involvement of participants from other institutions (such as Mental health hospital and Public Hospital) in the focus group discussion. The non-co-operation of some hospitals in relation to my study was somewhat disappointing, although through sheer determination I could achieve the participant count necessary for a study of this kind.

I ultimately gathered together a participant cohort that encompassed three hospitals and the nursing college preliminary data and outcomes were communicated to a range of health care professionals through all stages of the research process, as described in Appendix XII. **"**Invitation later to Director of Education and Training department" from the initial planning phase to the collection and analysis of data. The purpose of this was an ethical obligation to communicate information to (and receive feedback from) service provider who has given their time to participate in the study.

This process proved fruitful, as the feedback received forced a re-evaluation of my presumptions and expectations for the study. The process of communicating the study outcomes gave rise to the recognition that existing educational and clinical procedures could not be altered simply through re-education. However, as a forum to deliver and discuss the findings with the healthcare staff, this communication process was deemed to be of value. The prospect of undertaking the survey data analysis did not initially present a challenge, given my background and previous experience in conducting quantitative research. While preparing the research protocol, however, it became apparent that additional training in qualitative research and its evaluation was required. In this undertook a substantial study of issues related to phenomenology.

The phenomenological approach was useful in the exploration of how participants conceptualise themselves and their place in society. Phenomenology concerns meanings, experiences and conditions, and how these impact upon participants. To achieve deep understanding, it is important that the various aspects of the participants' lives are fully and critically examined. My study involved the examination of stigma as its relates to the individual, together with the relevance of culture, religion, community and any number of self-identified related factors. Phenomenology is also characterised by dynamism rather than stasis, involving the researcher as co-participant. Given its discursive and reflective elements, it is not surprising that, as Taylor *et al.* (2010) note, phenomenology engages closely with the cognitive psychology and social cognition methods employed in social and clinical psychology. Furthermore, my research skills, both abstract and applied, and my progression, both personal and professional, have benefited from the exposure I had to the process of amalgamating methodology with outcomes in my study. More significantly, however, was my increased awareness that the model of phenomenology is as effective as interpretivism, and that the mixed methodology approach, which was adopted in my research, I can generate credible data with a similar outcome.

Regarding my experiences in the PhD journey, I have found that a phenomenology is an important approach to applying using mixed research methodologies in order that research phenomenology may achieve deep and complex understanding. From a more individual perspective, through my involvement in my study, I have come to understand that research theory is at least equivalent to its application.

Notably, through the process of learning and doctoral research, I have attended many courses, classes, programs and workshops in Manchester, at the University of Salford, Manchester University, and Royal College of Psychiatrists in London to develop my skills and knowledge in terms of research, ethics, research proposals, literature reviews, methodologies, research analysis and the location of relevant publications. I also attended courses at the University of Salford to develop the personality and motivation necessary for successful study and research in the UK. I have also participated in many conferences and research symposia in Britain and elsewhere, including Saudi Arabia, to present scientific research papers concerning the issue of stigma in the context of mental health. Can be found in the (Appendix XL: Research Training). These experiences have enabled me to develop a personality, rigour and confidence, as well as assisting in my development as an open-minded researcher who feels comfortable in a wide range of locations and cultures and can work successfully in different research and teaching scenarios.

Study strengths and limitations

In the following part, an analytical assessment of the study is undertaken, alongside a discussion of the strengths and limitations of the study. With respect to its outcomes and their relevance to mental health research, the mixed methods technique that was applied in the research confers both strengths and limitations.

Strengths

The strategy of addressing the professional stigma towards people with mental health problems stems from a broader viewpoint than in terms of a given diagnosis or disorder, whatever that may be (psychotic or neurotic), which is one feature of the originality that this study delivers. More critically, my research identifies the urgent need for improvement in mental healthcare services, especially with respect to an evidence-based approach to strategy and processes, and their appropriate application and assessment in Saudi Arabia.

The study's participants were recruited from various backgrounds, including subspecialists of different mental health professions, such as psychiatrists, psychologists, mental health nurses, social workers, and faculty of mental health nurses. Accordingly, to develop strategies to specifically benefit to the overall mental health care service in Saudi Arabia and address issues related to professional stigma, as well as to shed further light on this topic, it would be advantageous to secure feedback from subspecialists working in different mental health professions throughout the country.

In addition, the main strength point from this study is the using a combination of methods also strengthens confidence in the validity of the results. Due to Bryman (2006), a mixed-method approach involves the combination of quantitative and qualitative data being collected and analysed accordingly. In this study a mixed-methodology design was used to collect data regarding mental health professional viewpoints, and these were evaluated using thematic analysis of professional stigma. Due to Tracy (2010) and Creswell (2013), a mixed-method design ensures that both the qualitative and quantitative methodological approaches assist one another, thereby creating a more comprehensive analysis regarding the research subject to answer the research questions and achieve the research objectives. A further strength of the research is the novel findings are introduced with respect to the opinions of professional mental health team stigma against people with mental health problems, their coping mechanisms, and their requirements. In addition, another strong point of this study pertains to the literature review, as qualitative studies were considered important as they provide the opportunity to describe the actual experiences of participants. In this study, therefore, the first-hand experiences of caregiving to people with mental health problems were described and analysed by implementing the thematic analysis interpretation for qualitative data. The analysis was supported by using the NVivo 10.1 software (Hoover & Koerber, 2011) and, as mentioned in the previous literature review, in terms of adopting the perspective of Heidegger (1889–1976) as the research philosophy, the concept of phenomenology - emphasis away from consciousness – maintains that the relationship between people and their environment is essentially active as 'being-in-the-world'.

This study has focused on the qualitative approach – interpretive perspective. This concerns explanations of why things happen in "a specific way", with lived phenomena focused on people's "lived experiences" and "perceptions of the world". Through this, a focus group discussion interview technique was used, which facilitated considering human preferences and tendencies. Consequently, using the interpretive perspective, it was possible to identify how the causal explanations of social reality are served by motivation, dialogue and human

perception, and the term has grown beyond the boundaries of its original meaning to now include “understanding human action in context”. Moreover, in terms of the interpretive paradigm regarding “being in the world”, reference may be made to Heideggerian hermeneutic phenomenology (Willis *et al.,* 2007, p. 104).

What are of relevance are the subjective experiences of individuals and groups. Hence, it is possible to expose the universe as experienced by individuals as it is filtered through their own narrative accounts. The analysis of these discussions identified the experience of professional stigma in multiple instances, many which have not been addressed in the literature to date, including the effect of stigma on personal and professional interactions and on the provision of mental healthcare services. This research topic has not been addressed to date in the literature in a Saudi Arabian (or, indeed, an Arabic) context. A range of emotions attributable to instances of professional stigma and the bias inherent in support of self and social stigmatising principles were identified in the present study. Ultimately, study participants revealed the magnitude of how their exposure to stigma had affected their professional development.

A further point of strength point that derives from this study is the use of phenomenological methodology, in a quantitative approach, to carry out a cross-sectional survey using self-reported questionnaires. Similarly, the cross-sectional nature of the study design was a further advantage; out of the professional mental health team groups, approximately equal numbers of subjects were selected for participation. Meanwhile, the reliability statistics of the instruments as measured by Cronbach's Alpha were significant.

The implementation of a verified and appropriate strategy, as described by Song, Chang, Shih, Lin and Yang (2005), is another of the advantages of the research strategy, which permits it to be evaluated in relation to other research, which adopted the emotional reaction and attitude scales. In addition, the self-reported questionnaires, which are forms of measurement that are shown to have good psychometric properties in a pilot study, were prepared, while existing research has used these to assess emotional reactions and attitude questionnaires to the measurement of the stigma of the mental health team. The emotional reactions and attitudes were subsequently evaluated using the measurements of stigma; “Test–confirmatory factor analysis has demonstrated the reliability and validity of this model”. Confirmatory factor analysis, as described by Corrigan (2000, p. 56), has been used to determine the accuracy and effectiveness of this approach, through exploring the correlation between the emotional reactions and attitudes, related outcomes, and subsequent conclusions about people with mental health problems.

An additional topic that has been highlighted in this study, which warrants greater attention in the context of Saudi Arabia, is grounded in the observation that the provision of care is mainly influenced by cultural, rather than the professional background. Hence, the effects of culture are more significant and can instigate professional stigma towards individuals with mental health problems.

With respect to the previous literature review, the questionnaire was structured for ease of comprehension and rapid completion, which was based on the work by Mitchell and Hastings (1998). It focused on how emotional reactions and attitudes towards individuals with mental health problems may be shaped by the influence, impact, opinion and experience of prejudice by the attitude displayed by mental health professionals who completed the attitude and emotional reaction questionnaires. Furthermore, another strength of this research is the quantitative approach, which permitted an evaluation of the extent to which specific factors account for any dissimilarity. The aim of this evaluation approach was to identify the linear combination of variables, which contributed to the highest the level of common variance of the level of professional stigma. This took the form of a factor in the principle component analysis, which indicated connections between individual relationships. Indeed, positive outcomes in the research relate to the correlations observed between the factors and their associated variables. After the presentation of these factors, a series of questions were introduced to assess the recognition of the problem, stigmatising attitudes and emotional reactions towards people with mental health problems, to determine whether the respondents held professional stigma toward those individuals. Subsequently, future work can implement the determined existing factors as a tool to assess and evaluate stigma using the emotional reaction and attitudes scales. Nevertheless, potential limitations must be analysed simultaneously.

Limitations

A few limitations to the research must be acknowledged. One such limitation is that the outcomes of the survey information obtained from the mental health professional group cannot be generalised beyond the professional mental health team of the hospitals and universities in Riyadh. Indeed, this study has limitations, with respect to the quantitative and qualitative study. This is because it is not possible to correlate or generalize these findings to previous research. Considering the small sample size of participants in the qualitative phase (five participants in the focus group discussion, and 50 in the quantitative phase), and given that the data comes from a convenience sample, these study findings are limited to generalization, with respect to

other mental health teams in Saudi Arabia, as well as in other countries. In addition, as this involved quantitative descriptive research, only the parameters under evaluation can be depicted in the data obtained. Under the qualitative process, participants were purposefully selected by the head of the mental health department at each hospital, meaning that the views expressed by the five participants interviewed in the research study may not reflect the perceptions of all mental health teams caring for people with mental health problems in Saudi Arabia. Furthermore, this work cannot be generalised to the entire city of Riyadh or the population of Saudi Arabia, as the study was exploratory by design, and was never intended to be generalizable. It could be argued that, given the sensitivity of the study topic, and the limited size of the population who was surveyed, that the pattern of stigmatisation experiences identified might not represent the complete picture of professional stigma, as to obtain the sample of professional mental health team workers from the University hospital, permission was obtained from the chairs of the research centre with full support for both quantitative and qualitative questions. In addition, per the representative of the workforce of mental health professional in Saudi Arabia, the study conducted by Qureshi *et al.* (2013, p. 35) "there is a mental health care workforce gap around the world, although it is more obvious in low- and middle-income countries (LAMICs), and Saudi Arabia is no exception". Moreover, due to Ahmedani (2011), there the lowest rate of psychiatrist's field in the Arab world and there is an absence of professionals who specialize in mental health. Saudi Arabia, Sudan and Libya were especially low in terms of the presence of psychiatrists, whereas other nations had a higher number. And that the reason of that the workforce of mental health professional workers in each hospital in Riyadh city conducted with, was not clear.

Moreover, in the focus group discussion in University Hospital in relation to the qualitative study, the inclusion of only one participant from each speciality was permitted. Any further addition, however, of participants from outside the University Hospital was not accepted, except for one participant from Nursing College. Furthermore, to preserve the confidentiality of information, each participant was requested to not discuss the study in the workplace in front of participants from outside the hospital, except the university members. The permission to collect both quantitative and qualitative information from the sample of professional mental health team workers at Mental Health Hospital of Psychiatric and Mental Health in Riyadh was obtained from the chairs of the research centre. However, the participants were not well to share to undertake the focus group discussion in the qualitative phase. And just stated collected the quantitative questioners from the participants. Furthermore, permission to collect both

quantitative and qualitative information from the sample of the professional mental health team at the Public Hospital was also obtained from the chairs of the research centre.

However, the sample suffered from a lack of specialisation in psychiatric and mental health nursing and social workers within the psychiatric department. In addition, regarding the quantitative data analysis results, the demographic questionnaire to the completion of the questionnaires, the sample population gave details regarding their demographics and filled in their questionnaires. This questionnaire gave the researcher the data required to complete the study, including the data regarding the sample population's details (including elements such as their nation of birth; gender; grouping of specialists; qualifications and experience in field) and aspects regarding their profession (level of degree; connection to their working environment), while the hierarchy or ethnicity was not included in the demographic questionnaires, regarding Saudi culture does not contain multiple ethnicities (Talic & Alshakhs, 2008).

From the information that was observed in the data analysis, some results corresponded to the responses of the mental health nurse and were related to the role of the mental health nurse working in the field of mental health in the hospitals, without specialist certification or any requirement to become a mental health nurse in Saudi Arabia. Even though Saudi Arabian universities do not offer the opportunity for nurses to graduate in the field of mental health without completing a master's degree or post-graduate 'diploma' in mental health, all nurses who participated in this research study, however, had obtained a bachelor and diploma degree as a general nurse. Furthermore, as a form of phenomenological research, the effect or existence on the outcomes of the study resulted in subliminal ideology or justification on the part of the participant, although the investigator was not considered. For a possibility existed that the participants' reservations about professional stigma towards people with mental health problems would hinder them from openly discussing their experiences. It may also have been the case that participants subconsciously rejected specific elements of their experiences of professional stigma, and thus, neglected to describe specific scenarios, emotions or ideas related to stigma. This was represented by the case of a participant who verified that he/she did stigmatise people with mental health problems based on the nature of their illness or diagnosis.

Nevertheless, the participant also rejected the assertion that he/she did show a real stigma towards people with mental health problems. In this example, the participant's professional team produced the answer during the focus group discussion, although he/she also displayed emotions and attitude, perhaps unbeknownst to him/herself, which was indicative of a stigma that may have arisen through such influences as a society and religious beliefs. Indeed, given that the researcher undertakes some clinical duties at the same location ascertain participants,

the potential for social desirability bias was present in the data from both mixed methods approaches. This may have caused respondents to provide answers that they deemed acceptable to the researcher.

Implications and recommendations

The study's outcomes were mainly applicable to the professional mental health team; education and clinical practice, community, and provision of mental health care services, additionally the potential future research of relevance to the health care providers and society. This study has highlighted the impact of care provision in mental health care, given that the extent of professional stigma observed was comparable to that reported in other countries, per the existing literature.

Education and clinical practice

To facilitate the addition of mental health modules to the curriculum, the study's outcomes should be shared with those responsible for delivering mental health education. The majority have proposed an increased understanding and modified perceptions by strengthening educational and mental health care guidelines with the aim of instigating behavioural changes (Pinfold, Byrne, & Toulmin, 2005). Some indications exist to demonstrate that individuals who receive education about mental health problems are less likely to show stigma and have a greater tendency to empathise with individuals with mental health problems. Additionally, people with mental health problems should be encouraged to participate in the development, review and assessment of mental health services, meaning that they are effective participants rather than acquiescent service users; so, healthcare professionals should incorporate employment, learning and up-skilling considerations into treatment plans to reduce stigma and prejudice, and to facilitate the social inclusion of individuals with mental health problems.

In addition, to educate the public in terms of mental health problems, there exists a requirement to compel mental health professionals to improve their perceptions of people with mental health problems; both globally and in the community. Subsequently, individuals can then receive appropriate care and experience fewer instances of stigma and lack of family, cultural and community support. More generally all health care staff should address the timely identification and treatment to reduce the outcomes of mental health problems. This can be achieved through an adequate outreach program and sufficient primary care. As conflicting opinions on people with mental health problems can be observed amongst the professionals,

initiatives to combat stigma and negative perceptions about people with mental health problems should become routine hospital practice. Accordingly, the mental healthcare professionals in both the primary care and clinical environments should directly educate the Saudi community. This strategy would benefit society and improve mental health education, and thus minimise the effects of professional stigma displayed by nursing and mental health staff in the clinic and in academia. To deliver relevant information and ensure improved perceptions towards matters related to mental health, the professional mental healthcare team must be clear on the content and method of delivery of this information. As described by Corrigan (2004, p. 614), perceptions about mental health among the public are reflected in the wide range of perceptions of stigma displayed by mental health professionals and are therefore frequently noted. Additionally, the New Zealand Nursing Council has compiled guidelines applicable to nursing education and practice that address local cultural concerns. These guidelines reflect the changes that have taken place in New Zealand in respect of the indigenous Maori population (Jacobs *et al.,* 2004; Hogg & Holland, 2010). Moreover, Girish and Gill (2003) noted that nursing training was being tailored to address the cultural mores of patients, particularly of people with mental health problems.

To assist people with mental health problems to better manage their mental health and wellbeing and feel less stigmatised, culturally appropriate mental health teaching standards should be established as part of the routine treatment delivered by the professional mental health team. In 2003, the UK's Royal Colleges of Physicians and Psychiatrists recommended that commissioners facilitate improvements in the education of general hospital staff in respect of the mental health needs of mature people (Hogg & Holland, 2010). It has recently emerged, however, that recommendations concerning the education of mental healthcare professionals in respect of mental health education have not been satisfactorily fulfilled. In 2008, for example, in Australia, the Children's and Families' National Service Framework specified that liaison arrangements must provide education and training for all healthcare staff involved with children in the mental health needs of children and their family members and carers (Moynihan *et al.,* 2013). Initially, this could be achieved through a process whereby mental health professionals work in collaboration with imams in the community, to increase their knowledge of cultural and religious principles within Saudi Arabian society and how this may manifest as various forms of stigma. Anticipated feelings about stigma may affect the level of mental health care that is delivered to individuals with mental health problems, as described in Chapter 2. By collaborating with religious leaders, mental health professionals may better incorporate local mental health services and gain an increased awareness of the specific requirements of people

from the Saudi population who suffer from these issues. This would also affect professional stigma in respect of people with mental health problems within a Saudi Arabian culture and some aspects of the Islamic religion. The mental health professional would be more aware of how the human rights of people with mental health problems should be respected within Islamic guidance and minimise the stigma towards those people, and consequently, deliver effective mental health care services.

In general, the outcomes reveal that much remains to be done to boost the level of knowledge on perceptions of professional stigma towards people with mental health problems by mental health professionals. The outcomes may contribute to the development of suitable strategies to combat stigmatisation (anti-stigma campaigns), given that they highlight the high incidence of stigmatising behaviour displayed by mental health professionals (Jacobs *et al.,* 2004; Hogg & Holland, 2010). Such strategies could be aimed at clinical practitioners and the entire Saudi society, ensuring that appropriate consideration is given to cultural and religious elements. Thus, the outcome of this approach would be increased accessibility to mental health services delivered by mental health care practitioners to Saudi Arabian society.

Community

The healthcare professionals have made some effort in relation to the cultural aspects of healthcare. These efforts have been predicated upon the differing requirements of increasingly diverse communities, resulting in flexible and culturally aware healthcare that seeks efficiently and humanely to meet a variety of cultural needs (Hogg & Holland, 2010). UK healthcare professionals are aware that the performance of their duties in both hospital and community scenarios requires them to have the cultural sensitivity and training necessary for the delivery of high-quality services within multi-ethnic and multicultural communities (Hogg & Holland, 2010). For such training and sensitivity to be fully utilised, however, it is necessary that all such professionals be given opportunities to exercise their skills; the following items should be understood and practised by the community:

The identifying symptoms of conditions or degrees of psychological disorder:

- Understanding and perception of risk factors and their origins;
- Understanding and perception of how individuals can care for their own mental health;
- Understanding and perception of the professional services on offer to the community;
- Perceptions, which permit individuals to acknowledge issues, obtain the necessary assistance, and access information on mental health.

A mixture of educational and delivery strategies usually forms the basis of recommendations for raising the standard of community mental health knowledge. These strategies may be grouped under various headings, and can be stratified with respect to extent (meaning broad preventive approaches, for instance, directed at the entire population or a subset of it), method of delivery (including the mainstream media, printed literature, lectures by professionals, religious or community leaders, and level, be it small, local or extensive (Pirkis & Francis, 2012, p. 8). To deliver these objectives, curricula should be developed and delivered through a range of approaches including increased community awareness, such as campaigns and discussion groups in mosques, schools, non-governmental organisations, and all other areas to increase local knowledge and change the perceptions of society towards those living with mental health problems. As suggested by Hogg and Holland (2010), mental health practitioners should deliver educational programs about mental health problems to the local community with the purpose of aiding the recovery of people with mental health problems and supporting their families.

Under the Ministry of Health in Saudi Arabia, the families of individuals with mental health problems should deliver public information to address stigma and raise awareness of community mental health. Thornicroft *et al*. (2008) describe how personal interaction with people with mental health problems is one of the most powerful methods for minimising stigma, as it provides a forum for individuals to describe their perspectives. This could also be implemented in Saudi Arabia to reduce the incidence of a stigma that originated in the community, influenced professional mental healthcare workers, and was expressed towards people with mental health problems. Besides, the more contemporary literature describes studies that test theory-based paradigms in relation to the stigmatisation of people with mental health problems, with time–trends analysis and cross-cultural comparisons, and the appraisal of anti-stigma campaigns, such as that carried out in Switzerland (Lauber *et al.* 2006). Likewise, the support of care providers within the mental health team in delivering the necessary level of care to people with mental health problems, managing individuals with mental health problems and their families, and avoiding instances of professional and social stigma among families, society, and mental health care services, was considered of paramount importance. The research recommendations can, therefore, be classified as relevant to mental health professionals, mental health care provision, society and investigators. In addition, the media can serve an educational purpose through widespread public exposure, the importance of providing them with sufficient knowledge to ensure their unbiased coverage of these issues remains clear.

