International Journal of Innovative Research in Medical Science (IJIRMS)
Volume 02 Issue 07 July 2017, ISSN No. – 2455-8737
Available online at - www.ijirms.in

Open Access Journal | Research Article | DOI: 10.23958/ijirms/vol02-i07/02

Exploring the Emotional Reaction of Mental Health Professional in Related to Stigma on People with Mental Health Problems in Saudi Arabia

Dr. Seham Mansour Alyousef
Assistant Professor in Mental Health Care, Department of Community and Psychiatric Nursing, College of Nursing, King Saud University, Riyadh, Kingdom of Saudi Arabia
Email id - smansour@ksu.edu.sa

Abstract:

People's beliefs on people with mental health problems set the stage for how they interact with, provide opportunities for, and help support a person with mental health issue in mental health care services. Of concern is the prevalence of these beliefs and emotional among professional mental health workers, which are also embedded in Saudi Arabian culture and the community in the KSA. The present study aimed to assess the application of the concept of stigma; will focus on professional's emotional reaction on people with mental health problems in mental health care services. Overall, stigma is defined as a cultural and professional phenomenon that manifests at both a structural and individual level.

A quantitative approach was applied and data was collected a total of 50 mental health care professionals, men and women in different health professions, via the emotional reactions Scale on mental illness short form which tested in several studies worldwide. Data was analysed using SPSS. The reliability of the scale was evaluated by measuring internal consistency using SPSS. Participants also completed a demographic data sheet. The findings of the present study point to the significant convergent between emotional reactions exhibited with regard to people with mental health problems. Significant statistical differences exist between the five different specialist groups [F (11.646); p=. 000<0.05]. When analysing the results of the dimension reduction factors, two component factors existed regarding attitude attribution test. The high scores of each component affected the results with stigma analysis; 'exclusion', 'rejection and caution'

Keywords: ***Stigma, mental-health Problems, mental illness, professionals.***

INTODUCTION

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.[1,2] Mental health problems are generally prevalent in societies and cultures of all kinds and in 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.[3] Corrigan created a framework to explain the dichotomy between public stigma and self-stigma.[4] 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. Even though these individuals interact with people with mental health problems, and Corrigan describes how, with respect to individual circumstances, various emotional and behavioural responses arise in individuals to whom achievements or failings are attributed.[5] Furthermore, it is true that stigma has been described by experts from many different backgrounds.[6] In addition, believes that peoples' beliefs 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.[7] 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.

The role of emotional reactions in mediating the impact of beliefs on behaviour has been highlighted in Corrigan model of public stigma.[8] This model was informed by attribution theory. Attribution theory assumes that individuals are motivated to search for causal understandings of events and,

 DOI: 10.23958/ijirms/vol02-i07/02

in turn, these understandings influence their emotional and behavioural responses.[9] A different, but not mutually exclusive, model of stigma evolved conceptualisation of stigma to encompass the role of emotional reactions.[10] It attributions about the effects it can have on a person's life, professional and social stigma may further exacerbate mental health problems. This may result in people feeling inferior or unequal[11,12], inferring that an individual is responsible for a negative event may trigger anger and consequently diminish helping behaviour, whereas if the individual is not held responsible others are likely to feel pity and thus forth a desire to help.[8] An additional pathway specific to mental health problems to account for beliefs about dangerousness has also been proposed.[13] which also it can make mental health professional's roles in their careers even more challenging.[14] It may restrict access to medical care.[15] 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.[16] In this way, negative attributions and stereotypes may result in negative judgments and negative emotional reactions toward people with mental health problems, the combined result of which is discriminatory behaviours. Three components of stigma were emphasised: identifying social differences, linking differences to negative stereotypes (e.g. a person hospitalised for mental health problems can be violent) and establishing separation between "us" and "them". Emotional reactions, which may be trivial or intense, are thought to feature in each of the three processes and may include anger, irritation, anxiety, pity and fear. Furthermore,[6] stressed that the ways in which the public behaves in response to their emotional reactions results in discrimination and loss of status for people with mental health problems. Thus, contemporary models of stigma of mental health problems concur that negative emotional reactions contribute to discriminatory behaviours that limit the quality of life and opportunities available to people with a mental health problem. Research has found negative effects of stigma, for example, on personal relationships, parenting, childcare, education and training, employment and housing.[17] In addition, it is important to understand the mental health professional's experiences are influenced by holding such views when relating to people with mental health problems.[18] 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. This research will examine the concept of stigma; will focus on professionals 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.

