إقـــــرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان :

The Effectiveness of Proposed Counseling Program on Reducing Level of Stigma among Families of Schizophrenic Patients in Gaza Strip

أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص ، باستثناء ما تمت الإشارة إليه حيثما ورد ، وإن هذه الرسالة ككل أو أي جزء منها لم يقدم من قبل لنيل درجة أو لقب علمي أو بحثي لدى أي مؤسسة تعليمية أو بحثية أخرى .

DECLARATION

The work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

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The Islamic University - Gaza (IUG)
Research & Graduate Affairs
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Community Mental Health Nursing

The Effectiveness of Proposed Counseling Program on Reducing Level of Stigma among Families of Schizophrenic Patients in Gaza Strip

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نتيجة الحكم على أطروحة ماجستير

بناءً على موافقة شئون البحث العلمي والدراسات العليا بالجامعة الإسلامية بغزة على تشكيل لجنة الحكم على أطروحة الباحث/ **محمد فايز عبد الرحمن البرعي** لنيل درجة الماجستير في **كلية *التربية*/ قسم صحة نفسية ومجتمعية التمريض** وموضوعها:

The effectiveness of proposed counseling program on reducing level of stigma among families of schizophrenic patients in Gaza strip

وبعد المناقشة العلنية التي تمت اليوم الثلاثاء 16 صفر 1436هـ، الموافق 2014/12/09م الساعة الثامنة صباحاً بمبنى القدس، اجتمعت لجنة الحكم على الأطروحة والمكونة من:

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د. نبيل كامل دخان	مشرفاً	.....
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د. يوسف إبراهيم الجيش	مناقشاً خارجيًا	.....

وبعد المداولة أوصت اللجنة بمنح الباحث درجة الماجستير في **كلية *التربية*/قسم صحة نفسية ومجتمعية التمريض.**

واللجنة إذ تمنحه هذه الدرجة فإنها توصيه بتقوى الله ولزوم طاعته وأن يسخر علمه في خدمة دينه ووطنه.

والله ولي التوفيق،،،

مساعد نائب الرئيس للبحث العلمي و للدراسات العليا

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"يَرْفَعِ اللَّهُ الَّذِينَ آَمَنُوا مِنْكُمْ وَالَّذِينَ أُوتُوا الْعِلْمَ دَرَجَاتٍ وَاللَّهُ بِمَا تَعْمَلُونَ خَبِيرٌ"

صدق الله العظيم

سورة المجادلة الأية (11)

Dedication

I dedicate this work to

My father's soul

My mother

My brothers and sisters

My wife

My children (Ruaa , saja , Anas , Ahmed , Nada)

And my colleagues

Who provide support from the

Beginning to the end

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First of all, I would like to thank "The Almighty ALLAH" for the help and full care.

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I would like to express my deepest love to my wife and my children for their encouragement, and unlimited support throughout my master program.

My thanks are extended to all those not mentioned in person and who contributed in any way during this research.

I wish all of them long and prosperous life.

Abstract

General Objective:

Aim of this study was to know the effectiveness of proposed counseling program on reducing level of stigma among families of schizophrenic patients in Gaza strip.

Study design:

Case Control Study. Approach of intervention group and control group.

Sample:

The sample of the study was (38) participants divided into two groups, (17) Participants for intervention group and another (21) participants for control group. Homogeneity between the two groups in demographic variables was statistically achieved. Stigma Scale prepared by the researcher himself are used to evaluate Stigma level among the participants. Both groups, intervention and control, completed the Stigma Scale before and after applying the counseling program.

The counseling program consists of (12) sessions, each session (45) minutes.

The program techniques were (De-briefing , relaxation exercise, psychodrama, and religious counseling).

Results:

The results of the study indicated that there were statistically significant differences in stigma level of the intervention group before and after applying the counseling program. ETA square value was high (D = 7.9) this means that the counseling program has a positive effect on reducing the level of stigma among the intervention group. The percentage of change was (45.9%) for the intervention group at the level of stigma after applying the program where the efficiency value ranged between (35.7% - 52.6%).

Furthermore, after one month there was no statistically significant differences between the scores of post test and the score of sequential test of stigma scale (P.value was //0.27), Z.value was (-1.15). This ensures the continuity of the positive impact of counseling program on reducing level of stigma among the intervention group.

Recommendations:

This counseling program could be used to reduce level of stigma among families of schizophrenic patients and building other programs to treat other negative effects related to stigma of mental illness.

Key words: Schizophrenia, Stigma, counseling program.