With respect to insufficient self-knowledge about stigma amongst health professionals, the appropriate health authorities within communities throughout Saudi Arabia should launch awareness initiatives.

Organization of Mental health care services

Based on outcomes achieved from research into existing mental health policies and services, and the appraisal of previous reforms, the World Health Organization (2003) has provided significant recommendations and practical guidance concerning the organisation of mental health services and the improvement of mental health via its Mental Health Policy and Service Guidance Package. With respect to the limited mental healthcare provisions in place nationally in Saudi Arabia, and particularly in terms of the centres of health care provision in the community, the Ministry of health must acknowledge that the provision of care by families and by mental health care staff is not feasible in all circumstances.

The recommendations, which aim at the implementation of a holistic approach to the provision of mental health services, offer a model that seeks to resolve issues associated with the various requirements of people with mental health problems and provide definition to many basic organisational principles. Firstly, accessibility refers to the provision of basic mental health care provisions at a local level within communities, so that long-distance travel to care facilities is not necessary. Such a basic mental health provision includes inpatient, outpatient and, rehabilitative care. Secondly, Comprehensiveness refers to the fact that mental health services should comprise the range of facilities and treatments necessary to satisfy the basic mental health needs of the community concerned. It is essential that services, which provide for people with mental problems work together to ensure that such people's medical, psychological and social requirements are satisfied through coordination and continuity of care. Thirdly, effectiveness is highly important and the development of service provision should be firmly based on empirical evidence that demonstrates the success of previous examples of the proposed development.

Moreover, Respect for human rights means that mental health provision should pay attention to maintaining the personal autonomy of individuals with mental health problems; it should authorise and provide encouragement to such individuals to exercise choice concerning their treatment, and such treatment should be non-restrictive fully feasible World Health Organization (WHO, 2003). The coordination of specialist and primary care services are key factors in the successful running of mental health services, as is the coordination of medical

and non-medical departments and agencies. Specialist and primary care service coordination are necessary due to the function of primary care in the initial diagnosis and early-stage treatment of people with mental health problems. Similarly, inter-departmental and inter-agency co-ordination is necessary, as health service departments frequently should work with other agencies, such as social services, social housing departments, day-care providers and psychosocial rehabilitation programme providers.

The Ministry of Healthcare should also evaluate the current regulations and functions of mental health care services to avoid the professional stigma by establishing appropriate skill development, introduce on boarding of new staff members of mental health teams, and deliver a good quality service to people with mental health problems. This strategy would assist mental health workers to avail and develop the provision of mental health care and ensure suitable training of mental health care nursing practitioners. In addition to the development of care worker skills related to the management of mental health conditions, the provision of community health services should be re-established, thus permitting increased support to staff in the community environment. To further address the issues of social stigma and discrimination related to mental health, the relevant bodies should explore the possibility of targeted and culturally appropriate measures. The Ministry of Healthcare should evaluate the possibility of a partnership between official and unofficial healthcare providers, and incorporate appropriate legislation into the Mental Health Act, to ensure transparency in the procedures for referral of cases that lie outside of their realm of expertise.

Another recommendation of this study is the requirement for healthcare professionals to adopt a concerted and effective approach to delivering the appropriate treatment to service users, whilst also remaining diplomatic in dealing with stigmatising perceptions, which can be interpreted negatively by the affected individual. It is the proposition of this study that the mental health professionals in clinical practice evaluate and modify their inherent opinions and attitudes about mental health problems and their interactions with service users, to avoid unintended aggravation by stigma. Ultimately, when equality and social recognition for service users reaches an appropriate level of recognition and quality, social inclusion of affected individuals can improve and the effects of stigma reduced (Boraska *et al.,* 2014). Yet, despite the current support for a deinstitutionalisation approach, it remains necessary to establish long-term care residences for individuals that cannot be cared for at home. Day care facilities, where individuals can receive treatment as outpatients while remaining resident at home, should also be secured. Such an option would relieve families and mental healthcare staff of some of their tasks and permit them to participate in fundraising or a return to employment.

To avoid the situation where families must finance medication or commute a long distance to obtain it, mental health service providers should guarantee that all centres retain sufficient stocks of appropriate medications. Corrigan (2004) noted some practical instances from Europe, including sector psychiatry in France, primary care social psychiatry and mental health in the UK, as well as the reform of psychiatric practice and deinstitutionalisation in Italy. Indeed, a significant proportion of people with mental health problems faced discrimination, societal isolation (Corrigan, 2004). This is particularly the case where education, employment and general healthcare are concerned.

Inpatient care is sometimes characterised by being placed in solitary confinement and being denied opportunities to socialise with others and detention that would be unlawful under normal conditions. Treatment is also frequently compulsory; such inhumanity is frequently accompanied by denial of political and civil freedoms and the denial of means of appeal and redress. Considering these problems, institutional care provision is the focus of much criticism in Europe, despite attempts to implement deinstitutionalisation policies (Corrigan, 2004). The delineation and promotion of those care initiatives that achieve success in terms of the maximisation of autonomy, care within the community and ultimate resolution of serious mental problems together with, throughout, the upholding of human rights, are clearly desirable. Accompanying this delineation and promotion of successful care initiatives should be mechanisms to ensure that quality standards are set and maintained.

Future Research

In Saudi Arabia and other countries, it would be more effective to determine the professional stigma towards people with mental health problems by these means. Also, it would be beneficial through international studies to compare other countries and cultures. Similarly, a study to evaluate the implications of providing care to people with mental health problems in Saudi Arabia would be of further benefit. Moreover, a study into the degree of stigma held by professional healthcare workers toward people with mental health problems in a larger sample size would be beneficial. The present lack of existing literature on status and perceptions towards mental health problems, and the consideration given towards people with mental health problems has been highlighted.

Additional research is required to evaluate these variables and how they interact and modify one another. This may be achieved through research in a larger sample population, not restricted to full-time mental healthcare staff, to more thoroughly divulge the correlation

between religion, culture, media and the stigma of mental health problems. Such research could determine the instigators of a stigma of mental health problems, including character, anxiety and compassion, and produce a more thorough determination of how the various stigmas relate to people with mental health problems. Similarly, research into the mechanisms for providing service and interactions between healthcare professionals would be important to facilitate an improved structure for caregivers, such as, given the lack of adequate provision of mental health care in the community, additional research on public perceptions towards mental health problems would be beneficial. Consideration should be given to employment, education and up-skilling initiatives in care plans so that health care professionals can reduce the incidence of stigma and prejudice by supporting individuals in becoming accepted by society. Furthermore, a study to evaluate the regulations and function of the delivery of education by the government, ministry of health and mental healthcare providers in Saudi Arabia would be of value. Despite the identification of certain interesting observations in the data analysis, the primary determination of this study is that further attention and endeavour should be applied to future research to guarantee the active involvement of mental health professionals. With this in place, the study would be better equipped to determine whether these professionals undergo sufficient training and education for their role, and therefore, whether they actively contribute to the provision of a healing atmosphere for the individuals in their care. This consideration would also raise the perceptions of mental health professionals to eliminate professional stigma through a better standard of care.

A broad range of data derived from subjective experiences was identified in this research study, covering various levels and arguments, all of which would be applicable for forming the basis of a future qualitative study in the field of stigma by mental health workers with respect to mental health problems. Additionally, a further suggestion for research of relevance to mental health professionals might include the establishment of recommendations to further the knowledge and perceptions of mental health professionals and members of society towards mental health problems. Previous research has reported that multiple elements contribute to professional stigma; the outcome of the present research study has been the implementation of measures, with limited success, to develop knowledge regarding mental health amongst health care professionals and the community. Therefore, mental healthcare professionals should evaluate their personal perceptions, be cognisant of stigmatising habits and their effects on service users, and address the issue of stigma by promoting the values of user participation within an equal and fair society. Within Saudi Arabia, several topics remain to be assessed with respect to the effect of perceptions of mental health considerations and persons with mental

health problems. Of further value, would be a study of the increased incidence of stigmatisation within professional mental health teams and specific service users, and the cultural effects of stigma.

Additionally, phenomenological qualitative research themes could be based on: (a) the effects of the postgraduate curriculum, teaching staff, and fellow students on the origins and expression of stigma against mental health problems; (b) the effect of an individual's family history on the instigation and perceptions of stigma related to mental health problems; (c) the effect of covert stigma on the welfare of mental health professionals; and (d) the effect of implementing a self-disclosure approach in the interactions between the individual and the healthcare professional; (e) the effect of stigma on society, arising from culture and religion, on people with mental health problems; (f) the effect of the media in increasing knowledge within the community and minimising stigma against individuals with mental health problems; (g) assessing and exploring the stigma among mental health professional and community towards people suffering from neurotic and psychotic mental health problems; (h) To what extent does the self- reporting of stigmatizing attitudes correlate with behavior?.

Separately, quantitative themes could incorporate questionnaires or the use of a correlational approach to evaluating: (a) the frequency of stigma associated with mental health problems reported by graduate students within universities, teaching and support staff, and fellow students; (b) the possible relationship between religious environment and stigma against mental health problems; (c) the correlation between issues of stigma and esteem against oneself and the confirmation of the psychological condition. In addition, a wide range of suitable research subjects identified in the notable outcomes could be appropriate for the investigation of future, statistically significant relationships, possibly reflective of a broader representation of mental health professionals. Ford, Goodman and Meltzer (2003) describe how the New Freedom Commission Report, established by the U.S. presidency in 2002, sought to improve the treatment of mental health problems by establishing anti-stigma organisations and policies. A superior comprehension of the issue of stigmatisation phenomenon is required to implement the progression of such anti-stigma schemes and institutions. Overall, there are numerous directions in which the progress of future research will benefit, many of which have been noted in this study. Mental health professionals that can adopt this research directive can serve as a form of support and encourage agents to address the issue of stigmatization attitudes, improving treatment and treatment utilization thus.

Dissemination Plan

This research has investigated the phenomena of mental health professional stigma, demonstrated by mental health teams in the KSA, and has sought to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems. The results will be disseminated the following ways: The University of Salford, King Saud University, Saudi MOH, publication in mental health and community journals, as well as International conferences and National conferences.

- The findings will be at the University of Salford website.
- A copy of the results will be sent to the Saudi MOH and King Saud University to raise awareness regarding the mental health profession, to consider the future positions of mental health professionals involved in mental health care.
- After that, the researcher will request a meeting with the director of the General Directorate of Health Affairs in Riyadh, and other cities in S.A.
- An oral presentation with a brief description of the study and the results will be given at the King Saud University and to the General Directorate of Nursing in the Middle Region.
- An interest group will be established with a seminar to update information regarding the stigma among mental health professionals and the effectiveness on users of mental health care services by the mental health nurse department in the nursing college of Saudi Arabia.
- This research will be published across the Saudi Commission in health specialities, and from this perspective as a researcher with a doctorate, we will demand classification of the Saudi psychiatric nursing.
- Through the dissemination of research, the role of nurses working in psychiatric settings across the Kingdom will be focused on, as well as the importance of the role of psychiatric nurses for the rest of the psychological disciplines.
- Extract minor sections of the thesis, such as 'The Stigma Surrounding Mental Illness and the Role of the Media in Shaping Public Opinion'.
- Extract research from the "literature review, methodology, and analysis findings" and the dissemination of thesis articles will be included in the Saudi Journal of Medicine and Medical Sciences, Saudi journals in health science and in the research centre at King Abdul Aziz University, International Journal of Methods in Psychiatric Research, Journal of Psychiatric and Mental Health Nursing. There will be a focus on publication in Wiley ISI journals.
- Publications about reducing stigma among professionals in S.A. will be encouraged.

- Publication in professional peer-reviewed national and international journals, for example, Saudi medical journal (SAUDI MED J), The Journal of Nursing and Adolescents Health, and Journal of Professional Nursing.
- Publication about "Using mixed methods to identify phenomena in mental health fields across S.A".
- "Service User Involvement in Health Research, the Case of Saudi Arabia". These two papers can be published in the PubMed Journal, which has literature from MEDLINE, life science journals, and online books. Also, this journal is a peer-reviewed international journal.
- National conferences; at the King Saud University, and future working groups, for best regional impact.
- International conferences such as Gulf Cooperation Council conferences, annual British, American and Australian conferences of mental health nurses, and psychiatrists in Saudi Arabia.

Conclusion

This chapter, is the last section in this study, and it has highlighted the contribution of this research to existing knowledge. This study has proposed an applicable starting point for facilitating the efforts of mental health workers to improving mental health care services by reducing professional stigma against people with mental health problems in Saudi Arabia. It has also explained the strengths and limitations of this research, as it was conducted in a special context, where there is a specific culture that must be followed. In addition, the implications for mental health education and clinical practice, community, and organisation of mental health care services, and future research. There is a plan for dissemination of the results which has been explained. This research extends our knowledge of the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Saudi Arabia have been identified as indicated by the outcomes of the mixed methods approach. Therefore, it can be assumed that this research will serve as a basis for future studies about mental health professionals in S.A.

REFERENCES

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical psychology review*, *31*(6), 934-948.

Abu-Ras, W., Gheith, A., & Cournos, F. (2008). The Imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim community. *Journal of Muslim Mental Health*, *3*(2), 155-176.

Acker, G. M., & Lawrence, D. (2009). Social work and managed care measuring competence, burnout, and role stress of workers providing mental health services in a managed care era. *Journal of Social Work*, *9*(3), 269-283.

Adbowale, V., Farmer, P., Rose-Quirie, A., Jenkins, P., Greatley, A., & Bailey, S. (2014). The Pursuit of Happiness: A new ambition for our mental health.

Afifi, M. M. (2005). Mental health publications from the Arab world cited in PubMed, 1987-2002.

Almalki, M., FitzGerald, G., & Clark, M. (2011). Health care system in Saudi Arabia: an overview/Aperçu du système de santé en Arabie saoudite. *Eastern Mediterranean health journal*, *17*(10), 784.

Ahmedani, B. K. (2011). Mental health stigma: Society, individuals, and the profession. *Journal of social work values and ethics*, *8*(2), 4-1.

Ahmed, I., Mugen, P. E. N. G., & Wenbo, W. A. N. G. (2008). Exploiting geometric advantages of cooperative communications for energy efficient wireless sensor networks. *Int'l J. of Communications, Network and System Sciences*, *1*(01), 55.

Alagaili, A. N., Briese, T., Mishra, N., Kapoor, V., Sameroff, S. C., de Wit, E., ... & Epstein, J. H. (2014). Middle East respiratory syndrome coronavirus infection in dromedary camels in Saudi Arabia. *MBio*, *5*(2), e00884-14.

Al-Ahmadi, K., See, L., Heppenstall, A., & Hogg, J. (2009). Calibration of a fuzzy cellular automata model of urban dynamics in Saudi Arabia. *Ecological Complexity*, *6*(2), 80-101.

Albejaidi, F. M. (2010). Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges. *Journal of Alternative Perspectives in the Social Sciences*, *2*(2), 794-818.

Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, *12*(3), 271-289.

Ali, A. H. (2006). *The caged virgin: An emancipation proclamation for women and Islam*. Simon and Schuster.

Al-Krenawi, A., & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work*, *25*(1), 9-22.

Almazeedi, H., & Alsuwaidan, M. T. (2014). Integrating Kuwait's Mental Health System to end stigma: A call to action. *Journal of Mental Health*, *23*(1), 1-3.

Alonso, J., Buron, A., Rojas-Farreras, S., De Graaf, R., Haro, J. M., De Girolamo, G., ... & ESEMeD/MHEDEA 2000 Investigators. (2009). Perceived stigma among individuals with common mental disorders. *Journal of affective disorders*, *118*(1), 180-186.

AI-Osimy, M. H. (1994). Evaluation of primary health care in Riyadh, Saudi Arabia. *Journal of family & community medicine*, *1*(1), 45.

Aloud, N., & Rathur, A. (2009). Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. *Journal of Muslim Mental Health*, *4*(2), 79-103.

Al-Shahri, M. Z. (2002). Culturally sensitive caring for Saudi patients. *Journal of Transcultural Nursing*, *13*(2), 133-138.

Alshareef, M. (2014). *Alamal hospital does not carry the name of something!* Available: http://www.alriyadh.com/928449. Last accessed 19th april.

Alsughayir, M. A. (1996). A Study in Saudi Society. *Arab journal of psychiatry*, *7*(2), 152-160.

Al-Twaijry, A. A., Brierley, J. A., & Gwilliam, D. R. (2003). The development of internal audit in Saudi Arabia: an institutional theory perspective. *Critical Perspectives on Accounting*, *14*(5), 507-531.

Al-Yousuf, M., Akerele, T. M., & Al-Mazrou, Y. Y. (2002). Organization of the Saudi health system. *East Mediterr Health J*. 8 (5), 645-653.

Al-Zahrani, S. S. A., & Kaplowitz, S. A. (1993). Attributional biases in individualistic and collectivistic cultures: A comparison of Americans with Saudis. *Social Psychology Quarterly*, 223-233

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Anderson Jr, I. H. (2014). *Aramco, the United States, and Saudi Arabia: A study of the dynamics of foreign oil policy, 1933-1950*. Princeton University Press.

Andrew, S., & Halcomb, E. (Eds.). (2009). *Mixed methods research for nursing and the health sciences*. Wiley-Blackwell Pub.

Angermeyer, M. C., Beck, M., Dietrich, S., & Holzinger, A. (2004). The stigma of mental illness: patients' anticipations and experiences. *International Journal of Social Psychiatry*, *50*(2), 153-162.

Angermeyer, M. C., Holzinger, A., & Matschinger, H. (2009). Mental health literacy and attitude towards people with mental illness: a trend analysis based on population surveys in the eastern part of Germany. *European Psychiatry*, *24*(4), 225-232.

Angermeyer, M. C., & Matschinger, H. (1996). Public attitude towards psychiatric treatment. *Acta Psychiatrica Scandinavica*, *94*(5), 326-336.

Angermeyer, M. C., & Matschinger, H. (2003). Public beliefs about schizophrenia and depression: similarities and differences. *Social psychiatry and psychiatric epidemiology*, *38*(9), 526-534.

Angermeyer, M. C., & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia. *The British Journal of Psychiatry*, *186*(4), 331-334.

Angermeyer, M. C., Matschinger, H., & Schomerus, G. (2013). Attitudes towards psychiatric treatment and people with mental illness: changes over two decades. *The British Journal of Psychiatry*, bjp-bp.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of advanced nursing*, *23*(4), 705-713.

Aphroditi, Z. (2010). Stigma related to help-seeking from a mental health professional. *Health Science Journal*.

Aronson, J. (1995). A pragmatic view of thematic analysis. *The qualitative report*, *2*(1), 1-3.

Asharaf Abdul Salam. (2013). Population and Household Census, Kingdom of Saudi Arabia 2010: Facts and Figures. *nternational Journal of Humanities and Social Science*, 3 (12), 258-262.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative research*, *1*(3), 385-405.

Aydin, N., Yigit, A., Inandi, T., & Kirpinar, I. (2003). Attitudes of hospital staff toward mentally ill patients in a teaching hospital, Turkey. *International Journal of Social Psychiatry*, *49*(1), 17-26.

Bahora, M., Hanafi, S., Chien, V. H., & Compton, M. T. (2008). Preliminary evidence of effects of crisis intervention team training on self-efficacy and social distance. Administration and Policy in Mental Health and Mental Health Services Research, 35(3), 159-167.

Baker, R., & Hinton, R. (1999). Do focus groups facilitate meaningful participation in social research. *Developing focus group research. Politics, theory and practice. Thousand Oaks: Sage*, 79-98.

Barnard, C. I. (1968). *The functions of the executive* (Vol. 11). Harvard university press.

Barney, L. J., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health*, *9*(1), 1.

Bathje, G. J., & Pryor, J. B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, *33*(2), 161.

Baxter, J., & Eyles, J. (1997). Evaluating qualitative research in social geography: establishing 'rigour'in interview analysis. *Transactions of the Institute of British Geographers*, *22*(4), 505-525.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, *13*(4), 544-559.

Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2000). Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine*, *25*(24), 3186-3191.

Beckert, T. (2007). Cognitive autonomy and self-evaluation in adolescence: A conceptual investigation and instrument development. *North American Journal of Psychology*, *9*(3), 579-594.

Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Religion and mental health. *Indian journal of psychiatry*, *55*(6), 187.

Belloch, A., del Valle, G., Morillo, C., Carrió, C., & Cabedo, E. (2009). To seek advice or not to seek advice about the problem: the help-seeking dilemma for obsessive-compulsive disorder. *Social psychiatry and psychiatric epidemiology*, *44*(4), 257-264.

Bernstein, P. A., Hadzilacos, V., & Goodman, N. (1987). Concurrency control and recovery in database systems.

Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, *23*(1), 75-91.

Blevins, J. (2005). Broadening the family of God: Debating Same-sex marriage and queer families in America. *Theology and Sexuality*, *12*(1), 63-80.

Bonney, S., & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of psychiatric and mental health nursing*, *15*(2), 140-153.

Boraska, V., Franklin, C. S., Floyd, J. A., Thornton, L. M., Huckins, L. M., Southam, L., ... & Lewis, C. M. (2014). A genome-wide association study of anorexia nervosa. *Molecular*

psychiatry, *19*(10), 1085-1094.

Bowen, W. H. (2014). *The History of Saudi Arabia*. ABC-CLIO.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Boyd, C. M., Boult, C., Shadmi, E., Leff, B., Brager, R., Dunbar, L., ... & Wegener, S. (2007). Guided Care for Multimorbid Older Adults Kathleen Walsh Piercy, PhD, Editor. *The Gerontologist*, *47*(5), 697-704.

Boynton, P. M., & Greenhalgh, T. (2004). Selecting, designing, and developing your questionnaire. *Bmj*, *328*(7451), 1312-1315.