The purpose of the present study is to develop our understanding of professional stigma by evaluating existing evidence about emotional reactions. The following questions will be addressed:

1. To measure the extent of stigmatising emotional reactions and beliefs, that mental health professionals demonstrate towards people living with mental health problems.
2. What factors are associated with emotional reactions toward people with mental health problems?

METHODOLOGY

Study Design and Setting

A descriptive design was used in carrying out this study, which was conducted with members of the mental health professional team, in four setting; government hospital, university hospital, mental health hospital, and nursing college at the university. Quantitative research methods are particularly suited for addressing emotional reaction on an issue. Data was collected from the self-report questioners. The participants working in the settings who provide mental health services for Riyadh city formed the study population of this research (n=50) were all members of the mental health professional team. The following categories were included: 10 Psychiatrists; 10 Clinical psychologists; 10 Clinical social workers; 10 Mental health nurses; and 10 Faculty of mental health nurses.

Demographic Questionnaire

Each participant was required to fill out a demographic questionnaire, the demographic questionnaire allowed the acquisition of demographic data from the participants, including (Group of specialties, Nationality, Gender, Qualification, Post-graduate qualification, Experience years, and Work Setting).

Emotional Reaction on people with mental health problems Scale

The research instruments were created and developed by the researcher to measure the key objectives of this study, as well as taking the Saudi Arabian culture into consideration. The instrument in accordance to the AQ-29 as a 29-item scale, 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'. According to emotional reactions could potentially further anticipate discrimination and stereotypes.[19] Moreover, "to assess emotional reactions towards people with mental health problems, most focus on aggressive emotions; pro-social reactions; and feelings of anxiety".[20] Through these sources are derived to created a questionnaire of Emotional Reaction on People with mental health problems scale, and how opinions towards people

DOI: 10.23958/ijirms/vol02-i07/02

with mental health problems may be shaped by mental health problems and community influence, opinion and experience of prejudice.

Cronbach's alpha coefficient was used to appraise the consistency of the instrument and to test its reliability in respect of emotional reaction scale. Due to population-based studies have typically underestimated the importance of attitudes and emotional reactions as influential factors upon mental health stigma.[21] The instrument's reliability coefficient is in proportion to its consistency.[22] Previous studies have indicated that a reliability coefficient with a minimum value of 0.70 is required.[23]

Ethical Considerations and Procedure

For the quantitative aspect, participants were selected from various study settings, according to eligibility criteria (including in mental health worker team). The permission was obtained from chairs of the hospitals and the college to perform quantitative data collection. In this study, information was gathered over the course of two months (January and February 2015). 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.

Statistical Analysis

Following the data collection stage, the data entry and analysis was done by using SPSS (version 20) for Windows. Chicago, IL, USA. Descriptive (frequency and percentage) (The independent samples t-test and One-way Analysis of Variance (ANOVA)) were employed to determine the differences among study groups. For statistical purposes, the demographic item that consists of categorical data showing differences between each level were presented as a percentage. Statistical significance was assumed at p-value <0.05.

RESULTS

Respondents' characteristics

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).

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

The first research question ("To measure the extent of stigmatising emotional reactions and beliefs, that mental health professionals demonstrate towards people living with mental health problems?") will now be addressed.

Table 1: Analytical results of the raw score frequency of distribution of Emotional reaction on people with mental health problems scores

		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

DOI: 10.23958/ijirms/vol02-i07/02

	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**	

		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 1. 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) Indicated that a 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 Figure.1 Meanwhile, it is evident that all the participants hold a professional stigma towards people with mental health problems of varying degrees.