ملخص الدراسة

هدف الدراسة :

تهدف هذه الدراسة إلى معرفة مدى فعالية برنامج إرشادي مقترح لتخفيف مستوى الوصمة لدى أهالي مرضى الفصام في قطاع غزة.

منهج الدراسة :

اعتمدت هذه الدراسة على المنهج التجريبي،نموذج العينة التجريبية والعينة الضابطة.

عينة الدراسة :

اشتملت عينة الدراسة على (38) مشاركاً قسمت إلى مجموعتين، (17) مشاركاً للمجموعة التجريبية و(21) مشاركاً للمجموعة الضابطة، وقد تم التحقق من التجانس بين المجموعتين في المتغيرات الديموغرافية، مقياس الوصمة المستخدم في الدراسة من إعداد الباحث نفسه وهو يهدف لتقييم مستوى الوصمة لدى المشاركين، كلتا المجموعتين أتمتا تعبئة مقياس الوصمة قبل وبعد تطبيق البرنامج الإرشادي الذي يتألف من (12) جلسة، كل جلسة (45) دقيقة، كما تم استخدام المهارات الارشادية التالية في البرنامج (التفريغ الانفعالي، تمارين الاسترخاء، السيكودراما، والإرشاد الديني).

النتائج :

أشارت نتائج الدراسة إلى وجود فروق ذات دلالة إحصائية في مستوى الوصمة لدى المجموعة التجريبية قبل وبعد تطبيق البرنامج الإرشادي فقد تبين أن حجم التأثير بواسطة مربع إيتا كان كبير لأن قيمة (د = 7.9) وهذا يعني أن البرنامج الإرشادي له تأثير ايجابي في خفض مستوى الوصمة لدى أفراد المجموعة التجريبية ، فقد بلغت نسبة التغيير(45.9%) لدى أفراد المجموعة التجريبية في مستوى الوصمة بعد تطبيق البرنامج حيث تراوحت نسبة الفعالية للبرنامج من (35.7%-52.6%).

وبعد مرور شهر من تطبيق البرنامج الإرشادي أشارت النتائج إلى عدم وجود فروق ذات دلالة إحصائية بين درجات الاختبار البعدي ودرجات الاختبار التتبعي لمقياس الوصمة لدى أفراد المجموعة التجريبية حيث بلغت قيمة (Z.value -1.15) (P.value // 0.27) وهذا يدل على استمرارية الأثر الإيجابي للبرنامج في خفض مستوى الوصمة لدى أفراد المجموعة التجريبية.

التوصيات :

أوصت الدراسة باستخدام البرنامج الإرشادي المقترح لخفض مستوى الوصمة لدى أهالي مرضى الفصام العقلي وبناء برامج إرشادية مماثلة لمعالجة التأثيرات السلبية المترتبة على وصمة المرض النفسي.

الكلمات الدالة : الفصام العقلي، الوصمة، البرنامج الإرشادي.

Contents

List of abbreviations

PCBS	Palestinian Central of Bureau of Statistics.
WHO	World Health Organization.
DSM-IV	Diagnostic and Statistic Manual of Mental Disorder 4th edition.
MOH	Ministry of Health.
SPSS	Statistical Package for the Social Sciences.
ICD	International Classification of Diseases
UNODC	United Nations Office of Drugs and Crime
BC	Before Christ
NARSAD	National Alliance for Research on Schizophrenia and Depression
NAMI	National Alliance on Mental Illness
CAMIMH	Canadian Alliance on Mental Illness and Mental Health
NIMH	National Institute of Mental Health
NCCMH	National Collaborating Centre for Mental Health
CPA	Canadian Psychiatric Association
ECT	Electro Convulsive Treatment
CBT	Cognitive Behavioral Therapy
UNESCO	United Nations Educational, Scientific and Cultural Organization
IPT	Interpersonal Therapy (IPT)
DBT	Dialectical Behavior Therapy
BCIS	Beck Cognitive Insight Scale
SUMD	Scale to Assess Unawareness of Mental Disorder
CNVs	Copy Number Variations
BD	Bipolar Disorder
QOL	Quality Of Life
PANSS	Positive and Negative Syndrome Scale
OSG	Online Support Group
CAINS	Clinical Assessment Interview for Negative Symptoms
CVD	Cardiovascular Disease
NIS	New Israeli Shekels

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Chapter 1

Background

1.1 Introduction:

The ongoing war on Gaza Strip, the impact and long-term effects of the political conflict on Palestinians in Gaza Strip represent traumatic events with ramifications for their social system, and the predictive relationship between war traumas and the normative stressors in psychological distress has received increasing attention.