Bradbury-Jones, C., & Alcock, J. (2010). Nursing students as research participants: a framework for ethical practice. *Nurse education today*, *30*(2), 192-196.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health services research*, *42*(4), 1758-1772.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2014). What can ‘‘thematic analysis’’offer health and wellbeing researchers?. *International journal of qualitative studies on health and well-being*, *9*.

Brohan, E., Clement, S., Rose, D., Sartorius, N., Slade, M., & Thornicroft, G. (2013). Development and psychometric evaluation of the Discrimination and Stigma Scale (DISC). *Psychiatry research*, *208*(1), 33-40.

Brohan, E., Elgie, R., Sartorius, N., Thornicroft, G., & GAMIAN-Europe Study Group. (2010). Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: the GAMIAN-Europe study. *Schizophrenia research*, *122*(1), 232-238.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done?. *Qualitative research*, *6*(1), 97-113.

Burton, P. R., Clayton, D. G., Cardon, L. R., Craddock, N., Deloukas, P., Duncanson, A., ... & Todd, J. A. (2007). Genome-wide association study of 14,000 cases of seven common diseases and 3,000 shared controls. *Nature*, *447*(7145), 661-678.

Byrne, P. (1997). Psychiatric stigma: past, passing and to come. *Journal of the Royal Society of Medicine*, *90*(11), 618.

Byrne, P. (2001). Psychiatric stigma. *The British Journal of Psychiatry*, *178*(3), 281-284.

Cahal, C. H. (2007). *Attitudes Towards Individuals with Mental Disorders: The Effect of Career Choice and Previous Experience with Psychological Services*. ProQuest.

Carter, R., & Golant, S. (2013). Helping yourself help others: A book for caregivers. PublicAffairs.

Carulla, L. S., Reed, G. M., VAEZ-AZIZI, L. M., COOPER, S. A., LEAL, R., Bertelli, M., ... & Girimaji, S. C. (2011). Intellectual developmental disorders: towards a new name, definition and framework for "mental retardation/intellectual disability" in ICD-11. *World Psychiatry*, *10*(3), 175-180.

Chang, K. H., & Horrocks, S. (2006). Lived experiences of family caregivers of mentally ill relatives. *Journal of advanced nursing*, *53*(4), 435-443.

Chilisa, B., & Preece, J. (2005). *Research methods for adult educators in Africa*. Pearson South Africa.

Chou, K. L., & Mak, K. Y. (1998). Attitudes to mental patients among Hong Kong Chinese: A trend study over two years. *International Journal of Social Psychiatry*, *44*(3), 215-224.

Chou, K. L., Mak, K. Y., Chung, P. K., Chan, D., & Ho, K. (1996). Attitudes towards mental patients in Hong Kong. *International Journal of Social Psychiatry*, *42*(3), 213-219.

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, *7*(1), 21-26.

Cizza, G., Marincola, P., Mattingly, M., Williams, L., Mitler, M., Skarulis, M., & Csako, G. (2010). Treatment of obesity with extension of sleep duration: a randomized, prospective, controlled trial. *Clinical trials*.

Clark, V. L. P., Huddleston-Casas, C. A., Churchill, S. L., Green, D. O. N., & Garrett, A. L. (2008). Mixed methods approaches in family science research. *Journal of Family Issues*, *29*(11), 1543-1566.

Clayton, S., Bambra, C., Gosling, R., Povall, S., Misso, K., & Whitehead, M. (2011). Assembling the evidence jigsaw: insights from a systematic review of UK studies of individual-focused return to work initiatives for disabled and long-term ill people. *BMC Public Health*, *11*(1), 1.

Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Sage Publications.

Cohen, A. B., & Koenig, H. G. (2004). Religion and mental health. *Encyclopedia of applied psychology*, *3*(1), 255-258.

Cohen, L., Manion, L., & Morrison, K. (2013). *Research methods in education*. Routledge.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of women's health & gender-based medicine*, *11*(5), 465-476.

Collins, P. H. (1997). Comment on Hekman's" Truth and Method: Feminist Standpoint Theory Revisited": Where's the Power?. *Signs*, *22*(2), 375-381.

Collins, J. A., & Fauser, B. C. (2005). Balancing the strengths of systematic and narrative reviews. *Human reproduction update*, *11*(2), 103-104.

Collier, E., & McQuarrie, C. (2014). 5 OLDER PEOPLE. *Mental Health Policy for Nurses*, 79.

Compton, M. T., Bahora, M., Watson, A. C., & Oliva, J. R. (2008). A comprehensive review of extant research on crisis intervention team (CIT) programs. Journal of the American Academy of Psychiatry and the Law Online, 36(1), 47-55.

Cooper, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (1997). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of general internal medicine*, *12*(7), 431-438.

Corbiere, M., Samson, E., Villotti, P., & Pelletier, J. F. (2012). Strategies to fight stigma toward people with mental disorders: perspectives from different stakeholders. *The Scientific World Journal*, 2012 (1), 10.

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice*, *7*(1), 48-67.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American psychologist*, *59*(7), 614.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, *52*(1), 31-39.

Corrigan, P. W. (2011). Best practices: Strategic stigma change (SSC): Five principles for social marketing campaigns to reduce stigma. *Psychiatric Services, 62*(1), 824-826.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *57*(8), 464.

Corrigan, P. W., Larson, J. E., & Kuwabara, S. A. (2007). Mental illness stigma and the fundamental components of supported employment. *Rehabilitation Psychology*, *52*(4), 451.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services*

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, *13*(6), 537-548.

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*(9), 765.

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campion, J., Mathisen, J., ... & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology*, *28*(1), 91-102.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, *9*(1), 35-53.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of social and clinical psychology*, *25*(8), 875-884.

Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, *20*(2), 239.

Coverdale, J., Nairn, R., & Claasen, D. (2002). Depictions of mental illness in print media: A prospective national sample. *Australian and New Zealand Journal of Psychiatry*, *36*(5), 697-700.

Crabtree, A. S. (2003). Asylum blues: staff attitudes towards psychiatric nursing in Sarawak, East Malaysia. *Journal of psychiatric and mental health nursing*, *10*(6), 713-721.

Creswell, J. W. (2009). Editorial: Mapping the field of mixed methods research. *Journal of Mixed Methods Research*, *3*(2), 95-108.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Creswell, J. W., Hanson, W. E., Plano, V. L. C., & Morales, A. (2007). Qualitative research designs selection and implementation. *The counseling psychologist*, *35*(2), 236-264.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. *Handbook of mixed methods in social and behavioral research*, 209-240.

Creswell, J. W., & Tashakkori, A. (2007). Editorial: Differing perspectives on mixed methods research. *Journal of mixed methods research*, *1*(4), 303-308.

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World psychiatry*, *4*(2), 106-113.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, *177*(1), 4-7.

Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology*, *35*(1), 89-107.

Guest, G., Namey, E. E., & Mitchell, M. L. (2012). *Collecting qualitative data: A field manual for applied research*. Sage.

Cutts, D., Fieldhouse, E., & John, P. (2009). Is voting habit forming? The longitudinal impact of a GOTV campaign in the UK. *Journal of Elections, Public Opinion and Parties*, *19*(3), 251-263.

Dalky, H. F. (2012). Arabic translation and cultural adaptation of the stigma-devaluation scale in Jordan. *Journal of Mental Health*, *21*(1), 72-82.

Dalky, H. F. (2012). Perception and coping with stigma of mental illness: Arab families' perspectives. *Issues in mental health nursing*, *33*(7), 486-491.

Davidson-Hunt, I. J., Turner, K. L., Mead, A. T. P., Cabrera-Lopez, J., Bolton, R., Idrobo, C. J., ... & Robson, J. P. (2012). Biocultural design: a new conceptual framework for sustainable development in rural indigenous and local communities. *SAPI EN. S. Surveys and Perspectives Integrating Environment and Society*, (5.2).

Deen, T. L., Bridges, A. J., McGahan, T. C., & Andrews III, A. R. (2012). Cognitive appraisals of specialty mental health services and their relation to mental health service utilization in the rural population. *The Journal of Rural Health*, *28*(2), 142-151.

Department of health (1996) *the patients Charter and you.* HMSO,London.

Devers, K. J., & Frankel, R. M. (2000). Study design in qualitative research--2: Sampling and data collection strategies. *Education for health*, *13*(2), 263.

Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness. *The British Journal of Psychiatry*, *184*(2), 176-181.

Doherty, D. T., Moran, R., & Kartalova-O'Doherty, Y. (2008). Psychological distress, mental health problems and use of health services in Ireland.

Dols, M. W. (2007). Insanity in Islamic law. *Journal of Muslim Mental Health*, *2*(1), 81-99.

Doody, O., & Doody, C. M. (2015). Conducting a pilot study: case study of a novice researcher. *British Journal of Nursing*, *24*(21).

Dowling, M. (2004). Hermeneutics: an exploration: The terms 'hermeneutics' and 'phenomenology'are often used interchangeably in the literature, which can result in confusion for the reader. In this article, Maura Dowling traces the relationship between these two philosophies and explains the various terms used when describing the different schools of phenomenology. The association between positivism and descriptive phenomenology is mapped. The origin of hermeneutics is traced, and the role of Gadamer in developing the work .... *Nurse Researcher*, *11*(4), 30-39.

Druss, B. G., Bradford, W. D., Rosenheck, R. A., Radford, M. J., & Krumholz, H. M. (2001). Quality of medical care and excess mortality in older patients with mental disorders. *Archives of general psychiatry*, *58*(6), 565-572.

Dudley, J. R. (2000). Confronting stigma within the services system. *Social Work*, *45*(5), 449.

Dziak, R. P., & Fox, C. G. (1999). Long-term seismicity and ground deformation at Axial Volcano, Juan de Fuca Ridge. *Geophysical research letters*, *26*(24), 3641-3644.

Eker, D., & Arkar, H. (1991). Experienced Turkish nurses' attitudes towards mental illness and the predictor variables of their attitudes. *International journal of social psychiatry*, *37*(3), 214-222.

Emma, P., Akre, R., Arthur, J., Bionta, R., Bostedt, C., Bozek, J., ... & Ding, Y. (2010). First lasing and operation of an ångstrom-wavelength free-electron laser. *nature photonics*, *4*(9), 641-647.

Emmel, N. (2013). *Sampling and choosing cases in qualitative research: a realist approach*. Sage.

Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural diversity and ethnic minority psychology*, *7*(4), 308-327.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4.

Fabrega, H. (1991). Psychiatric stigma in non-Western societies. *Comprehensive psychiatry*, *32*(6), 534-551.

Farooqi, Y. N. (2006). Traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. *International Journal of Disability, Development and Education*, *53*(4), 401-415.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International journal of qualitative methods*, *5*(1), 80-92.

Ferreira, E. S., Giacomelli, C., Giacomelli, F. C., & Spinelli, A. (2004). Evaluation of the inhibitor effect of L-ascorbic acid on the corrosion of mild steel. *Materials Chemistry and Physics*, *83*(1), 129-134.

Ford, T., Goodman, R., & Meltzer, H. (2003). The British child and adolescent mental health survey 1999: the prevalence of DSM-IV disorders. *Journal of the American academy of child & adolescent psychiatry*, *42*(10), 1203-1211.

Franz, L., Carter, T., Leiner, A. S., Bergner, E., Thompson, N. J., & Compton, M. T. (2010). Stigma and treatment delay in first-episode psychosis: A grounded theory study. *Early intervention in psychiatry*, *4*(1), 47-56.

Friswell, M. I., & Penny, J. E. (2002). Crack modeling for structural health monitoring. *Structural Health Monitoring*, *1*(2), 139-148.

Gabriels, R. L., Agnew, J. A., Miller, L. J., Gralla, J., Pan, Z., Goldson, E., ... & Hooks, E. (2008). Is there a relationship between restricted, repetitive, stereotyped behaviors and interests and abnormal sensory response in children with autism spectrum disorders?. *Research in Autism Spectrum Disorders*, *2*(4), 660-670.

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in mental health nursing*, *26*(10), 979-999.

Gawronski, B., & Bodenhausen, G. V. (2006). Associative and propositional processes in evaluation: an integrative review of implicit and explicit attitude change. *Psychological bulletin*, *132*(5), 692.

Gee, G. C. (2002). A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. *American Journal of Public Health*, *92*(4), 615-623.

Gillard, S., Borschmann, R., Turner, K., Goodrich-Purnell, N., Lovell, K., & Chambers, M. (2010). 'What difference does it make?'Finding evidence of the impact of mental health

service user researchers on research into the experiences of detained psychiatric patients. *Health Expectations*, *13*(2), 185-194.

Girish, K., & Gill, N. S. (2003). Electroconvulsive therapy in lorazepam non-responsive catatonia. *Indian journal of psychiatry*, *45*(1), 21.

Glenn, F., & Coleman, L. (2009). Relationships and the Recession. *London: OnePlusOne*.

Goffman, E. (1963). *Behavior in public places: Notes on the social organization of gatherings* (p. 248). New York: Free Press.

Gostin, L. O., & Gable, L. (2004). The human rights of persons with mental disabilities: a global perspective on the application of human rights principles to mental health. *Maryland Law Review*, *63*(20), 08-31.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*, *24*(2), 105-112.

Grove, S. K., Gray, J. R., & Burns, N. (2014). *Understanding Nursing Research: Building an Evidence-Based Practice*. Elsevier Health Sciences.

Grzywacz, J. G., & Bass, B. L. (2003). Work, family, and mental health: testing different models of work-family fit. *Journal of Marriage and Family*, *65*(1), 248-261.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), 105.

Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry*, *186*(5), 436-441.

Haghighat, R. (2001). A unitary theory of stigmatisation. *The British Journal of Psychiatry*, *178*(3), 207-215.

Hahn, A. (2002). The effect of information and prior contact on attitudes towards mental illness. *IU South Bend Undergraduate Research Journal*, *5*, 28-35.

Handzo, R. G., & Koenig, H. G. (2004). Spiritual care: whose job is it anyway?. *Southern Medical Journal*, *97*(12), 1242-1245.

Haque, A. (2005). Mental health concepts and program development in Malaysia. *Journal of Mental Health*, *14*(2), 183-195.

Hassan, T. M., Ahmed, S. O., White, A. C., & Galbraith, N. (2009). A postal survey of doctors' attitudes to becoming mentally ill. *Clinical Medicine*, *9*(4), 327-332.

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of advanced nursing*, *32*(4), 1008-1015.

Hardy, B., Mur-Veemanu, I., Steenbergen, M., & Wistow, G. (1999). Inter-agency services in England and the Netherlands: a comparative study of integrated care development and delivery. *Health policy*, *48*(2), 87-105.

Hartford, K., Carey, R., & Mendonca, J. (2007). Pretrial court diversion of people with mental illness. *The journal of behavioral health services & research*, *34*(2), 198-205.

Heeren, T., & D'Agostino, R. (1987). Robustness of the two independent samples t-test when applied to ordinal scaled data. *Statistics in medicine*, *6*(1), 79-90.

Heidegger, M. (1992). *History of the concept of time: Prolegomena* (Vol. 717). Indiana University Press.

Heidegger, M. (1988). *The basic problems of phenomenology* (Vol. 478). Indiana University Press.

Hepworth, D. G., & Vincent, J. F. V. (1999). The growth response of the stems of genetically modified tobacco plants (Nicotiana tabacum 'Samsun') to flexural stimulation. *Annals of Botany*, *83*(1), 39-43.

Henderson, C., & Thornicroft, G. (2009). Stigma and discrimination in mental illness: Time to Change. *The Lancet*, *373*(9679), 1928-1930.

Hertzog, M. A. (2008). Considerations in determining sample size for pilot studies. *Research in nursing & health*, *31*(2), 180-191.

Hinkelman, L., & Granello, D. H. (2003). Biological sex, adherence to traditional gender roles, and attitudes toward persons with mental illness: An exploratory investigation. *Journal of Mental Health Counseling*, *25*(4), 259.

Hogg, C., & Holland, K. (2010). *Cultural awareness in nursing and health care: an introductory text*. London: Hodder Arnold.

Holmesland, A. L., Seikkula, J., Nilsen, Ø., Hopfenbeck, M., & Arnkil, T. E. (2010). Open Dialogues in social networks: professional identity and transdisciplinary collaboration. *International journal of integrated care*, *10*(3), 53.

Hoover, R. S., & Koerber, A. L. (2011). Using NVivo to answer the challenges of qualitative research in professional communication: Benefits and best practices tutorial. *Professional Communication, IEEE Transactions on*, *54*(1), 68-82.

Horovitz, E. G. (2002). *Spiritual art therapy: An alternate path*. Charles C Thomas Publisher.

Huang, B., & Priebe, S. (2003). Media coverage of mental health care in the UK, USA and Australia. *The Psychiatrist*, *27*(9), 331-333.

Innes, N. L., & Murphy, D. J. (2008). Plant Breeding and Biotechnology. Societal Context and the Future of Agriculture. *Experimental Agriculture*, *44*(2), 274.

Irvine, A. (2011). Something to declare? The disclosure of common mental health problems at work. *Disability & Society*, *26*(2), 179-192.

Isaacs, A. N., Pyett, P., Oakley-Browne, M. A., Gruis, H., & Waples-Crowe, P. (2010). Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: seeking a way forward. *International journal of mental health nursing*, *19*(2), 75-82.

Jaalouk, D., Okasha, A., Salamoun, M. M., & Karam, E. G. (2012). Mental health research in the Arab world. *Social psychiatry and psychiatric epidemiology*, *47*(11), 1727-1731.

Jack, E. P., & Raturi, A. S. (2006). Lessons learned from methodological triangulation in management research. *Management Research News*, *29*(6), 345-357.

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.

Jacobs, I., Nadkarni, V., Bahr, J., Berg, R. A., Billi, J. E., Bossaert, L., ... & Halperin, H. (2004). Cardiac arrest and cardiopulmonary resuscitation outcome reports: update and simplification of the Utstein templates for resuscitation registries.: A statement for healthcare professionals from a task force of the international liaison committee on resuscitation (American Heart Association, European Resuscitation Council, Australian Resuscitation Council, New Zealand Resuscitation Council, Heart and Stroke Foundation of Canada, InterAmerican Heart Foundation, Resuscitation Council of Southern Africa). *Resuscitation*, *63*(3), 233-249.

Jenkins, R. G., Kaim, A., & Hikida, Y. (2007). Antiquity of the substrate choice among acmaeid limpets from Late Cretaceous chemosynthesis-based communities. *Acta Palaeontologica Polonica*, *52*(2), 369.

Jerrell, J. M., & Wilson, J. L. (1997). Ethnic differences in the treatment of dual mental and substance disorders: A preliminary analysis. *Journal of Substance Abuse Treatment*, *14*(2), 133-140.

Joffe, H., & Yardley, L. (2004). 4. Content and thematic analysis. *Research methods for clinical and health psychology. California: Sage*, 56-68.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, *33*(7), 14-26.

Johnson, J. G., Alloy, L. B., Panzarella, C., Metalsky, G. I., Rabkin, J. G., Williams, J. B., & Abramson, L. Y. (2001). Hopelessness as a mediator of the association between social support and depressive symptoms: findings of a study of men with HIV. *Journal of consulting and clinical psychology*, *69*(6), 1056.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about. *British Journal of Psychiatry*, *177*, 396-401.

Jorm, A. F., Jorm, A. F., Christensen, H., Griffiths, K. M., Jorm, A. F., Christensen, H., & Griffiths, K. M. (2005). The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zealand Journal of Psychiatry*, *39*(4), 248-254.

Kadri, N., Manoudi, F., Berrada, S., & Moussaoui, D. (2004). Stigma impact on Moroccan families of patients with schizophrenia. *Canadian Journal of Psychiatry*, *49*(9), 625.

Kafle, N. P. (2013). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal*, *5*(1), 181-200.

Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., ... & Flisher, A. J. (2010). Mental illness-stigma and discrimination in Zambia. *African Journal of Psychiatry*, *13*(3),192-203.

Karam, E. G., Mneimneh, Z. N., Karam, A. N., Fayyad, J. A., Nasser, S. C., Chatterji, S., & Kessler, R. C. (2006). Prevalence and treatment of mental disorders in Lebanon: a national epidemiological survey. *The Lancet*, *367*(9515), 1000-1006.

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological medicine*, *35*(12), 1795-1803.

Kazdin, A. E. (2011). *Single-case research designs: Methods for clinical and applied settings* . Oxford University Press.

Keane, R. M. (1990). Contemporary beliefs about mental illness among medical students: Implications for education and practice. *Academic psychiatry*, *14*(3), 172-177.

Keeney, S., Hasson, F., & McKenna, H. (2006). Consulting the oracle: ten lessons from using the Delphi technique in nursing research. *Journal of advanced nursing*, *53*(2), 205-212.

Kelly, C. M., Jorm, A. F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Med J Aust*, *187*(7 Suppl), S26-30.

Kent, G., & Wahass, S. (1996). The content and characteristics of auditory hallucinations in Saudi Arabia and the UK: a cross-cultural comparison. *Acta Psychiatrica Scandinavica*, *94*(6), 433-437.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., ... & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health services research*, *36*(6), 987.

Keyes, C. L., Wissing, M., Potgieter, J. P., Temane, M., Kruger, A., & van Rooy, S. (2008). Evaluation of the mental health continuum-short form (MHC-SF) in Setswana-speaking South Africans. *Clinical psychology and psychotherapy*, *15*(3), 181.

Khangura, S., Polisena, J., Clifford, T. J., Farrah, K., & Kamel, C. (2014). Rapid review: an emerging approach to evidence synthesis in health technology assessment. *International journal of technology assessment in health care*, *30*(01), 20-27.

Kim, Y., & Given, B. A. (2008). Quality of life of family caregivers of cancer survivors. *Cancer*, *112*(S11), 2556-2568.