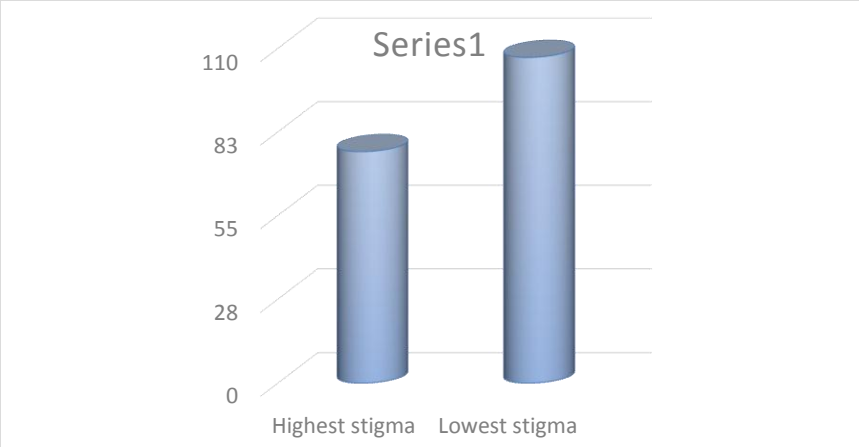

Figure 1: Raw Score Frequency on Emotional Reaction on People with mental health problems Scale.

Relationships between participants' demographics and Emotional Reactions

This analysis was performed to determine the existence of any differences between response type and factor scores (See Table 2).

DOI: 10.23958/ijirms/vol02-i07/02

Table 2: Participants' demographic characteristics and Emotional Reaction on People with mental health problems scores

	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		

**significant at 0.05level*

I. 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. Consequently, the

DOI: 10.23958/ijirms/vol02-i07/02

demographic variables did not significantly account for any variance in the model. 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.

II. 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. 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).

Principal Component Analysis

To address the second research question ("What factors are associated with emotional reactions toward people with mental health problems?"), When analysing the results of the dimension reduction factors, three 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.

Extract the factors

Three main analysis results of principle component factors were selected 'Exclusion',' Rejection', and 'Caution' (See Table 3.). The principle components analysis. The first factor (Exclusion) is the main contributor for the highest level of common variance (23.743), representing an Eigenvalue of 6.885.

Table 3: 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 in 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.						

DOI: 10.23958/ijirms/vol02-i07/02

Correlation relationship between the exiting factors and profile of the participants

Table 4: The 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		

**significant at 0.05level*

DOI: 10.23958/ijirms/vol02-i07/02

To indicate any differences between the factors scores and the type of response. Correlation relationship between the exiting factors and profile of the participants. In Table 4. 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 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).

DISCUSSION

The primary objective of this survey was to investigate the emotional reactions resulting from the stigma of mental health professionals towards people with mental health problems. Due to 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 in "perceptions" of stigma towards people with mental health problems during interpersonal interaction.[21]

In this research, results indicated that there was 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 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.[18] In addition, to 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.[24] 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 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.[25] 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. Additionally, stigma can be considered a multi-layered phenomenon that incorporates undesirable attitudes, negative emotional reactions, and biased actions.[26] Any assessment of a theme, as general as stigma, will certainly be accompanied by conceptual and operational demands.[27] 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. 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 with the likelihood that health professionals may hold a stigmatising against their patients, particularly those who are confronted with significant barriers to treatment, appears to be low.[28] As there are a number of reasons why acquiring an understanding of how health professionals perceive the person is significant.[14] The negative emotional 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, many of studies have shown there is minimal difference between the behaviour of psychiatrists and members of the public regarding these matters.[29] What is more, among the findings were that aspects 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.[30] Specifically, given that several 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 stigmatising views. The findings in this study are consistent with variations among professionals that can be attributed to professional identity can also be observed using this strategy.[31]

The findings of this study suggest that the stigma on 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 stigmatisation may be fully understood. The study of local conceptualisations, experiences and societal effects concerning mental health and mental health care in relation to stigma may be fruitful.[32] In addition, a consideration of the effects of subspecialists' differences, qualifications, cultures, and

DOI: 10.23958/ijirms/vol02-i07/02

experiences, together with availability of mental healthcare services, was a unique contribution to the existing literature. The findings of this study are corroborated in respect of the prevalence of mental health problem stigma in Asian cultures, which show some degree of superficial regional correspondence.[33] There are, however, some intercultural differences and it can be discerned that the stigmatisation of people with mental health problems across Asian cultures varies in terms of prevalence and severity.[33,34]

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 stigmatising 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,[35,36] and education and training.[37, 38] Hence, these aspects will be examined in depth in the qualitative discussion for Phase two.