Counseling has become one of the most important challenges when treating patients with schizophrenia. In the past, according to the problem solving framework, this social dysfunction was described as the conjunction of disabilities in social cognition (which refers to the mental operations and capacities that underlie social interactions) and social competence (which refers to communication skills, e.g., the verbal and nonverbal communication skills that allow successful execution of interpersonal interactions) (Calafell, 2013).

Since the patient and the family are often under enormous emotional strain, it may be advantageous to obtain counseling from professionals who understand the illness. A more integrated mental health system must also be linked to, rather than isolated from, all parts of the community and other service systems. Family doctors, teachers, police personnel, and long-term care workers are among those who should work with each other and with mental health service providers to address people's mental health needs. A more coordinated and integrated system will make available multiple resources to help facilitate recovery: timely access to medications and to adequate and affordable housing; professional counseling, as well as readily available peer support; and help in setting and meeting educational and employment goals.

Evidence suggests that people with a severe mental illness still suffer high levels of stigma and discrimination. However little is known about how people with a severe mental illness manage such stigma (Whitley, 2014).

The word 'stigma' originated as a noun in ancient Greek, which literally meant a 'brand' or 'mark'. The concept of stigma has since entered the social sciences, mainly through the seminal work of scholars such as Goffman (1963) and Foucault (1995). Goffman (1963, p3) defined stigma as 'an attribute that is deeply discrediting…turning a whole and usual person to a tainted and discounted one'. He further noted that stigma can be divided into that which is *discredited*- this being an obvious mark easily perceived by an observer, or *discreditable*- this being a secret stigma not readily apparent to an observer. Goffman states that, once noted by an observer, stigma can mark out the bearer for undue scrutiny, criticism, ridicule, mockery and discrimination (Whitley, 2014).

Although Goffman acknowledges that the stigma process is not confined to face-to-face interactions (for example, reading a negative newspaper account of a person with mental illness is part of the stigma process), Stigma is concerned with what he calls "mixed contacts" between what he calls "normals" and stigmatized people (Phelan, 2014).

Stigma exists when the following interrelated components converge. In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them.' In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination expectation of being rejected and of being treated as having lower status (Phelan et al, 2014).

Schizophrenia is one of the most heterogeneous and detrimental psychiatric disorders accompanied by major neuropsychological, social, and educational impairments. While research has shown that schizophrenia is associated with increased criminal behavior, male but not female patients have been mostly investigated. Hence, gender- specific trajectories to schizophrenia and criminal behavior are rather poorly understood (Landgraf, 2013).

Lack of insight is a common feature of schizophrenia, it has an important impact on several markers of clinical outcome. In particular, studies have demonstrated that lack of insight is linked to greater overall severity of psychopathology and to poorer medication adherence, which is in turn associated with more frequent relapses and hospitalizations (Misdrahi et al, 2014).

1.2 Objectives of the study:

1.2.1 General Objective :

This study aimed to identify the effectiveness of proposed counseling program on reducing level of stigma among families of patients with schizophrenia in Gaza strip.

1.2.2 Specific Objectives of the Study:

- To evaluate level of stigma among families of patients with schizophrenia.
- To examine the effectiveness of counseling program on reducing level of stigma among families of patients with schizophrenia in Gaza Strip.
- To build an effective counseling program.
- To explore the effectiveness of counseling program on stigma.

1.3 Significance of the study:

This study is to explain the stigma causes, signs and symptoms, factors impact the increase or decrease level of stigma, factors impacting ability to cope with mental illness as schizophrenia and the socio cultural effect of stigma.

Also this study is conducted to know the dimensions of stigma and related knowledge and how to reduce level of stigma of mental illness.

This study is to explore effectiveness of counseling program on reducing the level of family stigma toward mental illness. Although we need much knowledge about the stigma outcome of schizophrenia patients in terms of recovery.

There has been no evidence that any research has been conducted in Gaza Strip to evaluate level of stigma and its impact on schizophrenic patients' families.

1.4 Research questions:

1.4.1 The main questions of the study:

1. What is the level of stigma among the families of patients with schizophrenia in Gaza Strip?
2. What is the level of stigma among the intervention group members and control group members in the pre test and post test of counseling program intervention?