King, M., McKeown, E., Warner, J., Ramsay, A., Johnson, K., Cort, C., ... & Davidson, O. (2003). Mental health and quality of life of gay men and lesbians in England and Wales. *The British Journal of Psychiatry*, *183*(6), 552-558.

Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, *11*(sup1), S15-S23.

Kitchenham, B., Brereton, O. P., Budgen, D., Turner, M., Bailey, J., & Linkman, S. (2009). Systematic literature reviews in software engineering–a systematic literature review. *Information and software technology*, *51*(1), 7-15.

Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *BMJ: British medical journal*, *311*(7000), 299.

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of health communication*, *13*(5), 434-449.

Knopman, D. S., Kramer, J. H., Boeve, B. F., Caselli, R. J., Graff-Radford, N. R., Mendez, M. F., ... & Mercaldo, N. (2008). Development of methodology for conducting clinical trials in frontotemporal lobar degeneration. *Brain*, *131*(11), 2957-2968.

Koehn, M. L., & Lehman, K. (2008). Nurses' perceptions of evidence-based nursing practice. *Journal of advanced nursing*, *62*(2), 209-215.

Koenig, H. G. (2008). Religion and mental health: what should psychiatrists do?. *The Psychiatrist*, *32*(6), 201-203.

Koenig, H. G., Al Zaben, F., Sehlo, M. G., Khalifa, D. A., Al Ahwal, M. S., Qureshi, N. A., & Al-Habeeb, A. A. (2014). Mental Health Care in Saudi Arabia: Past, Present and Future. *Open Journal of Psychiatry*, *4*(02), 113.

Kokanovic, R., Petersen, A., & Klimidis, S. (2006). 'Nobody Can Help Me... I am Living Through it Alone': Experiences of Caring for People Diagnosed with Mental Illness in Ethno-Cultural and Linguistic Minority Communities. *Journal of Immigrant and Minority Health*, *8*(2), 125-135.

Kosslyn, S. M., Thompson, W. L., & Ganis, G. (2006). *The case for mental imagery*. Oxford University Press.

Krishnaswamy, A. (2012). Strategies and tools for effective public participation in natural resource management. *Journal of Ecosystems and Management*, *13*(2).

Kroenke, C. H., Bennett, G. G., Fuchs, C., Giovannucci, E., Kawachi, I., Schernhammer, E., ... & Kubzansky, L. D. (2005). Depressive symptoms and prospective incidence of colorectal cancer in women. *American Journal of Epidemiology*, *162*(9), 839-848.

Kua, J. H. K., Parker, G., Lee, C., & Jorm, A. F. (2000). Beliefs about outcomes for mental disorders: a comparative study of primary health practitioners and psychiatrists in Singapore. *Singapore medical journal*, *41*(11), 542-547.

Kuoppala, J., Lamminpää, A., Liira, J., & Vainio, H. (2008). Leadership, job well-being, and health effects—a systematic review and a meta-analysis.*Journal of occupational and environmental medicine*, *50*(8), 904-915.

Lai, Y. M., Hong, C. P. H., & Chee, C. Y. (2001). Stigma of mental illness. *Singapore Medical Journal*, *42*(3), 111-114.

Landers, R. N., & Behrend, T. S. (2015). An inconvenient truth: Arbitrary distinctions between organizational, Mechanical Turk, and other convenience samples. *Industrial and Organizational Psychology*, *8*(02), 142-164.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Larkings, J. S., & Brown, P. M. (2012). Mental Illness Stigma and Causal Beliefs: Among Potential Mental Health Professionals. *World Academy of Science, Engineering and Technology, International Journal of Social, Behavioral, Educational, Economic, Business and Industrial Engineering*, *6*(6), 1283-1289.

Lauber, C., Nordt, C., Braunschweig, C., & Rossler, W. (2006). Do mental health professionals stigmatize their patients?. *Acta Psychiatrica Scandinavica*, *113*(s429), 51-59.

Lauber, C., Nordt, C., & Wulf, R. (2005). Lay beliefs about treatments for people with mental illness and their implications for antistigma strategies. *Canadian Journal of Psychiatry*, *50*(12), 745.

Lauber, C., & Rossler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International review of psychiatry*, *19*(2), 157-178.

Law, I. (2012). Poverty and income maintenance. *Understanding'Race'and Ethnicity: Theory History, Policy, Practice*, 191.

Lawton, R., & Parker, D. (1999). Procedures and the professional: the case of the British NHS. *Social Science & Medicine*, *48*(3), 353-361.

Lee, S., Lee, M. T., Chiu, M. Y., & Kleinman, A. (2005). Experience of social stigma by people with schizophrenia in Hong Kong. *The British Journal of Psychiatry*, *186*(2), 153-157.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School psychology quarterly*, *22*(4), 557.

Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. Cambridge University Press.

Leslie, E., & Cerin, E. (2008). Are perceptions of the local environment related to neighbourhood satisfaction and mental health in adults?.*Preventive medicine*, *47*(3), 273-278.

Lester, H. E., Hannon, K. L., & Campbell, S. M. (2011). Identifying unintended consequences of quality indicators: a qualitative study. *BMJ quality & safety*, *20*(12), 1057-1061.

LeVasseur, J. J. (2003). The problem of bracketing in phenomenology. *Qualitative health research*, *13*(3), 408-420.

Liamputtong, P., & Ezzy, D. (2005). Qualitative research methods.

Liggins, J., & Hatcher, S. (2005). Stigma toward the mentally ill in the general hospital: a qualitative study. *General hospital psychiatry*, *27*(5), 359-364.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research*, *4*, 97-128.

Lindlof, T. R. (2001). The Challenge of Writing the Qualitative Study. *How to Publish Your Communication Research: An Insider's Guide*, 77.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, *30*(3), 511-541.

Linstone, H. A., & Turoff, M. (Eds.). (1975). *The Delphi method: Techniques and applications* (Vol. 29). Reading, MA: Addison-Wesley.

Littlewood, J., & Yousuf, S. (2000). Primary health care in Saudi Arabia: Applying global aspects of health for all, locally. *Journal of Advanced Nursing*, *32*(3), 675-681.

Long, A. F., & Godfrey, M. (2004). An evaluation tool to assess the quality of qualitative research studies. *International Journal of Social Research Methodology*, *7*(2), 181-196.

Lopez, R. A. (2005). Use of alternative folk medicine by Mexican American women. *Journal of Immigrant Health*, *7*(1), 23-31.

Lucas, S. R. (2014). An inconvenient dataset: bias and inappropriate inference with the multilevel model. *Quality & quantity*, *48*(3), 1619-1649.

Lyons, C., Hopley, P., & Horrocks, J. (2009). A decade of stigma and discrimination in mental health: plus ca change, plus c'est la même chose (the more things change, the more they stay the same). *Journal of Psychiatric and Mental Health Nursing*, *16*(6), 501-507.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research*, *16*(2), 193-205.

Madriz, E. (2000). Focus groups in feminist research. *Handbook of qualitative research*, *2*, 835-850.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annu. Rev. Psychol.*, *56*, 393-421.

Mansell, J. (2005). Deinstitutionalisation and community living: An international perspective. *Housing, Care and Support*, *8*(3), 26-33.

Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, *12*(6), 595-612.

Marrow, J., & Luhrmann, T. M. (2012). The zone of social abandonment in cultural geography: on the street in the United States, inside the family in India. *Culture, Medicine, and Psychiatry*, *36*(3), 493-513.

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*(1), 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*, 208-223.

Martin, A., & Sherington, J. (1997). Participatory research methods—implementation, effectiveness and institutional context. *Agricultural systems*, *55*(2), 195-216.

Masuda, A., & Boone, M. S. (2011). Mental health stigma, self-concealment, and help-seeking attitudes among Asian American and European American college students with no help-seeking experience. *International Journal for the Advancement of Counselling*, *33*(4), 266-279.

Mathews, M. (2007). *Clergy & Counsellors: Mental Health Care in Singapore* (Doctoral dissertation).

McCabe, D. M., & Rabil, J. M. (2002). Ethics and Values in Nonunion Employment Arbitration: A Historical Study of Organizational Due Processin the Private Sector. *Journal of Business Ethics*, *41*(1-2), 13-25.

McEvoy, P., & Richards, D. (2003). Critical realism: a way forward for evaluation research in nursing?. *Journal of advanced nursing*, *43*(4), 411-420.

McKeon, P. (1998). Defeating or preventing stigma of mental illness?. *The Lancet*, *352*(9144), 1942.

McLafferty, I. (2004). Focus group interviews as a data collecting strategy. *Journal of advanced nursing*, *48*(2), 187-194.

Memish, Z. A., Zumla, A. I., Al-Hakeem, R. F., Al-Rabeeah, A. A., & Stephens, G. M. (2013). Family cluster of Middle East respiratory syndrome coronavirus infections. *New England Journal of Medicine*, *368*(26), 2487-2494.

Merton, R. K. (1975). Thematic Analysis in Science: Notes on Holton's Concept. *Science*, *188*(4186), 335-338.

Miguel, F. S., Ryan, M., & Amaya-Amaya, M. (2005). 'Irrational'stated preferences: a quantitative and qualitative investigation. *Health economics*,*14*(3), 307-322.

Miles, M. B., & Huberman, A. M. (2002). *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills, CA: Sage.

Mingers, J. (2003). A classification of the philosophical assumptions of management science methods. *Journal of the Operational Research Society*, 559-570.

Mitchell, G., & Hastings, R. P. (1998). Learning disability care staffs emotional reactions to aggressive challenging behaviours: Development of a measurement tool. *British Journal of Clinical Psychology*, *37*(4), 441-449.

Mobaraki, A. E. H., & Soderfeldt, B. (2010). Gender inequity in Saudi Arabia and its role in public health/L'inégalité entre hommes et femmes en Arabie saoudite et ses

conséquences sur la santé publique. *Eastern Mediterranean health journal*, *16*(1), 113.

Moffitt, J., Bostock, J., & Cave, A. (2014). Promoting well-being and reducing stigma about mental health in the fire service. *Journal of Public Mental Health*, *13*(2), 103-113.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Reprint—preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Physical therapy*, *89*(9), 873-880.

Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews*, *4*(1), 1.

Morales, M. M., Martı, P., Llopis, A., Campos, L., & Sagrado, S. (1999). An environmental study by factor analysis of surface seawaters in the Gulf of Valencia (Western Mediterranean). *Analytica Chimica Acta*, *394*(1), 109-117.

Moreira-Almeida, A., Lotufo Neto, F., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Revista brasileira de psiquiatria*, *28*(3), 242-250.

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., & Priebe, S. (2007). Social exclusion and mental health. *The British Journal of Psychiatry*, *191*(6), 477-483.

Morrow, S. L. (2007). Qualitative research in counseling psychology conceptual foundations. *The Counseling Psychologist*, *35*(2), 209-235.

Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. *Nursing research*, *40*(2), 120-123.

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social science & medicine*, *70*(7), 985-993.

Moynihan, R., Glasziou, P., Woloshin, S., Schwartz, L., Santa, J., & Godlee, F. (2013). Winding back the harms of too much medicine. *Bmj*, *346*(2), 1271.

Nabolsi, M. M., & Carson, A. M. (2011). Spirituality, illness and personal responsibility: the experience of Jordanian Muslim men with coronary artery disease. *Scandinavian journal of caring sciences*, *25*(4), 716-724.

Nelson, E. S. (2000). Questioning practice: Heidegger, historicity, and the hermeneutics of facticity. *Philosophy today*, *44*(Supplement), 150-159.

Nelson, W., Lushkov, G., Pomerantz, A., & Weeks, W. B. (2006). Rural health care ethics: Is there a literature?. *The American Journal of Bioethics*, *6*(2), 44-50.

Ng, C. H. (1997). The stigma of mental illness in Asian cultures. *Australian and New Zealand Journal of Psychiatry*, *31*(3), 382-390.

Ng, P., & Chan, K. F. (2000). Sex differences in opinion towards mental illness of secondary school students in Hong Kong. *International Journal of Social Psychiatry*, *46*(2), 79-88.

Nieswiadomy, R. M. (2011). *Foundations in nursing research*. Pearson Higher Ed.

Nieswiadomy, M. L., Strazicich, M. C., & Clayton, S. (2012). Was There a Structural Break in Barry Bonds's Bat?. *Journal of Quantitative Analysis in Sports*, *8*(3), 1559-0410.

Nieuwsma, J. A., Pepper, C. M., Maack, D. J., & Birgenheir, D. G. (2011). Indigenous perspectives on depression in rural regions of India and the United States. *Transcultural psychiatry*, *48*(5), 539-568.

Newsome, L. T., Weller, R. S., Gerancher, J. C., Kutcher, M. A., & Royster, R. L. (2008). Coronary artery stents: II. Perioperative considerations and management. *Anesthesia & Analgesia*, *107*(2), 570-590.

Nordt, C., Rossler, W., & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia bulletin*, *32*(4), 709-714.

Okasha, A. (2003). Mental health services in the Arab world. *Arab Studies Quarterly, 25*(1),39-52.

Okasha, A., Karam, E., & Okasha, T. (2012). Mental health services in the Arab world. *World Psychiatry*, *11*(1), 52-54.

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed research. *Research in the Schools*, *13*(1), 48-63.

Ostman, M., & Kjellin, L. (2002). Stigma by association. *The British Journal of Psychiatry*, *181*(6), 494-498.

Oxman, A. D., & Guyatt, G. H. (1988). Guidelines for reading literature reviews. *CMAJ: Canadian Medical Association journal*, *138*(8), 697.

Padela, A. I., Killawi, A., Forman, J., DeMonner, S., & Heisler, M. (2012). American Muslim perceptions of healing key agents in healing, and their roles. *Qualitative health research*, *22*(6), 846-858.

Panic, N., Leoncini, E., de Belvis, G., Ricciardi, W., & Boccia, S. (2013). Evaluation of the endorsement of the preferred reporting items for systematic reviews and meta-analysis (PRISMA) statement on the quality of published systematic review and meta-analyses. *PloS one*, *8*(12), e83138.

Parle, S. (2011). How does stigma affect people with mental illness?. *Nursing times*, *108*(28), 12-14.

Patton, G. C., Coffey, C., Carlin, J. B., Degenhardt, L., Lynskey, M., & Hall, W. (2002). Cannabis use and mental health in young people: cohort study. *Bmj*, *325*(7374), 1195-1198.

Patton, G. C., Coffey, C., Sawyer, S. M., Viner, R. M., Haller, D. M., Bose, K., ... & Mathers, C. D. (2009). Global patterns of mortality in young people: a systematic analysis of population health data. *The Lancet*, *374*(9693), 881-892.

Pautasso, M., Dehnen-Schmutz, K., Holdenrieder, O., Pietravalle, S., Salama, N., Jeger, M. J., ... & Hehl-Lange, S. (2010). Plant health and global change–some implications for landscape management. *Biological Reviews*, *85*(4), 729-755.

Peat, J., Mellis, C., & Williams, K. (Eds.). (2002). *Health science research: a handbook of quantitative methods*. Sage.

Pelzang, R. (2010). Attitude of nurses towards mental illness in Bhutan. *Journal of Bhutan Studies*, *22*(3), 60-77.

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.

Penn, D. L., & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly*, *69*(3), 235-247.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared?. *Journal of Health and Social Behavior*, *41(2)*,188-207.

Pilgrim, D., & Rogers, A. E. (2005). Psychiatrists as social engineers: A study of an anti-stigma campaign. *Social science & medicine*, *61*(12), 2546-2556.

Pinfold, V., Byrne, P., & Toulmin, H. (2005). Challenging stigma and discrimination in communities: a focus group study identifying UK mental health service users' main campaign priorities. *International Journal of Social Psychiatry*, *51*(2), 128-138.

Pinto, M. D., Hickman, R., Logsdon, M. C., & Burant, C. (2012). Psychometric evaluation of the revised attribution questionnaire (r-AQ) to measure mental illness stigma in adolescents. *Journal of nursing measurement*, *20*(1), 47.

Pirkis, J., & Francis, C. (2012). Mental illness in the news and the information media. *A critical review. www. mindframe-media. info*.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.

Poreddi, V., Thimmaiah, R., & Pashupu, D. R. (2014). Undergraduate Nursing Students' Attitudes towards Mental Illness: Implications for Specific Academic Education. *Indian journal of psychological medicine*, *36*(4), 368.

Powell, R. A., Single, H. M., & Lloyd, K. R. (1996). Focus groups in mental health research: enhancing the validity of user and provider questionnaires. *International Journal of Social Psychiatry*, *42*(3), 193-206.

Pridmore, S., & Pasha, M. I. (2004). Psychiatry and Islam. *Australasian Psychiatry*, *12*(4), 380-385.

Procter, N., & Hafner, J. (1991). Student nurses' attitudes to psychiatry: the influence of training and personality. *Journal of Advanced Nursing*, *16*(7), 845-849.

Psarra, V., Sestrini, M., Santa, Z., Petsas, D., Gerontas, A., Garnetas, C., & Kontis, K. (2008). Greek police officers' attitudes towards the mentally ill. *International journal of law and psychiatry*, *31*(1), 77-85.

Qureshi, N. A. (2010). Triage systems: a review of the literature with reference to Saudi Arabia/Systèmes de triage: revue de la littérature et référence à l'Arabie saoudite. *Eastern Mediterranean Health Journal*, *16*(6), 690.

Qureshi, N. A., Al-Habeeb, T. A., Al-Ghamdy, Y. S., Magzoub, M. M., & Schmidt, H. (2001). Psychiatric referrals. In primary care and general hospitals in Qassim Region, Saudi Arabia. *Saudi medical journal*, *22*(7), 619-624.

Qureshi, N. A., Al-Habeeb, A. A., & Koenig, H. G. (2013). Mental health system in Saudi Arabia: an overview. *Neuropsychiatr Dis Treat*, *9*, 1121-35.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the nutrition society*, *63*(04), 655-660.

Rafii, S., Avecilla, S., Shmelkov, S., Shido, K., Tejada, R., Moore, M. A., ... & Hattori, K. (2003). Angiogenic factors reconstitute hematopoiesis by recruiting stem cells from bone marrow microenvironment. *Annals of the New York Academy of Sciences*, *996*(1), 49-60.

Raiborn, C. A., & Payne, D. (1990). Corporate codes of conduct: A collective conscience and continuum. *Journal of business Ethics*, *9*(11), 879-889.

Ramayah, T., May, O. S., & Omar, A. (2008). Behavioral determinants of online banking adoption: Some evidence from a multicultural society. *Journal of Management*, *2*(3), 29-37.

Rassool, G. H. (2000). The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. *Journal of advanced nursing*, *32*(6), 1476-1484.

Ratner, C., & El-Badwi, E. S. (2011). A cultural psychological theory of mental illness, supported by research in Saudi Arabia. *Journal of Social Distress and the Homeless*, *20*(3-4), 217-274.

Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: a review of the 'mental illness is an illness like any other'approach. *Acta Psychiatrica Scandinavica*, *114*(5), 303-318.

Read, J., & Law, A. (1999). The relationship of causal beliefs and contact with users of mental health services to attitudes to the'mentally ill'. *International Journal of Social Psychiatry*, *45*(3), 216-229.

Reavley, N. J., Mackinnon, A. J., Morgan, A. J., Alvarez-Jimenez, M., Hetrick, S. E., Killackey, E., ... & Jorm, A. F. (2012). Quality of information sources about mental disorders: a comparison of Wikipedia with centrally controlled web and printed sources. *Psychological medicine*, *42*(08), 1753-1762.

Redsell, S. A., & Cheater, F. M. (2001). The Data Protection Act (1998): implications for health researchers. *Journal of Advanced Nursing*, *35*(4), 508-513.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems?. *Medical Journal of Australia*, *187*(7), 35.

Ricoeur, P. (1991). What is a text. *From text to action: Essays in hermeneutics, II*, 105-124.

Robson, C. (1993). *Real world research: A resource for social scientists and practitioner-researchers*. Oxford, UK: Blackwell

Royster, P. (2005). University of Nebraska-Lincoln Digital Commons.

Rubin, A., & Babbie, E. (2016). *Empowerment Series: Research Methods for Social Work*. Cengage Learning.

Ruiz, J., & Miller, C. (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police Quarterly*, *7*(3), 359-371.

Salter, M., & Byrne, P. (2000). The stigma of mental illness: how you can use the media to reduce it. *The Psychiatrist*, *24*(8), 281-283.

Salve, H., Goswami, K., Sagar, R., Nongkynrih, B., & Sreenivas, V. (2013). Perception and Attitude towards Mental Illness in an Urban Community in South Delhi–A Community Based Study. *Indian journal of psychological medicine*, *35*(2), 154.

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description?. *Research in nursing and health*, *23*(4), 334-340.

Scheick, D. M. (2011). Developing self-aware mindfulness to manage countertransference in the nurse-client relationship: an evaluation and developmental study. *Journal of Professional Nursing*, *27*(2), 114-123.

Schulze, B. (2007). Stigma and mental health professionals: a review of the evidence on an intricate relationship. International Review of Psychiatry, 19(2), 137-155.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social science & medicine*, *56*(2), 299-312.

Schomerus, G., & Angermeyer, M. C. (2008). Special articles stigma and its impact on help-seeking for mental disorders: what do we know. *Epidemiol Psichiatr Soc*, *17*(1), 31.

Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M. G., & Angermeyer, M. C. (2011). The stigma of alcohol dependence compared with other mental disorders: a review of population studies. *Alcohol and Alcoholism*, *46*(2), 105-112.

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2006). Preferences of the public regarding cutbacks in expenditure for patient care. *Social psychiatry and psychiatric epidemiology*, *41*(5), 369-377.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social science & medicine*, *56*(2), 299-312.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for evaluation*, *2007*(114), 11-25.

Seloilwe, E. S. (2006). Experiences and demands of families with mentally ill people at home in Botswana. *Journal of Nursing Scholarship*, *38*(3), 262-268.