LIMITATIONS

One such limitation is that the outcomes of the study information obtained from the mental health professional group cannot be generalised beyond the professional mental health team of the hospitals in Riyadh in Saudi Arabia, considering the small sample size of participants.

CONCLUSION

It is also clear that, the elements of stigmatisation beliefs concerning the created the stereotype and discrimination of emotional reaction on people with mental health problems .This study explored and described the emotional reaction of mental health professional on people with mental health problems in hospitals and in nursing college in Riyadh city, in addition to experience in the practical field of working with the people with mental health problems is necessary for the task of varying degree of holding and demonstrated a stigma on those with mental health problem. Nonetheless, as previously mentioned, research has only recently begun to address the issue of stigma displayed by mental health professionals.

A comprehensive assessment of the results of this study would be that the stereotypes of the mental health workers in regard to people with mental health issue. Many others are sustained by experiences related to matters of environment and identity. Personality issues such as inborn prejudices also contribute to a significant degree. The stereotypes acquired may entrench themselves to the level of affecting the personality and conduct of the mental health workers towards people with mental health problems. However, the combined effects of learning the appropriate course and experience in the practical field of the mental health issue are necessary for the task of impacting of perception among the mental health professionals towards the people with mental health problems. Subsequently, these results will be used to underpin the further development of mental healthcare services in Saudi Arabia for future studies, and to highlight the importance of MOH within the mental healthcare 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.

AKNOWLEDGMENT

The author is thankful to the Deanship of Scientific Research, College of Nursing Research Center at King Saud University for funding this research.

REFERENCES

[1] Littlewood J, Yousuf S. Primary health care in Saudi Arabia: applying global aspects of health for all, locally. Journal of Advanced Nursing. 2000 Sep 1; 32(3):675-81.
[2] Pinto MD, Hickman R, Logsdon MC, Burant C. Psychometric evaluation of the revised attribution questionnaire (r-AQ) to measure mental illness stigma in adolescents. Journal of nursing measurement. 2012; 20(1):47.
[3] Holland K, Hogg C. Cultural awareness in nursing and health care: an introductory text.2010.
[4] Corrigan PW. Mental health stigma as social attribution: Implications for research methods and attitude change. Clinical Psychology: Science and Practice. 2000 Mar 1; 7(1):48-67.
[5] Corrigan PW, Watson AC, Barr L. The self–stigma of mental illness: Implications for self–esteem and self–efficacy. Journal of social and clinical psychology. 2006 Oct; 25(8):875-84.
[6] Link BG, Yang LH, Phelan JC, Collins PY. Measuring mental illness stigma. Schizophrenia bulletin. 2004 Jan 1; 30(3):511-41.
[7] Jorm AF, Christensen H, Griffiths KM. 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. 2005 Apr 1; 39(4):248-54.
[8] Corrigan PW, Rowan D, Green A, Lundin R, River P, Uphoff-Wasowski K, White K, Kubiak MA. Challenging two mental illness stigmas: Personal