1.4.2 The research hypotheses:

1. There are no statistically significant differences in the level of stigma among the intervention group and the control group before the application of the counseling program.
2. There are no statistically significant differences in the level of stigma among the intervention group and the control group after the application of the counseling program.
3. There are no statistically significant differences between the scores of pre-test and post-test of stigma level among the intervention group members in the counseling program.
4. There are no statistically significant differences between the scores of post-test and Sequential test of stigma scale among the intervention group in the counseling program.

1.5 Context of the study:

The study was conducted in the Gaza Strip, Palestine; therefore in this section the researcher will present basic information of the Palestinian population, geography, socio-economic situation, and mental health sector of the Gaza Strip.

1.5.1 Geographic and Demographic Context:

The Palestinian Territory comprises two areas separated geographically: the West Bank and Gaza Strip. Gaza Strip is very crowded place with a surface area of 365sq.Km and constitutes 6.1% of total area of Palestinian territory. Gaza Strip comprises the following main five governorates: North of Gaza, Gaza City, Mid-Zone, Khanyounis, and Rafah (MOH, 2006).

The total population of the Palestinian Territory at mid-2012 was about 4.29 million; 2.18 million males and 2.11 million females. The estimated population of West Bank was 2.65 million of which 1.35 million males and 1.30 million females. While the estimated population of Gaza Strip totaled 1.64 million of which 835 thousand males and 809 thousand females. The percentage of urban population mid-2012 was about 73.8%, while the percentage of population in rural and camps areas was 16.8% and 9.4% respectively [Palestinian Central Bureau of Statistics (PCBS), 2012].

The population of the Palestinian Territory is young; the percentage of individuals aged (0-14) constituted 40.4% of the total population at mid-2012 of which 38.4% in the West Bank and 43.7% in Gaza Strip. The elderly population aged (65 years and over) constituted 2.9% of the total population of which 3.3% in the West Bank and 2.4% in Gaza Strip of mid 2012(PCBS, 2012).

Population density of The Palestinian Territory is generally high at 713 persons/Km2.In Gaza Strip it is 4,505 persons/km2 compared to lower population density in the West Bank at 468 persons/Km2 at mid-2012 (PCBS, 2012).

1.5.2 Socio-economic Context:

Unemployment: The results showed that more than one fifth of participants in the labor force were unemployed in the 1st quarter of 2012 at 23.9% as of 20.1% in the West Bank and 31.5% in Gaza Strip. Unemployment rate reached 31.5% among females compared to 22.0% among males (PCBS, 2012).

Poverty: Poverty lines can be established in a relative or absolute way. Absolute poverty lines are often based on estimates of the cost of basic food needs (e.g., the cost of a nutritional basket considered minimal for the healthy survival of a typical family), to which a provision is added for non-food needs (The World Bank, 2011). In 2010 the $1.25-a-day poverty rate fell to less than half that of 1990. In China for example, 13 percent or 173 million people, lived below $1.25 in 2008. In India 43 percent of the population is living below $2 a day (Rastello and DeGeorge, 2012).

Relative poverty lines are defined in relation to the overall distribution of income or consumption in a country (e.g. 50 percent of the country's mean income or consumption) (The World Bank, 2011). The relative poverty line and the deep poverty line according to consumption patterns (for reference household consisted of 2 adults and 3 children) in the Palestinian Territory in 2012 were 2,293 NIS, and 1,832 NIS respectively. The poverty rate among Palestinian individuals was 25.8 (17.8% in the West Bank, and 38.8% in Gaza Strip) (PCBS, 2012).

Education: The 2011 data revealed that the percentage of individuals (15 years and over) who completed university education was 11.3%, while the percentage of individuals who did not complete any stage of education reached 10.8%. These results showed that there were differences between males and females in educational attainment, where the percentage of males who have completed university education was 12.0% compared to 10.5% for females. As for those who did not complete any stage of education, their percentage among males was 8.3% compared to 13.4% for females (PCBS, 2012).

1.5.3 Mental Health in Palestine:

It is within this challenging political and economic context that we find little in the way of epidemiological data on mental illness in Palestine. In this regard, the World Health Organization (WHO) claims that for mental health data in Palestine "No reliable national data exists (Jabr, 2013).

In the West Bank and Gaza Strip, mental disorders such as depression and anxiety, as well as more serious mental illness, such as schizophrenia, are underreported, under-resourced and under-treated. The occupation of the West Bank, blockade and siege of the Gaza Strip, violence, poverty and unemployment contribute substantially to the burden of mental health illness in the occupied Palestinian territory, and disproportionately affect the most vulnerable population groups –women, children and older people– as well as young adult men (WHO, 2013).