Sévigny, R., Wenying, Y., Peiyan, Z., Marleau, J. D., Zhouyun, Y., Lin, S., ... & Haijun, W. (1999). Attitudes toward the mentally ill in a sample of professionals working in a psychiatric hospital in Beijing (China). *International Journal of Social Psychiatry*, *45*(1), 41-55.

Shalowitz, D., & Wendler, D. (2006). Informed consent for research and authorization under the Health Insurance Portability and Accountability Act Privacy Rule: an integrated approach. *Annals of Internal Medicine*, *144*(9), 685-688.

Shamseer, L., Moher, D., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M., ... & Stewart, L. A. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: elaboration and explanation. *Bmj*, *349*, g7647.

Sharan, P., Gallo, C., Gureje, O., Lamberte, E., Mari, J. J., Mazzotti, G., ... & de Francisco, A. (2009). Mental health research priorities in low-and middle-income countries of Africa, Asia, Latin America and the Caribbean. *The British Journal of Psychiatry*, *195*(4), 354-363.

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*(pp. 1-3). London: Sainsbury Centre for Mental Health.

Shibre, T., Negash, A., Kullgren, G., Kebede, D., Alem, A., Fekadu, A., ... & Jacobsson, L. (2001). Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia.*Social Psychiatry and Psychiatric Epidemiology*, *36*(6), 299-303.

Siebert, DC. (2004). Depression in North Carolina social workers: Implications for practice and research. *Social Work Research*. 28 (1), 30–40.

Silton, N. R., Flannelly, K. J., Milstein, G., & Vaaler, M. L. (2011). Stigma in america: Has anything changed?: impact of perceptions of mental illness and dangerousness on the desire for social distance: 1996 and 2006. *The Journal of nervous and mental disease*, *199*(6), 361-366.

Silver, C., & Lewins, A. (2014). *Using software in qualitative research: A step-by-step guide*. Sage.

Sim, J., & Wright, C. C. (2005). The kappa statistic in reliability studies: use, interpretation, and sample size requirements. *Physical therapy*, *85*(3), 257-268.

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B. S. (2001). Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric services*

Small, M. L. (2009). How many cases do I need?'On science and the logic of case selection in field-based research. *Ethnography*, *10*(1), 5-38.

Smith, J. A. (Ed.). (2015). *Qualitative psychology: A practical guide to research methods*. Sage.

Socall, D. W., & Holtgraves, T. (1992). Attitudes toward the mentally ill. *The Sociological Quarterly*, *33*(3), 435-445.

Song, L. Y., Chang, L. Y., Shih, C. Y., Lin, C. Y., & Yang, M. J. (2005). Community attitudes towards the mentally ill: The results of a national survey of the Taiwanese population. *International Journal of Social Psychiatry*, *51*(2), 162-176.

Soteriou, A., & Zenios, S. A. (1999). Operations, quality, and profitability in the provision of banking services. *Management science*, *45*(9), 1221-1238.

Srinivasu, R., Reddy, G. S., & Rikkula, S. R. (2011). Utility of quality control tools and statistical process control to improve the productivity and quality in an industry. *International Journal of Reviews in Computing*, *5*, 15-20.

Stain, H. J., Galletly, C. A., Clark, S., Wilson, J., Killen, E. A., Anthes, L., ... & Harvey, C. (2012). Understanding the social costs of psychosis: the experience of adults affected by psychosis identified within the second Australian National Survey of Psychosis. *Australian and New Zealand Journal of Psychiatry*, *46*(9), 879-889.

Stanley, L., & Wise, S. (2002). *Breaking out again: Feminist ontology and epistemology*. Routledge.

Steinemann, S., Furoy, D., Yost, F., Furumoto, N., Lam, G., & Murayama, K. (2006). Marriage of professional and technical tasks: a strategy to improve obtaining Informed consent. *American Journal of Surgery*. 191 (5), 696-700.

Stengler-Wenzke, K., Trosbach, J., Dietrich, S., & Angermeyer, M. C. (2004). Experience of stigmatization by relatives of patients with obsessive compulsive disorder. *Archives of psychiatric nursing*, *18*(3), 88-96.

Stewart, D. W., & Shamdasani, P. N. (2014). *Focus groups: Theory and practice* (Vol. 20). Sage publications.

Stolley, J. M., & Koenig, H. (1997). Religion/spirituality and health among elderly African Americans and Hispanics. *Journal of psychosocial nursing and mental health services*, *35*(11), 32-38.

Strauss, G., Glenn, M., Reddi, P., Afaq, I., Podolskaya, A., Rybakova, T., ... & El-Mallakh, R. S. (2005). Psychiatric disposition of patients brought in by crisis intervention team police officers. *Community mental health journal*,*41*(2), 223-228.

Stuart, H. (2003). Stigmatisation. Leçons tirées des programmes visant sa diminution. *Santé mentale au Québec*, *28*(1), 54-72.

Stuart, H. (2005). Why stigma matters and why it should be beaten. *World Psychiatry*, *4*(51), 6-7.

Suckley, L., Kelly, S., Legge, D., & Pinder, J. (2014). Connecting workspace and health: a case study.

Sun, J., Xu, W., & Feng, B. (2004). A global search strategy of quantum-behaved particle swarm optimization. *Cybernetics and Intelligent Systems*, *1* (1), 111-116.

Symonds, J. E., & Gorard, S. (2010). Death of mixed methods? Or the rebirth of research as a craft. *Evaluation & Research in Education*, *23*(2), 121-136.

Talic, N., & Alshakhs, M. (2008). Perception of facial profile attractiveness by a Saudi sample. Saudi Dental Journal, 20(1), 17-23.

Tamim, H., Hejaili, F., Jamal, A., al Shamsi, H., & Al Sayyari, A. (2010). Professional boundary ethics attitudes and awareness among nurses and physicians in a university hospital in the Kingdom of Saudi Arabia. *Ethics & Behavior*, *20*(1), 21-32.

Tanskanen, S., Morant, N., Hinton, M., Lloyd-Evans, B., Crosby, M., Killaspy, H., ... & Johnson, S. (2011). Service user and carer experiences of seeking help for a first episode of psychosis: a UK qualitative study. *BMC psychiatry*, *11*(1), 1.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches* (Vol. 46). Sage.

Taylor, P. J., Awenat, Y., Gooding, P., Johnson, J., Pratt, D., Wood, A., & Tarrier, N. (2010). The subjective experience of participation in schizophrenia research: A practical and ethical issue. *The Journal of nervous and mental disease*, *198*(5), 343-348.

Taylor, T. L., Killaspy, H., Wright, C., Turton, P., White, S., Kallert, T. W., ... & Kališová, L. (2009). A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. *Bmc Psychiatry*, *9*(1), 1.

Taylor, S. J., Pinnock, H., Epiphaniou, E., Pearce, G., Parke, H. L., Schwappach, A., ... & Sheikh, A. (2014). A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: PRISMS–Practical systematic Review of Self-Management Support for long-term conditions.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling a typology with examples. *Journal of mixed methods research*, *1*(1), 77-100.

Thomas, R. M. (2003). *Blending qualitative and quantitative research methods in theses and dissertations*. Corwin Press.

Thornicroft, G., Brohan, E., Kassam, A., & Lewis-Holmes, E. (2008). Reducing stigma and discrimination: Candidate interventions. *International Journal of Mental Health Systems*, *2*(1), 1.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., Leese, M., & INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet*, *373*(9661), 408-415.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination?. *The British Journal of Psychiatry*,*190*(3), 192-193.

Thornicroft, G., Rose, D., & Mehta, N. (2010). Discrimination against people with mental illness: what can psychiatrists do?. *Advances in psychiatric treatment*, *16*(1), 53-59.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative inquiry*, *16*(10), 837-851.

Tricco, A. C., Strifler, L., Veroniki, A. A., Yazdi, F., Khan, P. A., Scott, A., ... & Cardoso, R. (2015). Comparative safety and effectiveness of long-acting inhaled agents for treating chronic obstructive pulmonary disease: a systematic review and network meta-analysis. *BMJ open*, *5*(10), e009183.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of advanced nursing*, *48*(4), 388-396.

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC medical research methodology*, *12*(1), 1.

Trusov, M., Bucklin, R. E., & Pauwels, K. (2009). Effects of word-of-mouth versus traditional marketing: findings from an internet social networking site. *Journal of marketing*, *73*(5), 90-102.

Tsang, H. W., Tam, P. K., Chan, F., & Cheung, W. M. (2003). Stigmatizing attitudes towards individuals with mental illness in Hong Kong: Implications for their recovery. *Journal of Community Psychology*, *31*(4), 383-396.

Tuckett, A. G. (2005). Part II. Rigour in qualitative research: complexities and solutions: Anthony G Tuckett outlines the strategies and operational techniques he used to attain rigour in a qualitative research study through relying on Guba and Lincoln's trustworthiness criterion. Research strategies such as use of personal journals, audio recording and transcript auditing, and operational techniques including triangulation strategies and peer review, are examined. *Nurse researcher*, *13*(1), 29-42.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: a researcher's experience. *Contemporary Nurse*, *19*(1-2), 75-87.

Ucok, A., Polat, A., Sartorius, N., Erkoc, S., & Atakli, C. (2004). Attitudes of psychiatrists toward patients with schizophrenia. *Psychiatry and Clinical Neurosciences*, *58*(1), 89-91.

Vancampfort, D., Rosenbaum, S., Probst, M., Connaughton, J., du Plessis, C., Yamamoto, T., & Stubbs, B. (2016). Top 10 research questions to promote physical activity in bipolar disorders: A consensus statement from the International Organization of Physical Therapists in Mental Health. *Journal of affective disorders*, *195*, 82-87.

Van-Teijlingen, E. R., Rennie, A. M., Hundley, V., & Graham, W. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey. *Journal of advanced nursing*, *34*(3), 289-295.

Vauth, R., Kleim, B., Wirtz, M., & Corrigan, P. W. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia.*Psychiatry research*, *150*(1), 71-80.

Veltman, A., Cameron, J. I., & Stewart, D. E. (2002). The experience of providing care to relatives with chronic mental illness. *The Journal of nervous and mental disease*, *190*(2), 108-114.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325.

Wahab, Y. A., Rahim, R. A., Rahiman, M. H. F., Aw, S. R., Yunus, F. R. M., Goh, C. L., ... & Ling, L. P. (2015). Non-invasive process tomography in chemical mixtures–A review. *Sensors and Actuators B: Chemical*, *210*, 602-617.

Wahass, S., & Kent, G. (1997). A comparison of public attitudes in Britain and Saudi Arabia towards auditory hallucinations. *International Journal of Social Psychiatry*, *43*(3), 175-183.

Wahl, O. F. (1999). Mental health consumers' experience of stigma.*Schizophrenia bulletin*, *25*(3), 467.

Wahl, O., & Aroesty, E. (2010). Attitudes of mental health professionals about mental illness: a review of the recent literature. *Journal of Community Psychology*, *38*(1), 49-62.

Wahlbeck, K., & Aromaa, E. (2011). Research on stigma related to mental disorders in Finland: a systematic literature review. *Psychiatrica Fennica*, *42*, 87-109.

Walach, H., Buchheld, N., Buttenmüller, V., Kleinknecht, N., & Schmidt, S. (2006). Measuring mindfulness—the Freiburg mindfulness inventory (FMI).*Personality and Individual Differences*, *40*(8), 1543-1555.

Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). Police officers' attitudes toward and decisions about persons with mental illness. *Psychiatric Services* .

Webb, C., & Kevern, J. (2001). Focus groups as a research method: a critique of some aspects of their use in nursing research. *Journal of advanced nursing*, *33*(6), 798-805.

Webb, D., & McMurran, M. (2007). Nursing staff attitudes towards patients with personality disorder. *Personality and Mental Health*, *1*(2), 154-160.

Welch, V., Petticrew, M., Tugwell, P., Moher, D., O'Neill, J., Waters, E., & White, H. (2013). PRISMA-Equity 2012 extension: reporting guidelines for systematic reviews with a focus on health equity. *Revista Panamericana de Salud Pública*, *34*(1), 60-67.

Wellington, J. J., Bathmaker, A. M., Hunt, C., McCulloch, G., & Sikes, P. (2005). *Succeeding with your Doctorate*. Sage.

Westbrook, C., Creswell, J. D., Tabibnia, G., Julson, E., Kober, H., & Tindle, H. A. (2013). Mindful attention reduces neural and self-reported cue-induced craving in smokers. *Social Cognitive and Affective Neuroscience*, *8*(1), 73-84.

Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of advanced nursing*, *52*(5), 546-553.

Wiederman, M. W. (1999). Volunteer bias in sexuality research using college student participants. *Journal of Sex Research*, *36*(1), 59-66.

Willis, J. W., Jost, M., & Nilakanta, R. (2007). *Foundations of qualitative research: Interpretive and critical approaches*. Sage.

Wilson, H. S., & Hutchinson, S. A. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research*, *1*(2), 263-276.

Wilson, C., Nairn, R., Coverdale, J., & Panapa, A. (2000). How mental illness is portrayed in children's television. *The British Journal of Psychiatry*, *176*(5), 440-443.

Witherell, G. W., & Beineke, P. (2001). Statistical analysis of combined substitutions in nonstructural 5A region of hepatitis C virus and interferon response. *Journal of medical virology*, *63*(1), 8-16.

Wright, E. R., Gronfein, W. P., & Owens, T. J. (2000). Deinstitutionalization, social rejection, and the self-esteem of former mental patients. *Journal of health and social behavior*, 41 (1), 68-90.

World Health Organization, WHO. (2001). World Health Organization spotlights mental health. *American Psychological Association*, 32 (2), 12.

World Health Organization, WHO. (2003). Caring for children and adolescents with mental disorders: setting WHO directions.

WonPat-Borja, A. J., Yang, L. H., Link, B. G., & Phelan, J. C. (2012). Eugenics, genetics, and mental illness stigma in Chinese Americans. *Social psychiatry and psychiatric epidemiology*, *47*(1), 145-156.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine*, *64*(7), 1524-1535.

Yusuf, A. J., Nuhu, F. T., & Akinbiyi, A. (2009). Caregiver burden among relatives of patients with schizophrenia in Katsina, Nigeria. *South African Journal of Psychiatry*, *15*(2),14-23.

Zahavi, D. (1996). Husserl's intersubjective transformation of transcendental philosophy. *Journal of the British Society for Phenomenology*, *27*(3), 228-245.

Zaini, R. G., Bin Abdulrahman, K. A., Al-Khotani, A. A., Al-Hayani, A. M. A., Al-Alwan, I. A., & Jastaniah, S. D. (2011). Saudi Meds: A competence specification for Saudi medical graduates.

Zartaloudi, A., & Madianos, M. G. (2010). Mental health treatment fearfulness and help-seeking. *Issues in mental health nursing*, *31*(10), 662-669.

APPENDICES

Appendix I

PRISMA Guidelines for systematic reviews and meta-analyses

Section/topic	#	Checklist item
TITLE		
Title	1	Identify the report as a systematic review, meta-analysis, or both
ABSTRACT		
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.
INTRODUCTION		
Rationale	3	Describe the rationale for the review in the context of what is already known.
Objectives	4	Provide an explicit statement of questions being addressed regarding participants, interventions, comparisons, outcomes, and study design (PICOS).
METHODS		
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, a length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in a systematic review, and, if applicable, included in the meta-analysis).
Data collection process	10	Describe a method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.

Risk of bias in individual studies	12	Describe methods used for assessing the risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.
Summary measures	13	State the principal summary measures (e.g., risk ratio, a difference in means).
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I2) for each meta-analysis.
Risk of bias across studies	15	Specify any assessment of the risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.
RESULTS		
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.
Risk of bias within studies	19	Present data on the risk of bias of each study and, if available, any outcome-level assessment (see item 12).
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.
Risk of bias across studies	22	Present results of any assessment of the risk of bias across studies (see Item 15).
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).
DISCUSSION		
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policymakers).
Limitations	25	Discuss limitations at study and outcome level (e.g., a risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.
FUNDING		
Funding	27	Describe sources of funding for the systematic review and other support (e.g., a supply of data); a role of funders for the systematic review.

The PRISMA Group.

Appendix II

[HCPRDU] Evaluation tools

Evaluation Tool for 'Mixed Methods' Study Designs

The 'mixed method' evaluation tool was developed from the evaluation tools for 'quantitative' and 'qualitative' studies,[i] themselves created within the context of a project exploring the feasibility of undertaking systematic reviews of research literature on effectiveness and outcomes in social care. The 'mixed method' tool draws on appropriate questions from the quantitative and qualitative evaluation tools. It provides a template of key questions to assist in the critical appraisal of studies using more than one method.[ii]

Review Area	Key Questions
(1) STUDY EVALUATIVE OVERVIEW	
Bibliographic Details	• Author, title, source (publisher and place of publication), year
Purpose	• What are the aims of this paper? • If the paper is part of a wider study, what are its aims?
Key Findings	• What are the key findings?
Evaluative Summary	• What are the strengths and weaknesses of the study and theory, policy and practice implications?
(2) STUDY AND CONTEXT (SETTING, SAMPLE AND OUTCOME MEASUREMENT)	
The Study	• What type of study is this? • What was the intervention? • What was the comparison intervention? • Is there sufficient detail given of the nature of the intervention and the comparison intervention? • What is the relationship of the study to the area of the topic review?
Context: (1) Setting	• Within what geographical and care setting is the study carried out? • What is the rationale for choosing this setting? • Is the setting appropriate and/or sufficiently specific for examination of the research question? • Is sufficient detail given about the setting? • Over what time period is the study conducted?
Context II: Sample	• What was the source population? • What were the inclusion criteria? • What were the exclusion criteria? • How was the sample (events, persons, times and settings) selected? (For example, theoretically informed, purposive, convenience, chosen to explore contrasts) • Is the sample (informants, settings and events) appropriate to the aims of the study? • If there was more than one group of subjects, how many groups were there, and how many people were in each group? • Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? • What are the key characteristics of the sample (events, persons, times and settings)?
Context III: Outcome Measurement	• What outcome criteria were used in the study? • Whose perspectives are addressed (professional, service, user, carer)? • Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)?

Appendix III

Search Strategy

Shows the databases that were searched using a combination of keywords (free text searching), subject headings to represent the concepts in the following table. The strategies were slightly adjusted to meet the specific functions and terminology of each database. The searches were limited to studies published after 1990 and by the inclusion criteria.

Search Strategy

Sources Searched	Keywords	No. Of Studies	Inclusion Criteria
CINAHL	The key search terms used were 'mental illness', 'exclusion' and 'inclusion'. The search terms used to describe the experience of the study subjects included 'mental health problem* and stigma*' along with 'stigma*', 'prejudice and stigma*', 'stereotype and stigma*', 'mental health professional* and stigma*' 'discrimination and stigma*'.	618 studies 1 selected	Using qualitative or quantitative approach as a method of research. Professional held stigma against people living with mental health problems. Drawn from the disciplines of psychiatry, psychology, social worker, mental health nurse, and faculty of mental health nurse. Written in English, the articles in medical or nursing field published the English language; the main science articles analysed in this area are published in the English language. All articles must have been published between 1990 and 2016; and all articles must be original research from the database, the rationale of this requirement is to ensure that research is of high quality thereby ensuring that the articles are of a high validity (Sun, Xu, & Feng, 2004). The search terms used to describe the experience of the study subjects included; depression, bipolar, paranoid, mania, personality disorder, schizophrenia, and stigma on mental health problems, mental health problems, mental illness and mental disorders, according to Jackson and Heatherington (2006) and Crisp, Gelder, Goddard and Meltzer (2005), the people with
MEDLINE		911 studies 2 selected	
PsycINFO		412 studies 2 selected	
Since Direct		113 studies 1 selected	
British Humanities Index		62 studies (Not relevant)	
British Nursing Index		121 studies (Not relevant)	
Applied Social Science Index and Abstract (ASSIA)		26 studies (Not relevant)	
International bibliography of social science (IBSS)		51 studies (Not relevant)	

Sources Searched	Keywords	No. Of Studies	Inclusion Criteria
EBSCO		212 studies (Not relevant)	mental health problems are most commonly stigmatised are depression, bipolar disorder and schizophrenia, so these conditions were selected as search terms. And only articles concerning the impact, attitudes and observations of mental health professionals are selected, this form of research offers further insight into stigma and its related factors and thus makes a valuable contribution to the topic (Schulze & Angermeyer, 2003).
Social services abstract		52studies (Not relevant)	
PsycARTICLES Full Text		102 studies 2 selected	
Grey literature		20 studies (Not relevant)	

Appendix IV

Data extractions of search strategies studies

No.	Author	Study location	Design and Data collection Method	Measures used	Sample	Research aim	Main findings
1	Eker and Arkar (1991)	The Turkish city of Izmir.	Quantitative Cross-sectional survey .	Self-report questionnaire to measure the social distance	91 psychiatric nurses.	Examined the attitudes towards people with mental health problems.	Those psychiatric nurses wanted to avoid paranoid schizophrenia more than both anxiety and depression.
2	Kua, Parker, Le and Jorm (2000)	Singapore .	Quantitative Cross-sectional Group survey comparisons	Self-report questionnaire to measure the attitude toward people with mental health problems.	42 participants in Out-patient department ‘practitioners in professional mental health’, 41 participant’s in in-patient department ‘practitioners in professional mental health’.	Explore the attitudes of mental health practitioners towards people living with mental health problems such as, schizophrenia, major depression and mania.	Out-patient mental health practitioners rated a higher proportion of more professional held stigma towards those people with mental health problems than mental health practitioners in in-patient department.