 DOI: 10.23958/ijirms/vol02-i07/02

responsibility and dangerousness. Schizophrenia bulletin. 2002; 28(2):293.
[9] Weiner B. A cognitive (attribution)-emotion-action model of motivated behavior: An analysis of judgments of help-giving. Journal of Personality and Social psychology. 1980 Aug; 39(2):186.
[10] Link BG, Phelan JC. Conceptualizing stigma. Annual review of Sociology. 2001 Aug; 27(1):363-85.
[11] Coffman E. Behavior in Public Places: Notes on the Social Organization of Gatherings. Free Press; 1966.
[12] Crocker J. Social stigma and self-esteem: Situational construction of self-worth. Journal of Experimental Social Psychology. 1999 Jan 31; 35(1):89-107.
[13] Corrigan P, Markowitz FE, Watson A, Rowan D, Kubiak MA. An attribution model of public discrimination towards persons with mental illness. Journal of health and Social Behavior. 2003 Jun 1:162-79.
[14] Wahl O, Aroesty-Cohen E. Attitudes of mental health professionals about mental illness: A review of the recent literature. Journal of Community Psychology. 2010 Jan 1; 38(1):49-62.
[15] Qureshi NA, Al-Habeeb AA, Koenig HG. Mental health system in Saudi Arabia: an overview. Neuropsychiatric disease and treatment. 2013; 9:1121.
[16] Alonso J, Buron A, Rojas-Farreras S, De Graaf R, Haro JM, De Girolamo G, Bruffaerts R, Kovess V, Matschinger H, Vilagut G, ESEMeD/MHEDEA 2000 Investigators. Perceived stigma among individuals with common mental disorders. Journal of affective disorders. 2009 Nov 30; 118(1):180-6.
[17] Thornicroft G. Shunned: discrimination against people with mental illness. New York. 2006.
[18] Chou KL, Mak KY, Chung PK, Chan D, Ho K. Attitudes towards mental patients in Hong Kong. International Journal of Social Psychiatry. 1996 Sep; 42(3):213-9.
[19] Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E. Reducing stigma and discrimination: Candidate interventions. International Journal of Mental Health Systems. 2008 Apr 13; 2(1):3.
[20] Angermeyer MC, Matschinger H. Public attitude towards psychiatric treatment. Acta Psychiatrica Scandinavica. 1996 Nov 1; 94(5):326-36.
[21] Angermeyer MC, Holzinger A, Matschinger H. 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. 2009 May 31; 24(4):225-32.
[22] Koehn ML, Lehman K. Nurses' perceptions of evidence-based nursing practice. Journal of advanced nursing. 2008 Apr 1; 62(2):209-15.
[23] Grove SK, Burns N, Gray J. Understanding nursing research: Building an evidence-based practice. Elsevier Health Sciences; 2014 Sep 18.
[24] Nordt C, Rössler W, Lauber C. Attitudes of mental health professionals toward people with schizophrenia and major depression. Schizophrenia bulletin. 2006 Mar 1; 32(4):709-14.
[25] Corrigan P. How stigma interferes with mental health care. American psychologist. 2004 Oct; 59(7):614.
[26] Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice. 2002 Mar 1; 9(1):35-53.
[27] Aloud N, Rathur A. Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. Journal of Muslim Mental Health. 2009 Oct 30; 4(2):79-103.
[28] Lyons C, Hopley P, Horrocks J. A decade of stigma and discrimination in mental health: plus ça change, plus c'est la même chose (the more things change, the more they stay the same). Journal of psychiatric and mental health nursing. 2009 Aug 1; 16(6):501-7.
[29] Ruiz J, Miller C. An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. Police Quarterly. 2004 Sep; 7(3):359-71.
[30] Friswell MI, Penny JE. Crack modeling for structural health monitoring. Structural Health Monitoring. 2002 Jun; 1(2):139-48.
[31] Holmesland AL, Seikkula J, Nilsen O, Hopfenbeck M, Arnkil E. Open Dialogues in social networks: professional identity and transdisciplinary collaboration. International Journal of Integrated Care. 2010; 10:331-8.
[32] Ahmedani BK. Mental health stigma: society, individuals, and the profession. Journal of social work values and ethics. 2011; 8(2):4-1.
[33] Ng CH. The stigma of mental illness in Asian cultures. Australian and New Zealand Journal of Psychiatry. 1997 Jan 1; 31(3):382-90.
[34] Procter N, Hafner J. Student nurses' attitudes to psychiatry: The influence of training and personality. Journal of Advanced Nursing. 1991 Jul 1; 16(7):845-9.
[35] Walach H, Buchheld N, Buttenmüller V, Kleinknecht N, Schmidt S. Measuring mindfulness—the Freiburg mindfulness inventory (FMI). Personality and Individual Differences. 2006 Jun 30; 40(8):1543-55.

DOI: 10.23958/ijirms/vol02-i07/02

[36] Tsang HW, Tam PK, Chan F, Cheung WM. Stigmatizing attitudes towards individuals with mental illness in Hong Kong: Implications for their recovery. Journal of community psychology. 2003 Jul 1; 31(4):383-96.

[37] Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M, INDIGO Study Group. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. The Lancet. 2009 Feb 6; 373(9661):408-15.

[38] Lauber C, Nordt C, Braunschweig C, Rössler W. Do mental health professionals stigmatize their patients?. Acta Psychiatrica Scandinavica. 2006 Feb 1; 113(s429):51-9.

DOI: 10.23958/ijirms/vol02-i07/02