3	Crabtree (2003)	Malaysia.	Qualitative Correlational	Observation of everyday practices, examination of hospital records, and interviews. An ethnographic approach.	15 psychiatrists 32 psychiatric nurses.	To gain an understanding of workplace culture in Sarawak, East Malaysia, to explore the issue of professionals stigmatising people with mental health problems.	Psychiatrists mentioned the likelihood of patients who are psychotic becoming violent during assessment prior to hospitalisation, whereas mental health nurses were more concerned with the possible dangers related to the monitoring of non-psychotic patients.
4	Aydin Yigit, Inandi, and Kirpinar (2003)	In the Turkish city of Erzurum Ataturk Universit y Hospital.	Quantitative Cross-sectional cultural group survey	comparison Self-report questionnaire to assess the Social Cultural Attitudes and social distance toward people with mental health problems.	The 160 participants were chosen at random and included 40 academics, 40 psychiatrists, 40 psychiatric nurses and 40 hospital workers.	A comparative analysis of the attitudes of hospital employees from several psychiatric clinics.	Positive attitudes, as reflected in reduced social distancing, were observed mostly among hospital workers.

5	Ucok, Polat, Sartorius, Erkoc and Atakli (2004)	Turkish.	Quantitative Cross-sectional survey	Self-report questionnaire to measure the attitude and social distance toward people with schizophrenia ‘.	60 psychiatrists.	Analysed the attitudes psychiatrists had stigma attitude towards people with schizophrenia.	Much of participants (95%) named schizophrenia as the most serious mental health problems from the perspective of the public.
6	Liggins and Hatcher (2005)	New Zeeland.	Qualitative Cross-sectional	The audio-recorded interviews with participants from general hospitals.	5 participants in mental Health workers.	Investigating how patients and mental health professionals experienced stigma based on a Liaison Psychiatry service.	The different perspectives on people with mental health problems were grouped into several categories within stereotyping and labelling the people with mental health problem.
7	Nordt, Rossler and Lauber (2006)	Switzerla nd, In 29 hospitals.	Qualitative and quantitative Cross-sectional	Interview, and self-report questioner to measure the social distance and attitude scale towards people with mental health problems.	1073 Mental health professionals (Social workers, psychiatric physiotherapi sts, mental health nurses, and Psychologists) and public participants 1737.	Examined the behaviour of employees at psychiatric inpatient and outpatient in the Switzerland were examined and compared with the behaviour of the public.	Psychiatrists were shown to have preconceived negative opinions of those with mental health problems more so than members of the public or other mental health professionals.

8	Mathews (2007)	Singapore.	Quantitative Cross-sectional cultural group survey	comparison Questionnaires to examine attitudes and knowledge.	79 psychiatric nurses and 21 psychiatrists.	Explored the issue of professional stigmatizing people with mental health problems.	A proportion of 60% of the nurses stated that they were derided، humiliated, and frustrated due to their line of work, while 30% mentioned that their own relatives attempted to dissuade them from entering the field of psychiatry. Furthermore, 51% of psychiatric nurses and 15 %of psychiatrists admitted that, if they had the choice again, they would avoid the psychiatric profession and people with mental health problems.

Appendix V

Emotional Reaction on People with mental health problems Scale
Quantitative questions
الاستبيان الكمي
مقياس الرد الفعلي العاطفي للأمراض العقلية والنفسية

Nationality:
Sex:
Specialist:
Experience:
Place of work:
Qualification:

No. الرقم	Item الفقرة	Item الفقرة	Strongly agree اوافق بشدة	Agree اوافق	Neutral عادي	Disagree غير موافق	Strongly disagree غير موافق و بشدة
1	The behaviour of People with mental health problems is unpredictable.	لا يمكن التنبؤ بسلوك وأفعال الاشخاص المصابين بالأمراض العقلية او النفسية					
2	Conversing with People with mental health problems is difficult.	التحدث مع شخص مختل عقليا او نفسيا أمر صعب					
3	Individuals suffering from mental health issues are considered a burden on others.	الاشخاص المصابين بمرض عقلي ونفسي يشكلون عبئا على الآخرين					
4	Individuals with a history of mental illness should be prohibited from employment in government positions.	لا ينبغي أن يسمح للأفراد الذين لديهم تاريخ مرضي في المرض العقلي والنفسي لمناصب الحكومة					
5	Segregation of the People with mental health problems from the rest of society is wrong.	فصل وإبعاد المريض العقلي والنفسي عن المجتمع هو أمر خاطئ.					
6	The rights of the People with mental health problems should be recognized.	ينبغي الاعتراف بحقوق المرضى عقليا ونفسيا					

No. الرقم	Item الفقرة	Item الفقرة	Strongly agree اوافق بشدة	Agree اوافق	Neutral عادي	Disagree غير موافق	Strongly disagree غير موافق و بشدة
7	No responsibilities should be assigned to the People with mental health problems.	ينبغي عدم تعيين وتسليم أي مسؤولية للمريض العقلي او النفسي					
8	It is therapeutic for the People with mental health problems to be integrated into health care, but disadvantageous to the other patients.	يجب ان يكون علاج المريض العقلي او النفسي متكامل مع المجال الصحي ككل في الرعاية الصحية، ولكنه غير متناسب مع الافراد الاخرين الذين يتلقون علاجا صحيا بشكل عام					
9	The arguments of local employees against the establishment of mental health services in the health care centre are well founded.	حجج ومناقشات الموظفين في المجال الصحي هو بعدم انشاء خدمة صحية عقلية ونفسية للمرضى في نفس الرعاية الصحية العامة.					
10	Isolating the People with mental health problems from their workplace is a direct violation of their rights.	عزل المصابين بأمراض عقلية او نفسية من مكان عملهم هو انتهاك مباشر لحقوقهم					
11	People with mental health problems can be developed by anyone.	يمكن تطوير المرض العقلي او النفسي من قبل أي شخص					
12	Society has a duty to ensure quality care for individuals with mental health problems.	يجب على المجتمع بتوفير جودة الرعاية الصحية النفسية للأفراد المصابين بمرض عقلي او نفسي					
13	Keeping the People with mental health problems locked away is the most appropriate way to deal with them.	الحفاظ على المريض النفسي بحبسه او عزلته هو انسب طريقة للتعامل معهم					
14	Isolation of the People with mental health problems from society is necessary.	عزل المريض العقلي او النفسي عن المجتمع هو أمر ضروري					

No. الرقم	Item الفقرة	Item الفقرة	Strongly agree اوافق بشدة	Agree اوافق	Neutral عادي	Disagree غير موافق	Strongly disagree غير موافق و بشدة
15	Social integration of the People with mental health problems is the optimal therapy for them.	الاندماج الاجتماعي للمريض العقلي او النفسي هو العلاج الأمثل بالنسبة لهم					
16	Individuals with mental health problems should not be shown any mercy.	لا ينبغي أن نظهر للأفراد المصابين بمرض عقلي او نفسي أية رحمة في التعامل					
17	It is important to encourage the People with mental health problems to taken on normal life responsibilities.	من المهم تشجيع المريض العقلي او النفسي بإعطائه وتسليمه من مسؤوليات الحياة العادية والطبيعية					
18	Individuals with mental health problems should not be shunned from society.	الأفراد المصابين بمرض عقلي او نفسي لا ينبغي نبذه من المجتمع					
19	An individual should be admitted to hospital at the first sign of mental health problems	يجب ادخال الفرد إلى المستشفى في أول بادرة او علامة من مرض عقلي ونفسي					
20	Mental health services are an unnecessary use of tax money.	خدمات الصحة النفسية هي امر غير ضروري لاستهلاك الصرف عليها					
21	People with mental health problems and individuals with mental health are two different things.	المرضى النفسيين او العقليين والأشخاص ذوي الصحة النفسية هما شيئين مختلفان عن بعضهما البعض					
22	I enjoy creating a personal rapport with my patients.	أنا أستمتع جدا بخلق علاقة شخصية مع مرضاي					
23	I like taking part in competitive activities with people of mental health problem, in-patient department	أحب المشاركة في الأنشطة التنافسية للمرضى النفسيين					

No. الرقم	Item الفقرة	Item الفقرة	Strongly agree اوافق بشدة	Agree اوافق	Neutral عادي	Disagree غير موافق	Strongly disagree غير موافق و بشدة
24	When dealing with People with mental health problems, it is necessary to bear in mind that their behaviour can be unpredictable.	عند التعامل مع المرضى المصابين بأمراض نفسية أو عقليه فمن الضروري أن نضع في اعتبارنا أن سلوكياتهم يمكن بان تكون غير متوقعة					
25	Mental hospitals are intended to separate the People with mental health problems from the rest of society.	يقصد بالمستشفيات العقلية والنفسية، بفصل المريض العقلي او النفسي عن بقية المجتمع					
26	The People with mental health problems may seem to be normal, but one must always remember that they are not.	قد يبدوا المريض العقلي او النفسي كشخص عادي وصحيح نفسيا وعقليا، ولكن يجب أن نتذكر دائما بأنهم ليسوا كذلك					
27	Negative social factors are at the root of mental health problems.	العوامل الاجتماعية السلبية هي اساس المرض العقلي او النفسي					
28	Individuals with a history of mental health problems should not be allowed to hold a job associated with responsibilities.	لا ينبغي أن يسمح للأفراد الذين لديهم تاريخ من المرض العقلي او النفسي بعقد عمل مرتبط بالمسؤوليات					
29	A person with mental health problems is no less important than physical illness.	الأمراض النفسية ليست أقل أهمية من مرض جسدي أخر.					

Appendix VI

Attitude Scale Questionnaire – Short Form (AQ-SF)
Attitude Scale Questionnaire – Short Form (AQ-SF)الاستبيان القصي

Nationality:
Sex:
Specialist:
Experience:
Place of work:
Qualification:

No. الرقم	Item الفقرة	Item الفقرة	Rarely قليل	Sometimes بعض الآحيان	Frequency دائما
1	I would think that it was a person with a mental health problem own fault that he is in the present condition.	الشخص المصاب بالمرض العقلي او النفسي، هو خطاه شخصيا ببقائه مريضا عقليا ونفسيا للوقت الحالي			
2	Do you think the psychiatric patient, is the cause of his/her mental problems?	ما هو برأيك، هل يمكن للمريض العقلي او النفسي السيطرة على مسببات مرضه النفسي في الوقت الحالي			
3	How responsible, do you think, is a person with a mental health problem for his present condition?	هل يمكن للمريض العقلي او النفسي في الوقت الحاضر بأن يتحمل مسؤولية			
4	I would feel aggravated by people with mental health problems.	اشعر بتفاقم من الغضب من الاشخاص المصابين بمرض عقلي او نفسي			
5	I would feel anxious or very uneasy in the presence of the person with mental health problems.	قد أشعر بالقلق أو بعدم الارتياح للغاية في وجود شخص مصاب بمرض عقلي او نفسي			
6	I don't think that I can relax and be myself when I'm around someone with mental health problems.	لا أعتقد أنني يمكنني الاسترخاء حقا او الراحة مع نفسي عندما يكون حولي او معي مريض عقلي او نفسي			
7	I would feel pity for people with mental health problems.	قد اشعر بالشفقة للأشخاص الذين يعانون من مرض عقلي او نفسي			
8	How much sympathy would you feel for people with mental health problems?	وكم اشعر بالتعاطف للأشخاص الذين يعانون من مرض عقلي او نفسي			

No. الرقم	Item الفقرة	Item الفقرة	Rarely قليل	Sometimes بعض الآحيان	Frequency دائما
9	How much concern would you feel for people with mental health problems?	وكم أشعر بقلق على الاشخاص الذين يعانون من مرض عقلي او نفسي			
10	I would be willing to talk to people about those mental health problems.	سأكون على استعداد للتحدث إلى الأشخاص الذين يعانون من مرض عقلي او نفسي عن مشاكلهم			
11	How certain would you feel that you would help?	كيف سيكون شعورك حين ترغب بمساعدة الاشخاص المصابين بالمرض عقلي او نفسي			
12	I would feel compassion for people with mental health problems.	اشعر بالرحمة نحو الاشخاص المصابين بالمرض العقلي او النسفي			
13	I would feel unsafe around a person with mental health problems.	لا اشعر بالأمان في وجود شخص مريض عقليا او نفسيا			
14	The person with mental health problems. Could be dangerous.	المريض العقلي او النفسي هو شخص خطير			
15	The person with mental health problems. Could be unpredictable.	الشخص المصاب بالمرض العقلي او النفسي لديه تصرفات غير متوقعة			
16	People with mental health problems would terrify me.	المريض العقلي او النفسي يسبب لي نوع من الترويع			
17	How scared of people with mental health problems. Would you feel?	كيف هو شعور الخوف لديك باتجاه المريض العقلي او النفسي			
18	When I am around someone with mental health problems, worry that he or she might harm me physically.	عندما أكون مع مريض عقلي او نفسي، اشعر بأنه قد يتسبب لي بأذى جسدي			
19	If I were an employer, I would interview a person with mental health problems for a job.	لو كنت مسؤول او صاحب عمل سوف أقابل مريض نفسي او عقلي متقدم على الوظيفة			
20	I would share a carpool with a person with mental health problems every day.	لا مانع لدي باستخدام المركبة مع شخص مصاب بمرض عقلي او نفسي كل يوم			

No. الرقم	Item الفقرة	Item الفقرة	Rarely قليل	Sometimes بعض الآحيان	Frequency دائما
21	If I were a landlord, I possibly would rent an apartment to the person with mental health problems.	إذا كنت املك منزل ربما قد أؤجر ذلك المنزل لشخص مصاب بمرض عقلي او نفسي			
22	I think a person with mental health problems poses a risk to his/her neighbours unless he/she is hospitalized.	اعتقد بأن الشخص المصاب بمرض عقلي او نفسي يشكل خطورة على الجيران والمجتمع إذا لم يوضع في المستشفى			
23	I think it would be best for people with mental health problems and keep them away in a psychiatric hospital.	وأعتقد أنه سيكون من الأفضل للأشخاص الذين يعانون من مرض عقلي او نفسي بوضعهم بعيدا في مستشفى للأمراض النفسية والعقلية			
24	A person with mental health problems can be isolated from his neighbours.	ما هو ر أيك، بإبعاد المرضى العقليين والنفسيين في مكان بعيد عن حييهم وجيرانهم			
25	If I oversaw person with mental health problems treatment, I would require him to take his medication.	لو كنت مسئولا عن علاج مريض عقلي او نفسي أفضل بأن اطلب منه اخذ علاجه بنفسه			
26	How much do you agree that any person with mental health problems should be forced into treatment with his/her doctor even if he does not want to?	كيف توافق على ذلك إذا كان هناك مريض عقلي او نفسي يجب فرضه وإجباره على تناول العلاج وجلسات العلاج النفسي مع معالجه حتى ان لم يرغب بذلك؟			
27	If I oversaw person with mental health problems treatment, I would force him to live in a group home.	لو كنت مسئولا عن علاج شخص مصاب بمرض عقلي او نفسي لأجبرته بالعيش مع المرضى النفسيين الآخرين بالمكان الخاص بهم.			

Appendix VII

The characteristics of the participants in the study sample of Self–Reported Questionnaires (n=50)

	Frequency	Per cent
Group of specialities		
Faculty of mental health nurse	10	20.0
Psychiatrist	10	20.0
Mental health nurse	10	20.0
Psychologist	10	20.0
Social worker	10	20.0
Nationality		
Saudi	36	72.0
Non-Saudi	14	28.0
Gender		
Male	23	46.0
Female	27	54.0
Qualification		
Diploma	6	12.0
Bachelor	19	38.0
Master	14	28.0
Doctorate	11	22.0
Post-graduate qualification		
No	25	50.0
Yes	25	50.0
Experience years		
<10	24	48.0
10+	26	52.0
Setting		
Nursing College	10	20.0
Mental health hospital	21	42.0
Public Hospital	3	6.0
University Hospital	16	32.0

Appendix VIII

Participants Invitation to focus group discussion / Email

Hello Mrs. / Miss.

I would like to invite you in (….) at (...)/ (...)/2014

In room number (….) at 00:00 am Until 00:00 am, to start our group discussion regarding my research study as the head of the department mentioned you before for; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia.

While, the aim of this study is to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. This study will address a gap in our knowledge and understanding of these phenomena.

It will be my pleasure to see you there.

Thank you for your cooperation

Kind regards.

Researcher /Seham alyousef

Appendix IX

The characteristics of the participants in the study sample of focus group discussion (n=5)

No.	Personal characteristics		
1	Group of specific specialists	Psychiatrist	1
		Psychology	1
		Social worker	1
		Mental health nurse	1
		Faculty of mental health nurse	1
2	Nationality	Saudi	3
		Non- Saudi	2
3	Gender	Male	2
		Female	3
4	Religion	Muslim	4
		Non-Muslim	1
5	Marital status	Married	4
		Non- married	1
6	Qualification	Diploma	1
		Postgraduate	1
		PhD	3
7	Years of professional experience	5-10	2
		26-30	1
		31-35	1
		40+	1
8	Socio- economic status	Low	0
		Middle	3
		High	2
9	Setting of workplace	University Hospital	4
		Nursing College	1
10	Age	25-39	1
		40-59	3
		60+	1

Appendix X

The Qualitative Form

الاستبيان الكمي Qualitative Form

Facilitator's Role: Seham Mansour Alyousef

اسم مقدم الدراسة: سهام منصور اليوسف

Research title:

THE EXTENT OF MENTAL HEALTH PROFESSIONAL STIGMA ON PEOPLE WITH MENTAL HEALTH PROBLEMS IN SAUDI ARABIA

عنوان البحث:

وجود وتأثير المهنيين في الصحة النفسية والعقلية لوصمة العار نحو الأشخاص المصابين بمرض عقلي ونفسي في الرياض، المملكة العربية السعودية

A student of Health and Social Science College at the University of Salford Manchester is undertaking this research. The PhD research study is; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia.

ويجري هذا البحث من قبل طالب من الكلية الصحية والعلوم الاجتماعية في جامعة سالفورد مانشستر. دراسة بحثية دكتوراه وهو: وجود وتأثير المهنيين في الصحة النفسية والعقلية لوصمة العار نحو الأشخاص المصابين بمرض عقلي ونفسي في الرياض، المملكة العربية السعودية

To get as much data as possible for the qualitative viewpoint I will be running discussion with a focus group. I will be asking about; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia.

I am aiming to have 2 participants for one focus group discussion will last for one hour. The focus group will be of mixed categories of people (all the five categories) to elicit different experiences and views.

من أجل الحصول على البيانات قدر الإمكان عن وجهة نظر النوعي وسوف يتم تشغيل والمناقشات مع مجموعة التركيز. وسوف يكون السؤال حول وجود وتأثير وصمة العار لدى المهنيين في الصحة العقلية تجاه الأشخاص الذين يعانون من مشاكل الصحة العقلية، وذلك بالتحدث عن تجاربهم من وصمة العار والمنضوية أفضل الطرق لمكافحته. أسعى أن يكون 2 مشاركين في مجموعة التركيز، وستكون مجموعة المناقشة تستمر لمدة ساعة واحدة. سوف تكون مجموعة التركيز من فئات متباينة من الناس (جميع الفئات الخمس) من أجل انتزاع تجارب مختلفة في وجهات النظر.

I will be asking questions about participant's experience of this internalized stigma and how the participants deal with it when it arises as an issue. You have agreed to participate in this

focus group, so I hope you will find it stimulating. I thank you for your cooperation in completing the questionnaire.

سوف اقوم بطرح أسئلة حول تجربة المهنيين في وصمة العار النفسية والمنضوية كيف يمكن للناس التعامل معها عند نشوئه كقضية. فان كنت قد وافقت على المشاركة بواحدة من هذه المجموعة. فإنني أقدم لك كل الشكر لتعاونكم في استكمال الاستبيان.

The Purpose Study الهدف من هذه الدراسة

The aim of this study is to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia.

This study explores the degree of stigma demonstrated by mental health professionals towards people with mental health problems. This study will address a gap in our knowledge and understanding of these phenomena.

الهدف من هذه الدراسة هو تحديد وجود وتأثير وصمة العار كما يتبين من العاملين في مجال الصحة النفسية لدى المهنيين المشاركين في تقديم وتوفير الرعاية الصحية النفسية في المملكة العربية السعودية

Information for the participant.

That I will prepare for the group meeting by becoming familiar with the definitions of internalized stigma and will prepare the set questions.

التحضير لمجموعة التركيز لكي تصبح مألوفة مع تعريفات من وصمة العار والمنضوية مجموعة الأسئلة

• I need to understand what is the purpose of the group discussion

• تأكد من أن المشاركين يدركون الغرض من هذه المجموعة

• I will fill in and sign a consent form, and indicate whether. I wish to receive copies of the final report.

• يجب على جميع المشاركين في ملء وتوقيع استمارة الموافقة، وبيان ما إذا كانوا يرغبون في الحصول على نسخ من التقرير النهائي.

• I expect that the focus group starts and finishes at the agreed time.

• يبدأ فريق التركيز وينتهي في الوقت المتفق عليه.

•At the beginning of group meeting I will all introduce myself.

• سأقدم نفسي إلى مجموعة المشاركين وكذلك تقديم المشاركين أنفسهم.

• I shall expect to find an environment where all the participants will feel able to express their views, experiences, perception, impact, practice, and opinions.

• السماح للمشاركين بالتعبير عن وجهات النظر والخبرات، والأثر، والآراء.

•There will be ground rules set for the group at the beginning of each meeting (confidentiality, respect for others etc.), and all participants should be aware of these.

• وضع القواعد الأساسية للفريق في البداية (السرية واحترام الآخرين وما إلى ذلك) ، والتأكد من أن جميع المشاركين على بينة من هذه

•I will return the completed consent forms.

• إرجاع استمارات الموافقة بعد الانتهاء منها

What you can expect from the researcher: ما يمكن أن تتوقعه من الباحث:

• She will be available to open the discussion and to talk through what happened during the discussion within the group.

•سوف يكون جاهز لبدء المناقشة والتحدث من خلال ما يحدث في المجموعة.

• She will provide participant information sheets, consent forms, and focus group outlines.

• تقديم أوراق معلومات المشارك، استمارات الموافقة، وتحديد العناوين التي ستناقش في مجموعة التركيز.

Background to the project خلفية المشروع

This research study seeks to examine whether those professionals providing treatment and care for people with mental health problems hold stigmatizing views and beliefs about mental health problems, and how the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. هذا المشروع لمواجهة وجود وتأثير الصمة في الصحة العقلية المهنية تجاه الأشخاص المصابين بمشاكل نفسية او عقلية في المملكة العربية السعودية، وإجراء البحوث والنظر في القضايا ذات خبرة العاملين في مجال الصحة النفسية نحو صمة أشخاص الذين يعانون من مشكلة صحية عقلية.

This study wills specifically the degree of stigma demonstrated by mental health professionals towards people with mental health problems. This study will address a gap in our knowledge and understanding of these phenomena.

ستستكشف هذه الدراسة على وجه التحديد الهدف من هذا الاستعراض لاستكشاف درجة من وصمة العار التي يبديها المهنيين في الصحة النفسية نحو الأشخاص الذين يعانون من مشاكل الصحة النفسية العقلية. وسوف تتناول هذه الدراسة وجود فجوة في معرفتنا وفهمنا لهذه الظاهرة. في الاماكن التي خضعت حتى الآن الحد الأدنى من المراجعة الأدبية أو التي قد تم التحقيق من منظور مختلف.

الهدف من هذه الدراسة هو تحديد وجود وتأثير وصمة العار كما يتبين من العاملين المهنيين في مجال الصحة النفسية العقلية والمشاركة في تقديم توفير الرعاية الصحية النفسية في المملكة العربية السعودية.

Who can participate?

I would like to involve people who have had professional experience of working with the mental health team.

من يمكنه المشاركة؟

وأود أن تتضمن المشاركين الذين لديهم خبرة مهنية في فريق الصحة النفسية.

Participants المشاركين

The mental health care professionals working providing mental health services in Riyadh city will form the study population of this research. These will include the following categories:

المهنيين العاملين في مجال الرعاية الصحية النفسية في اعداد توفير خدمات الصحة النفسية العقلية في مدينة الرياض تشكل مجتمع الدراسة من هذا البحث. وسوف تشمل هذه الفئات التالية:

Psychiatrists.الطبيب النفسي

Clinical psychologists. الاخصائي النفسي

Clinical social workers.الاخصائي الاجتماعي

Mental health nurses.ممرض نفسي

Faculty of mental health nurses.عضو هيئة التدريس في تمريض الصحة النفسية والعقلية

Introduction

Welcome to this group and thank you for taking the time to join this discussion. My name is (Seham Al-Yousef). You have been invited here as you have specific experience and knowledge of caring for those mental health problems and I want to tap into your experiences and views about the stigma held by professional mental health team towards or against the people with mental health problem. There are no right or wrong answers and I expect there will be different opinions, which is why we are a group to discuss our ideas. I would like to encourage everybody to share his or her point of view. I will use a tape-recording the session by video and audio records because I do not want to miss any of your comments. You can ask to stop a video record at any time, without reason and continue our discussion by an audio record. I assure you that your comments will remain confidential and no names will be included in any reports. I'm interested in your views whether they are positive or negative. If you want to follow up what someone has said, please feel free to do so and respond to the person directly. You don't have to respond to me. I am here to ask questions, listen and make sure that everyone has a chance to give their opinions. I'm interested in hearing from everyone so if someone is saying a lot, I may ask you to give others an opportunity to speak. Alternatively, if you're not saying much, I may ask you for your views. My aim is to try and get everybody's opinion included in the discussion.

Before we begin this discussion, there are some rules, which we must agree. First, everything that is said here is confidential. Nothing must be discussed outside the room, and no patient privacy will be discussed through the focus group discussion. Everyone shall say what they think and there should be no critique of people but open discussion. If you wish to speak to me afterwards that is possible. Could I go around the room and one at a time and ask what your

name is, how long you've been in the unit and whether you have had Professional experiences, perception, practice, and impact towards professional holds stigma and starting discuss our viewpoints.

مقدمة

مرحبا بكم في هذه المجموعة وشكرا لأخذ بعض الوقت منكم للانضمام إلى هذه المناقشة. اسمي هو (سهام اليوسف) ومن خلال تلك المناقشة سأستدرج استبيان لتوضيح وجود وتأثير الوصمة من العاملين المهنيين في الصحة النفسية تجاه الأشخاص الذين يعانون من مرض نفسي عقلي. كنت قد دعيت هنا لما لديكم من خبرة والمعرفة في الصحة النفسية العقلية، المرض النفسي والعقلي. لا توجد إجابات صحيحة أو خاطئة، وانا اريد الاستفادة من تلك الخبرات والآراء حول صمه وأتوقع أن تكون هناك وجهات نظر مختلفة. وأود أن نشجع الجميع لتبادل وجهات النظر.

وسوف يستخدم شريط تسجيل للدورة بسجلات الفيديو والصوت لأنني لا اريد أن تفوت أي من تعليقاتكم. بإمكانك طلب إيقاف تسجيل الفيديو بدون ذكر أي سبب والبقاء على التسجيل الصوتي خلال فترة المناقشة. أود أن أؤكد لكم أن تعليقاتك ستبقى سرية ولن يتم إدراج أي أسماء في أي تقارير. وانا مهتمة في وجهات النظر الخاصة بك سواء كانت إيجابية أو سلبية. إذا كنت ترغب في متابعة ما قاله شخص لا تتردد في القيام بذلك، والرد على الشخص مباشرة. أنا هنا لطرح الأسئلة، والاستماع، وتأكد من أن الجميع لديه فرصة لإبداء آرائهم. أنا مهتمة في الاستماع من الجميع، وقد اطلب منك إعطاء الآخرين فرصة للتحدث. هدفي النهائي هو محاولة الحصول على رأي الجميع المدرجة في المناقشة.

Information for participants

Participation in this research is voluntary, and you may withdraw from the research at any stage without having to give a reason. If you choose to end your participation all data collected will be erased. All participants are bound by professional codes of conduct and will have an appreciation of the rule governing patient confidentiality. However, participants will be reminded that they should not disclose information about patients in any way compromise patient confidentiality. The participants in the focus group will not be asked to discuss the past or current patients and will only be required to discuss their professional experiences while interacting with people living with mental health problems. This will ensure that the confidentiality and privacy of those with mental health problems are protected. If a breach of confidentiality occurs, I will end the discussion immediately and request that the participants stop talking and respect the privacy of patients if they wish to continue participating in the focus group. I will then return to the focus group discussion once patient confidentiality has been assured. If malpractice that is illegal or harmful to patients is discovered, the duty of care of the researcher in accordance with their professional code of conduct is to talk to the participant individually, outside of the group discussion, about their illegal or harmful attitude towards their patients and seek to establish the cause of this malpractice. Moreover, if necessary, the researcher will contact the chair of the psychiatric department to draw their attention to professional mental health care and services without naming the participants to

preserve the safety and privacy of the participants in the study. You will be asked to sign a consent form saying that you have read this information and have had an opportunity to ask any questions about the research. If you have, any questions feel free to ask.

المشاركة في هذا البحث هو طوعي، وان كنت تريد ان تنسحب من البحث في أي مرحلة، فلك ذلك دون الحاجة لإعطاء سبب.

وسوف يطلب منك التوقيع على استمارة الموافقة قائلا ان كنت قد قرأت هذه المعلومات وكان لك الفرصة لطرح أي أسئلة حول البحوث. إذا كان لديك أي أسئلة لا تتردد في الطلب.

The following questions are very sensitive. Please remember that the information gathered is completely anonymous and dealt with in the strictest confidence.

الأسئلة التالية هي حساسة للغاية. يرجى تذكر أن المعلومات التي تم جمعها ستكون تحت مجهول الهوية تماما، والتعامل معها في سرية تامة.

Data protection

This policy applies to all in Salford University who process personal information on the University. The Data Protection Act 1998 regulates the use of information relating to participants (personal information), protecting and giving rights those to whom that information relates. The Data Protection Act's requirements are based upon the eight Data Protection Principles. These state that personal information shall: 1. Be obtained and processed fairly and lawfully and not be processed unless certain conditions are met; 2. Be obtained for a specified and lawful purpose and not be processed in any manner incompatible with that purpose; 3. Be adequate, relevant and not excessive for that purpose; 4. Be accurate and kept up to date where necessary; 5. Not kept for longer than is necessary for that purpose; 6. Be processed in accordance with the data subject's rights; 7. Be kept secure, safe from unauthorized access, accidental loss, damage or destruction; 8. Not be transferred to a country outside the European Economic Area, unless that country has equivalent levels of protection for personal information.(Data protection policy university of Salford, 2013). The data will be kept for three years following PhD completion to enable publication and post-doctoral research. Following PhD completion, the anonymised data will be stored at Salford University for this period. Group discussion to colleagues and others.

حماية البيانات

تنطبق هذه السياسة على جميع جامعة سالفورد في معالجة المعلومات الشخصية. قانون حماية البيانات لعام 1998 ينظم استخدام المعلومات المتعلقة للمشتركين (المعلومات الشخصية)، وحماية حقوق وإعطاء أولئك الذين تتعلق تلك المعلومات بهم. تستند متطلبات قانون حماية البيانات وعلى مبادئ حماية البيانات الثمانية. هذه المعلومات الشخصية بما يلي: 1 يمكن الحصول عليها ومعالجتها بصورة عادلة وقانونية ولا يمكن معالجتها إلا إذا توافرت شروط معينة؛ 2 يمكن الحصول عليها لغرض محدد وقانونية ولا تتم معالجتها بأي طريقة لا تتوافق مع هذا الغرض؛ 3 تكن كافية وذات صلة وغير مفرطة لهذا

الغرض؛ 4 أن تكون دقيقة وتحديثه عند الضرورة؛ 5 لا تبقى لفترة أطول مما هو ضروري لهذا الغرض؛ 6 تتم معالجتها وفقا للحقوق موضوع البيانات؛ 7 أن تبقى آمنة ومأمونة من الوصول غير المصرح بهم، سيتم فقدانها أو التلف أو التدمير بعد الانتهاء منها؛ 8. لا يمكن نقلها إلى بلد خارج المنطقة الأوروبية، إلا أن البلاد لديها مستويات مماثلة لحماية المعلومات الشخصية.

سيتم الاحتفاظ البيانات لمدة ثلاث سنوات بعد الانتهاء دكتوراه لتمكين نشر أبحاث ما بعد الدكتوراه. بعد الانتهاء الدكتوراه سيتم تخزين البيانات في جامعة سالفورد مجهولة المصدر لهذه الفترة. لمناقشة جماعية للزملاء وغيرهم.

Consent to Participate in Research

Issues of Professional experience of stigma toward people with mental health problems; I have been given and understand an explanation of this research project, and have read the information sheet. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that taking part in this study is voluntary with video and audio record and that I may withdraw from this study and ask to stop a video record at any time, without reason. I understand through the focus group discussion will not discuss the past or current patients and will only be required to discuss our professional experiences while interacting with people living with mental health problems. This will ensure that the confidentiality and privacy of those with mental health problems are protected. If I choose to end my participation, all data collected will be erased. I understand that my participation in this study is confidential and that no material, which could identify me, will be used in any reports of this study. I would like to receive a summary of the results of this research when it is completed.

الموافقة على المشاركة في البحوث

قضايا الخبرة المهنية فريق الصحة النفسية نحو صمه العار من المشاكل النفسية والعقلية، ولقد أعطيت فهم تفسيرا لهذا المشروع البحثي، وقرأت ورقة المعلومات. وقد أتيحت لي فرصة لطرح الأسئلة والإجابة. أنا أفهم أن من يشارك في هذه الدراسة هو طوعي وأنني لدي حق الانسحاب من هذه الدراسة او طلب ايقاف تسجيل الفيديو في أي وقت، من دون سبب. واعلم ان جميع التسجيلات او البيانات المستمعة مني سوف تتلف. أنا أفهم أن مشاركتي في هذه الدراسة هي سرية، وأنه لا يمكن تحديد المواد التي سيتم استخدامها لي في أي تقارير من هذه الدراسة. وأود أن التقي ملخصا لنتائج هذا البحث عند اكتماله

Signed:التوقيع
Name of participant:اسم المشارك
Address:العنوان
Date:التاريخ

Focus Group Questions about you:بيانات المشاركين في مجموعة التركيز
Statements by participants in the focus group

Item					
Gender الجنس	Maleذكر				
	Female أنثى				
Nationality الجنسية					
Ethnic group					
Age العمر	Under 25 years' old اقل من 25 سنه				
	25-39				
	40-59				
	60+				
Marital status لحالة الاجتماعية					
Level of education المستوى التعليمي					
Specialties التخصص					
Place of work مكان العمل	Public hospital مستشفى عام	Name: الاسم	In the patient clinic: Outpatient clinic:		
	Private hospital مستشفى خاص	Name: الاسم	In the patient clinic: Outpatient clinic:		
Experience (Years) سنوات الخبرة					

Item					
Socio-economic status الحالة المادية الاجتماعية	Upper middle جيدا جدا				
	Middle متوسطة				
	Lower middle اقل من العادي				

Focus group discussion – Questions
Professional experience:
Regarding to the research questions;

A1. To what extent have mental health professionals personally experienced stigma in relation to their work with people with mental health problems in Saudi Arabia?

A2. What are the causes or factors in Saudi Arabia that may lead to mental health professionals holding stigmatising views towards people living with mental health problems?

A3. How do mental health professional teams in Saudi Arabia influence issues of professional stigma in mental health services?

A4. How has Saudi Arabia's mental health care service enhanced the level of resources and standards of care available to mental health care users, and to what extent can the provision of a mental health care service contribute to the diminishment of the stigma that surrounds those living with such a problem?

- The extent of mental health professional stigma on people with mental health problems.
- Negative thought or feelings towards people with mental health problem-based in the fact that they have a mental health problem.
- Professional experience in positive or negative belief, acceptance, relationship, married community, media, religion, etc. that have linked to the experience of mental health problems.
- During professional mental health team and those family experience.
- During professional mental health team in social, culture experience, media, religion and educational factors in Saudi Arabia that might lead to the societal stigmatization of people with mental health

- Reduce the level of stigma toward with those people living with mental health problems to improve societal attitudes towards those people with mental health problems and encourage sufferers to seek treatment

Ending Questions;

E1. If you had a chance to pick out one important topic from those that have been discussed what would it be?

E2. Summary of main points then question accuracy of summary

E3. Recommendations aimed at reducing the stigmatization of people with mental health problems and the role mental health services might have in achieving this objective.

E4. Have we missed anything? Is there anything that has been overlooked?

Appendix XI

Using Thematic Analysis

Thematic Analysis / Phase: Description of the process

1. Familiarizing yourself with your data:

Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.

2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

3. Searching for themes: Collating codes into potential themes, gathering all data relevant to each potential theme.

4. Reviewing themes: Checking whether the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.

5. Defining and naming themes: On-going analysis to refine the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme.

6. Producing the report: The final opportunity for analysis. Selection of vivid, compelling extract examples, the final analysis of selected extracts, relating back to the analysis of the research question and literature, producing a scholarly report of the analysis.

Appendix XII

Invitation later to Director of Education and Training department

Dear Director of Education and Training department.

My name is Seham alyousef. I am a lecturer in the College of Nursing at King Saud University Currently; I am a PhD student at Salford University in the UK. I am undertaking a PhD on the stigma toward people with mental health problem. My study topic is; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia. Saudi Arabia is at present undergoing a change in the mental healthcare and it is vital that information concerning health, how to maintain and increase it, is available for the whole people with mental health problem. My study will explore the degree of stigma demonstrated by mental health professionals towards people with mental health problems. And, this study will address a gap in our knowledge and understanding of these phenomena. While my aim of the study is to identify, the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. This study will address an experience an opinion in our knowledge and understanding of these phenomena. The outcome of the study will be the development of an evidence-based competency framework to underpin the delivery of mental health care services by professional mental health team, in Saudi Arabia.

I would like to get an Official agreement from you to let me start a data collection process, as I need your help and support for recruiting the expert participants to be involved in my study.

With all my respectfully for your cooperation.

Kind Regards,

Seham Mansour Al-Yousef

Appendix XIII

Invitation later for the Dean's voice of the (Nursing School)

Dear Head of the department, Dean's voice.

My name is Seham alyousef. I am a lecturer in the College of Nursing at King Saud University Currently, I am a PhD student at Salford University in the UK. I am undertaking a PhD on the stigmatization of people with mental health problem. My study topic is; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia. Saudi Arabia is at present undergoing a change in the mental healthcare and it is vital that information concerning health, how to maintain and increase it, is available for the whole people with mental health problem. My study will explore the degree of stigma demonstrated by mental health professionals towards people with mental health problems. And, this study will address a gap in our knowledge and understanding of these phenomena. While my aim of the study is to identify, the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. This study will address an experience an opinion in our knowledge and understanding of these phenomena. The outcome of the study will be the development of an evidence-based competency framework to underpin the delivery of mental health care services by professional mental health team, in Saudi Arabia.

I would like to get an Official agreement from you to let me start a data collection process, as I need your help and support for recruiting the expert participants to be involved in my study.

With all my respectfully for your cooperation.

Kind Regards,

Seham Mansour Al-Yousef

Appendix XIV

Invitation letter for Head manager of the department

Dear Sir/Madam

My name is Seham alyousef. I am a lecturer in the College of Nursing at King Saud University Currently; I am a PhD student at Salford University in the UK. I am undertaking a PhD on the stigmatization of people with mental health problem. My study topic is; The extent of mental health professional stigma on people with mental health problems in Saudi Arabia. Saudi Arabia is at present undergoing a change in the mental healthcare and it is vital that information concerning health, how to maintain and increase it, is available for the whole people with mental health problem. My study will explore the degree of stigma demonstrated by mental health professionals towards people with mental health problems. And, this study will address a gap in our knowledge and understanding of these phenomena. While my aim is to identify, the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. This study will address an experience an opinion in our knowledge and understanding of these phenomena. The outcome of the study will be the development of an evidence-based competency framework to underpin the delivery of mental health care services by professional mental health team, in Saudi Arabia.

I would like to book an appointment with you to discuss my study research and data collection process in depth, as I need your help and support for recruiting the expert participants to be involved in my study.

Kind Regards,

Seham alyousef

Appendix XV

Participant Information Sheet

Participant Information Sheet ورقة معلومات للمشارك

Informed consent from research participants is crucial. Therefore, your information sheet must use language that is readily understood by the public.

Overview of the Participant Information sheet

The information sheet should provide brief and clear information on the essential elements of the specific study: what the research is about, the condition or treatment under study, the voluntary nature of involvement, what will happen during and after the research has taken place, what treatment (if applicable) will be withheld, the participant's responsibilities, the potential risks, inconvenience or restrictions balanced against any possible benefits and the alternatives. It should allow the participant to decide whether the study is of interest to them and whether they wish to read and discuss it further.

نظرة عامة على ورقة معلومات المشارك

وينبغي أن تقدم ورقة المعلومات بالمعلومات الموجزة والواضحة على العناصر الأساسية للدراسة المحددة: بما هو البحث عنه، شرط المعاملة أو قيد الدراسة، والطابع الطوعي للمشاركة، ماذا سيحدث أثناء وبعد اتخذت الأبحاث مكانها، ما سيتم حجب العلاج (إن وجد)، ومسؤوليات المشاركين، والمخاطر المحتملة، إزعاج أو قيود متوازنة ضد أي الفوائد المحتملة والبدائل. ينبغي أن يسمح للمشارك أن يقرر ما إذا كانت الدراسة التي تهمها وعما إذا كانوا يرغبون في قراءة ومناقشة أكثر من ذلك.

Study Title

THE EXTENT OF MENTAL HEALTH PROFESSIONAL STIGMA ON PEOPLE WITH MENTAL HEALTH PROBLEMS IN SAUDI ARABIA.

عنوان الدراسة

وجود وتأثير العاملين المهنيين في الصحة النفسية والعقلية في صمه العار تجاه الأشخاص المصابين بمرض نفسي عقلي في المملكة العربية السعودية

Invitation paragraph

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take a time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether to take part.

فقرة الدعوة

وأود أن أدعوكم إلى المشاركة في دراسة بحثية. وقبل أن تقرر تحتاج إلى فهم لماذا يجري البحث وما ينطوي بالنسبة لك. يرجى أخذ الوقت لقراءة المعلومات التالية بعناية. طرح الأسئلة إذا كنت تقرأ أي شيء غير واضح أو ترغب في مزيد من المعلومات. يستغرق بعض الوقت لتقرر ما إذا كان أو عدم المشاركة.

Mental health professionals, through their work, may be faced with the problem of a stigma of working with persons with mental health problems. Research showed that health care professionals do hold stigma towards patients with mental health problems, in Netherlands (Gawley *et al.*, 2011).

قد يكون واجه العاملين في مجال الصحة النفسية خلال عملهم مشكلة صمه العاملين مع الأشخاص المصابين بأمراض عقلية أو الأشخاص الذين يعانون من مشاكل الصحة النفسية العقلية. وأظهرت الأبحاث أن العاملين في مجال الرعاية الصحية عقد صمه العار تجاه المرضى الذين يعانون من مرض عقلي، في هولندا.

(Gawley *et al,* 2011).

What is the purpose of the study?

And, the aim of this study is to identify the stigma surrounding mental health problems, as well as to identify the existing and latent views of mental health professionals holding a stigma towards people living with mental health problems in Riyadh, Saudi Arabia. This study will address a gap in our knowledge and understanding of these phenomena.

ما هو الغرض من هذه الدراسة؟

والهدف من هذه الدراسة هو تحديد وجود وتأثير وصمة العار كما يتبين من العاملين المهنيين في مجال الصحة النفسية العقلية والمشاركة في تقديم وتوفير الرعاية الصحية النفسية في المملكة العربية السعودية.

وسوف تتناول هذه الدراسة وجود فجوة في معرفتنا وفهمنا لهذه الظاهرة.

Why have I been invited?

You have been chosen, as you are a person from professional working in the mental health team in Riyadh. The mental health care professionals working in the settings providing mental health services in Riyadh city will form the study population of this research. These will include the following categories:

Psychiatrists

Clinical psychologists

Clinical social workers

Mental health nurses

Faculty of mental health nurses.

لماذا تمت دعوتي؟

لقد تم اختيارك كما انت الشخص المهني في فريق الصحة النفسية في الرياض.

فإن العاملين في مجال الرعاية الصحية النفسية والعقلية، العاملة في إعدادات وتوفير خدمات الصحة النفسية في مدينة الرياض تشكل مجتمع الدراسة من هذا البحث. وسوف تشمل هذه الفئات التالية:

الطبيب النفسي

الأخصائي النفسي

الأخصائي الاجتماعي

الممرض النفسي

عضو هيئة التدريس في تمريض الصحة النفسية والعقلية

Do I have to take part?

It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason. (If applicable – this will not affect the standard of care you receive).

هل لا بد لي من المشاركة؟

والأمر متروك لكم لاتخاذ قرار. سنقوم بشرح الدراسة وتذهب من خلال ورقة المعلومات، التي ستقدم لك. وسوف اقوم بعد ذلك بطلب منك التوقيع على استمارة الموافقة لإظهار أنك وافقت على المشاركة. أنت حر في الانسحاب في أي وقت، دون إعطاء سبب. (إن وجدت -وهذا لن يؤثر على مستوى تلقي الرعاية).

What will happen to me if I take part?

You will be asked to complete questionnaires that should not last longer than 30 minutes. You may choose to complete these questionnaires in private or with my assistance at a place of your choice. A translated questionnaire is also available if you prefer. After completing the questionnaire, I will be running a series of focus group around the country asking people with a professional team of mental health care about their experiences of internalized stigma and the best ways to combat it. I'm aiming to have approximately 2 participants for each category in focus group, and the group will last for two hours. I will be asking questions about people with professional in mental health team about their professional experience of internalized stigma and how people deal with it when it arises as an issue. You have agreed to facilitate one of this focus group. Then you will be thanked for your cooperation in completing the questionnaires.

ماذا سيحدث لي إذا كنت ستشارك؟

سيطلب منك لاستكمال الاستبيانات التي لا ينبغي أن تستمر لفترة أطول من 30 دقيقة. قد اخترت لإتمام هذه الاستبيان في المكان الخاص لك أو بمساعدتي في مكان من اختيارك. هذا الاستبيان ترجمتها باللغات إذا كنت تفضل ذلك.

بعد الانتهاء من الاستبيان وسوف يتم تشغيل سلسلة من مجموعات التركيز في جميع أنحاء القطاعات الصحية لطلب من المشاركة من فريق فني مهني في الصحة النفسية للمشاركة والتحدث عن تجاربهم من وصمة العار والمنضوية أفضل الطرق لمكافحته. أسعى أن يكون حوالي 2 لكل فئة المشاركين في مجموعة التركيز (لكل تخصص)، وسوف تستمر المجموعة ساعتين. سوف أكون اطرح أسئلة حول المهنيين في فريق الصحة النفسية حول الخبرة المهنية الخاصة بهم في وصمة العار المنضوية وكيفية يتعامل المشاركين معها عند نشوئه كقضية. كنت قد وافقت على تيسير واحد من هذه المجموعة التركيز. فإنك سوف يتم توجيه الشكر لتعاونكم في ملء الاستبيانات

Expenses and payments?

All the expenses for travel and any cost will be paid from Saudi Arabia embassy in the United Kingdom.

المصروفات والمدفوعات؟

وسوف يتم دفع جميع نفقات السفر وبأي ثمن من السفارة السعودية في المملكة المتحدة.

What will I have to do?

Completing questionnaires involves writing by hand answers to questions. There are two types of questions: 1. ‘Open-ended questions’ where a question is open for you to answer in any way or detail you prefer and; 2. ‘Multiple-choice questions’ where you will be given a selection of set answers to questions to choose from. You do not have to complete all the questions, although it would be far more helpful for me if you did. The completion of the questionnaires can be done at any place you prefer with or without my assistance. If you chose to complete the questionnaires in private, please answer your questions alone without any help from your friends of the family. This is because I am interested in your responses, and I do not wish for your responses to be influenced by anyone else. If you choose to take part in a one-to-one interview, I will arrange a time, day and venue that suit you best. The interview should be conducted in a quite undisturbed area. Although there is no set length for the interview I do not foresee an interview lasting more than two hours. However, you may withdraw from the interview at any time and without giving a reason. If you consent to it, the interview will be video and audio-recorded. I will later transcribe the recording and analyse the data. All your responses will remain completely anonymous. However, I will ask you whether it is ok to use anonymous quotations of your interview within the write-up of my study. You may choose to decline this at any time and without giving a reason.

ما سوف يكون عليه أن افعل؟

استكمال استبيانات تتضمن إجابات عن طريق الكتابة باليد على الأسئلة. هناك نوعان من الأسئلة: 1 'الأسئلة المفتوحة "حيث سؤال مفتوح بالنسبة لك للرد في أي وسيلة أو التفصيل الذي تفضله و؛ 2. حيث سيتم منحك مجموعة مختارة من مجموعة إجابات على أسئلة للاختيار من بينها 'أسئلة متعددة الخيارات'. لم يكن لديك لإكمال كل الأسئلة، على الرغم من أنه سيكون أكثر بكثير مفيدة بالنسبة لي إذا فعلتم. ويمكن أن يتم الانتهاء من الاستبيانات في أي مكان كنت تفضل

مع أو بدون مساعدتي. إذا اخترت لاستكمال الاستبيانات في مكان خاص لك، الرجاء الإجابة على الأسئلة الخاصة بك وحدها دون أي مساعدة من أصدقائك او من الأسرة. هذا هو لأنني مهتمة في ردودكم، وأنا لا أتمنى لردودكم أن تتأثر من قبل أي شخص آخر. إذا اخترت للمشاركة في لقاء واحد الى واحد، وسوف يقدم كل مرة، اليوم والمكان الذي تناسبك أفضل. وينبغي إجراء المقابلة في منطقة هادئة دون عائق. رغم عدم وجود طول المجموعة للمقابلة، لا أتوقع مقابلة بأن تستمر أكثر من ساعتين. ومع ذلك، قد تنسحب من المقابلة في أي وقت ودون إبداء أسباب. إذا كنت توافق على ذلك، وسوف تكون المناقشة بتسجيل الفيديو وتسجيل الصوت. وسوف انسخ لاحقا تسجيل وتحليل البيانات. لكل من ردودكم تظل مجهولة تماما.

ومع ذلك، وسوف يطلب منك ما إذا كان على ما يرام لاستخدام الاقتباسات مجهول من المقابلة ضمن متابعة الكتابة من دراستي. لك ان تختار الرفض في أي وقت ودون إبداء أسباب.

What are the possible disadvantages and risks of taking part?

We do not anticipate that these procedures will cause you any harm, but if you experience discomfort you may talk to the investigators about your concerns. You are free to skip any question that you do not wish to answer or that makes you feel uncomfortable. You are also free at any time to choose to end your participation. There will be no negative effects if you choose to skip a question or discontinue your participation in the study. If you choose to end your participation all data collected will be erased.

ما هي عيوب ومخاطر من يشارك؟

نحن لا نتوقع أن هذه الإجراءات سوف تسبب لك أي ضرر، ولكن إذا واجهت مشقة فقط تحدث إلى الباحث عن مخاوفك. أنت حر لتخطي أي سؤال أن كنت لا ترغب في الإجابة أو أن يجعلك تشعر بعدم الارتياح. أنت أيضا حرفي أي وقت لاختيار إنهاء مشاركتك. لن تكون هناك آثار سلبية إذا اخترت لتخطي سؤال أو التوقف عن مشاركتك في الدراسة. إذا اخترت لإنهاء مشاركتك سيتم مسح جميع البيانات التي تم جمعها

What are the possible benefits of taking part?

I cannot promise the study will help you but the information we get from the study will help to improve the treatment of people with (mental health services) and, will help to increase the understanding of identification of the magnitude of the problem of stigma among mental health professionals.

ما هي الفوائد المحتملة لمن يشارك؟

لا أستطيع أن أعدكم بأنه سوف تساعدك الدراسة ولكن فإن المعلومات التي نحصل عليها من هذه الدراسة تساعد على تحسين معاملة الناس مع (خدمات الصحة النفسية والعقلية)، وسوف تساعد على زيادة فهم التعرف على حجم المشكلة من وصمة العار بين المهنيين في الصحة النفسية والمصابين بمشاكل نفسية وعقلية.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions:

Call Nom: 0966544441982

Email: s.m.alyousef@edu.salford.ac.uk

If you remain unhappy and wish to complain formally you can do this through

(University complaints procedure).

Supervisor's name and contact details (Dr Tony Warne)

Email: T.warne@salford.ac.uk.

ماذا لو كان هناك مشكلة؟

إذا كان لديك قلق حول أي جانب من جوانب هذه الدراسة، يجب عليك أن تسأل التحدث إلى الباحث الذي سوف يبذل قصارى الجهد للرد على أسئلتكم (0966544441982).

s.m.alyousef@edu.salford.ac.uk

إذا كنت لا تزال غير سعيد وترغب في تقديم شكوى رسميا يمكنك القيام بذلك من خلال

(إجراءات الشكاوى الجامعة).

اسم وتفاصيل الاتصال المشرف (الدكتور توني وارن)

T. warne @ salford.ac.uk.

Will my taking part in the study be kept confidential?

All information that is collected about you during this study will be kept strictly confidential. Any information about you, which is used, will have your name and address removed so that you cannot be recognized from it. Confidentiality will be safeguarded during and after the study. Procedures for handling, processing, storage and destruction of their data match the Data Protection Act 1998. How their data will be collected.

That it will be stored safely, giving the custodian and level of identification, for example:

وهل سيبقى من يشاركون في الدراسة بحالة سرية؟

وستبقى جميع المعلومات التي يتم جمعها عنك خلال هذه الدراسة بسرية تامة. فإن أي معلومات عنك والذي وضع من اسمك وعنوانك يزال بحيث لا يمكن التعرف عليك. سيتم الحفاظ السرية أثناء وبعد الدراسة. إجراءات المناولة والتجهيز والتخزين وتدمير بياناتها تتطابق مع قانون حماية البيانات لعام 1998. في المملكة المتحدة.

كيف سيتم جمع البيانات الخاصة بكم، والتي سيتم تخزينها بأمان، وإعطاء الامن، وعلى سبيل المثال:

Individual participant research data, such questionnaires/interviews/samples/ x-rays will be anonymous and given a research code, known only to the researcher.

البيانات البحثية للمشارك الفردي، مثل الاستبيانات / المقابلات / عينات / الأشعة السينية سوف تكون مجهولة المصدر وإعطاء رمز البحوث، والوحيد المعروف للباحث

A master list-identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher.

وسيعقد قائمة رئيسية لتحديد المشاركين للبيانات ورموز البحوث على جهاز كمبيوتر محمي بكلمة مرور لا يمكن الوصول إليها إلا من قبل الباحث.

Hard paper/taped data will be stored in a locked cabinet, within locked office, accessed only by researcher.

سيتم تخزين ورق صلب لتخزين البيانات في خزانه مقفلة داخل مكتب مقفل لا يمكن الاطلاع عليه الا من قبل الباحث

Electronic data will be stored on a password-protected computer known only by researcher.

سيتم تخزين البيانات الإلكترونية على جهاز كمبيوتر محمي بكلمة مرور لا يعرفها إلا من قبل الباحث

What it will be used for. For example, it must be clear if the data is to be used for future studies and whether further RGEC (Research Governance and Ethics Committee) approval will be sought.

ما سوف تستخدم من أجله. على سبيل المثال يجب أن يكون واضحا إذا كانت البيانات التي ستستخدم ¬
(محكمة البحوث ولجنة الأخلاقيات).RGECللدراسات المستقبلية وعما إذا كان سيتم طلب المزيد من الموافقات

Who will access to view identifiable data (authorized persons such as researchers within the team, supervisors, sponsors and for monitoring the quality, regulatory authorities /R&D audit).

الذي سيتم الوصول لعرض البيانات المحددة (الأشخاص المرخص لهم مثل الباحثين داخل الفريق والمشرفين ¬
التدقيق).R & Dوالكفلاء ورصد نوعية والسلطات التنظيمية

Will it be retained and that is will be disposed of securely (the College RGEC recommends a minimum of 3 years)

سيتم الاحتفاظ بها لمدة 3 سنوات وبعد ذلك ستتلف

All information, which is collected, about you during the research will be kept strictly confidential, and any information about you which leaves the hospital/university will have your name and address removed so that you cannot be recognized.

وستبقى جميع المعلومات التي يتم جمعها عنك أثناء البحث في سرية تامة، وستكون أية معلومة عنك الذي هو في المستشفى / الجامعة، اسمك وعنوانك سيزال بحيث لا يمكن التعرف عليها

Involvement of the General Practitioner/Family Doctor (GP)

There are other studies/circumstances which may not impact on the health of the participant therefore it would not be appropriate for you to contact their GP.

الاشتراك مع ممارس عام / طبيب الأسرة

وهناك دراسات أخرى / الظروف التي قد لا تؤثر على صحة المشارك بالتالي فإنه لن يكون من الملائم بالنسبة لك في الاتصال مع الممارس الصحي او طبيب الأسرة.

What will happen if I don't carry on with the study?

If you withdraw from the study all the information and data collected from you, to date, will be destroyed and your name removed from all the study files.

ماذا سيحدث لو أنني لا اريد الاستمرار في الدراسة؟

إذا كنت الانسحاب من الدراسة فان جميع المعلومات والبيانات التي تم جمعها منك، حتى الآن، سيتم تدميرها وإزالتها من كافة الملفات الدراسية.

What will happen to the results of the research study?

The study will be completed and written up by 2016 at the latest. There is a possibility that I will publish some of the aspects of the study before 2016. If you wish, I can contact you when any results are published with details of how to obtain a copy. Just to reiterate, you will not be identified in any report or publication

ماذا سيحدث لنتائج الدراسة البحثية؟

وسيتم الانتهاء من الدراسة بحلول عام 2016 على أبعد تقدير. هناك احتمال أنني سوف انشر بعض جوانب الدراسة قبل عام 2016. إذا كنت ترغب في ذلك، يمكنني الاتصال بك عندما تنشر أي نتائج مع تفاصيل عن كيفية الحصول على نسخة. فقط أن أكرر، لن يتم تحديد في أي تقرير أو مطبوعة.

Who is organizing or sponsoring the research?

University of Salford Manchester.

منظم وراعي الابحاث العلمية؟

جامعة سالفورد مانشستر.

Further information and contact details:

Call Nom: 0966544441982

Email: s.m.alyousef@edu.salford.ac.uk

المعلومات والاتصال مزيد من التفاصيل:

رقم جوال: 0966544441982

Information Sheet based on: COREC/NHS National Patient Safety Agency. Information Sheets and Consent Forms – Guidance for Researcher and Reviewers' Version 3.0 Dec 2006.

Link to IRAS website - IRAS

Thank you for reading!

شكرا لقراءتكم وتعاونكم

Appendix XVI

Research Participant Consent Form

نموذج موافقة مشاركة البحث

Research Participant Consent Form

The Title of Project: عنوان البحث العلمي:

THE EXTENT OF MENTAL HEALTH PROFESSIONAL STIGMA ON PEOPLE WITH MENTAL HEALTH PROBLEMS IN SAUDI ARABIA.

وجود وتأثير الوصمة لدى المهنيين العاملين في الصحة النفسية تجاه الأشخاص المصابين بمرض نفسي عقلي في المملكة العربية السعودية

RGEC Ref No:
Name of Researcher:اسم الباحث
Seham. M. alyousef

سهام منصور اليوسف

(Delete as appropriate)

No. رقم	ITEM الفقرة	YES نعم	NO لا	NA لا أعلم
1	I confirm that I have read and understood the information sheet for the above study (version x- date) and what my contribution will be. أقر بأنني قد قرأت وفهمت ورقة المعلومات للدراسة أعلاه وما سوف تكون مساهمتي في الدراسة.			
2	I have been given the opportunity to ask questions (face to face, via telephone and e-mail) أعطيت لي الفرصة لطرح الأسئلة والاستفسار (وجها لوجه، عبر الهاتف والبريد الإلكتروني)			
3	I agree to take part in the interview أنا أوافق على المشاركة في المقابلة			
4	I agree to the interview being tape recorded أنا أوافق على اجراء المقابلة والمناقشة اثناء التسجيل			
5	I agree to digital images being taken during the research exercises أنا أوافق على الصور الرقمية التي يجري اتخاذها خلال التدريبات البحوث			
6	I understand that my participation is voluntary and that I can withdraw from the research at any time without giving any reason أنا أفهم أن مشاركتي طوعية وأستطيع أن الانسحاب من البحث في أي وقت دون إبداء أي سبب			
7	I agree to take part in the above study أنا أوافق على المشاركة في الدراسة المشار إليها أعلاه			

Name: Signature:
Specialist: Place of work:
Date:

Appendix XVII

A summary of the frequency of responses is supplied using code number with percentages.

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Total %	
Professional stigma	6	4	3	8	2	23	25.2%
Causes stigma	7	4	5	10	6	32	35.1%
Mental health service	5	1	2	2	3	13	14.2%
Recommendation	7	1	3	5	7	23	25.2%
Total number	25	10	13	25	18	91	%
	27.4%	10.9%	14.2%	27.4%	19.7%		

Appendix XVIII

Sub-themes and code numbers of experiences of stigma held by professionals toward people with mental health problems.

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Negative feeling	0	2	0	0	0
Positive attitude	2	0	0	2	1
Diagnosis	1	0	1	2	0
Relationship and interaction	1	1	0	2	0
Acceptance	1	0	1	1	0
Stigma experiences within marital relationships	1	1	1	1	1

Appendix XIX

Sub-themes and code numbers of causes of professionally held stigma towards people with mental health problems.

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Experience	1	1	1	0	1
Media	0	0	0	2	1
Community	4	3	2	6	3
Racism	0	0	1	0	0
Religion	1	0	1	1	0
labels	1	0	0	1	1

Appendix XX

Sub-themes and code numbers of an impact of professional stigma on mental health services.

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Deficiency	3	0	1	0	2
Immigration	1	1	1	1	1
Policy	1	0	0	1	0

Appendix XXX

Sub-themes and code numbers of participants' interventions recommended minimizing stigma in general and professional stigma.

Code	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Community	2	0	0	2	0
Education	2	1	1	0	1
Media	1	0	1	1	0
Mental health care services	1	0	1	2	1
Saudi government Support	1	0	0	0	5

Appendix XL

Research Training

No.	Title and Contents
1	How to complete learning agreement (which provide a clear definition of the L.A. as it is the base of the research).
2	Research Ethics.
3	Research methods Module (which covered the whole process of research from the Introduction and developing research question until the publication of research Studies). 2013-2014.
4	Introduction to Endnote ×7(which facilitates the references process).
5	Referencing your work APA (Harvard) style.
6	Postgraduate research week (which covered the important issue in the research proceeds aimed at PhD students).
7	Quantitative research Tools (SPSS using and analysis of data).
8	Effective Applications (REPEAT WORKSHOP).
9	Qualitative Research Tools: NVivo.
10	Personal Branding.
11	Myers Briggs Type Indicator.
12	Post-Graduate and Early Career Researcher Training and Development Advances in Qualitative Research Practice 2 day-coursest21 , May & 4th June 2014.
13	Electronic Resources for Researchers 2014
14	Teaching Futures - Routes into Teaching Event 2014
15	The launch of the Winston Churchill Memorial Trust And University of Salford report: No more! Turning the tide of child abuse and exploitation - lessons from abroad and evidence-based recommendations for the UK 2014
16	LEAP Higher Unit 4 (Academic Speaking) 2015
17	Intro to Endnote X7 2015
18	Postgraduate Research Experience Survey 2015
19	‘Putting Theory to Work’: The Application of Tools of Critical Analysis2015
20	Qualitative and Quantitative Research Training2015
21	Anxiety Workshop
22	Research Methods course- University of Salford
23	Assertiveness
24	Mixed Methodologies Workshop: Dancing among a potpourri of methods, representations and assumptions
25	The Interview: its place in social scientific research strategies
26	LEAP Higher learn English for academic PhD PURPOSES
27	Making the most of the feedback and working with your supervisors
28	The relationship between theory and practice in social work – putting theory to work
29	Organizing and synthesizing your work
30	Quantitative research methods course
31	Qualitative research methods course
32	Health Sciences Seminar Series

	Adult cycle training understanding barriers to utility cycling
33	Presenting at Academic Conferences
34	Critical Thinking and Critical Writing at Doctoral Level
35	Social Media for Postgraduate Researchers
36	Central Manchester University Hospitals NHS: Recruitment Open Day
37	How to get Search the Academic Way
38	Published by the IEEE
39	Referencing your APA (Harvard) style work
40	Planning and Writing a Thesis
41	Insight into musculoskeletal research
42	Research methods Module (which covered the whole process of research from the Introduction and developing research question until the publication of research Studies). 2013-2014.
43	Introduction to Endnote ×7(which facilitates the references process).
44	Referencing your work APA (Harvard) style.
45	Postgraduate research week (which covered the important issue in the research proceeds aimed at PhD students).
46	Endnote Basics for Researchers.