In the absence of reliable epidemiologic data, it is reasonable to assume that most common mental disorders occur at roughly the same rate in Palestine as they do globally, and indeed the WHO estimates that 5%–10% of the population in the occupied Palestinian territory may currently suffer some form of common mental disorder (Jabr, 2013).

1.5.4Community mental health centers:

In 1995, MOH established 6 community mental health centers that were distributed in Gaza Strip, One of them is in Rafah governorate, the second is in Khanyounis governorate, the third is in Mid-area, the forth is in Gaza city, the fifth is in north Gaza, and the sixth is in West Gaza, These mental health centers provide counseling for psychiatric patients and psychopharmacological treatments.

1.6 General view of the study chapters:

This study consists of five chapters. The first chapter presents a background for study subject. Problem, objectives, and study questions. The second chapter shows a conceptual framework, The third one views the literature that is related to the study subject, which was collected from scientific researchers, published magazine, and other scientific ways. The fourth views the methodology of the study. In the fifth the researcher views the research questions, study hypotheses, results in tables and interpretations . These results will be discussed in details and followed by a conclusion about the study as well as a recommendations in same chapter.

Chapter Two

Conceptual framework

2.1. Introduction to mental health:

This chapter consists of three parts; the first part put the reader on an overview of mental health definitions related to schizophrenia, the second part will show conceptual framework diagram, and the part discusses operational definitions of terms.

WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 1948-2013).

Mental health wellbeing requires that individuals enjoy the security and freedom provided by basic human rights, Rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health and human rights violations increase vulnerability, as do specific psychological and personality factors and some biological causes, including genetic factors and chemical imbalances in the brain (WHO, 2010).

People with mental illness are stigmatized and badly served by the health sector in the occupied Palestinian territory, as in the Region and most of the world. (WHO, 2012).

It is readily apparent that the Palestinian mental healthcare system cannot presently meet the needs of the population. Nonetheless, as is the case with epidemiology, we lack reliable system-wide data on the system of care. What is known: There is one governmental psychiatric hospital in Bethlehem with roughly 80 acute care and 20 long-term care beds and there is one governmental psychiatric hospital in Gaza with roughly 20 male and 20 female beds (El-Sarraj, 2013).

Both the Gaza and West Bank governments run community mental health systems, which, according to the WHO statistics, treat a subset of the 4,500 patients who receive treatment yearly.10 There are also a few nongovernmental organizations, which run mental health or counseling centers in the West Bank and Gaza .

2.2 Mental health in occupied Palestinian territory:

In the West Bank and Gaza Strip, mental disorders such as depression and anxiety, as well as more serious mental illness, such as schizophrenia, are underreported, under-resourced and under-treated. The occupation of the West Bank, blockade and siege of the Gaza Strip, violence, poverty and unemployment contribute substantially to the burden of mental health illness in the occupied Palestinian territory, and disproportionately affect the most vulnerable population groups –women, children and older people– as well as young adult men (WHO, 2013).

No reliable national data exist but WHO estimates that, globally, 25% of the general population can be expected to develop common mental disorders at some

point in their lives, and some may develop serious mental illness. Comparing WHO surveys in post-conflict countries and local studies, WHO estimates that 5%–10% of the population in the opt may currently suffer some form of common mental disorder; less than one in five of those in need currently accesses health care services: about 4500 individuals a year. Many Palestinians do not seek treatment as a result of neglect, or fear of discrimination or stigma. If treatment is sought and an accurate diagnosis is made, most mental disorders can be treated successfully at community mental health centre's and with simple low-cost medications (WHO, 2013).

People with mental disorders have a much higher mortality than the general population, dying on average more than 10 years earlier. That gap is widening as health gains have been made more quickly in the general population than for those with mental illness. A reason for this widening gap is the high prevalence of chronic diseases such as cardiovascular disease, cancer and diabetes, and the often poor access and quality of treatment for such conditions for people with mental illness. Similarly, people diagnosed with chronic physical health conditions suffer from high rates of depression, often remaining undiagnosed, and this is also associated with higher mortality.

The early stages of schizophrenia are often characterized by repeated exacerbation of symptoms such as hallucinations and delusions and disturbed behavior. While a high proportion respond to initial treatment with antipsychotic medication, around 80% will relapse within 5 years of a treated first episode, which is partly explained by discontinuation of medication (British Psychological Society, 2010: 18).

Individuals who develop schizophrenia will each have their own unique combination of symptoms and experiences, the precise pattern of which will be influenced by their particular circumstances (British Psychological Society, 2010: 16).

2.3 Theoretical Framework Diagram:

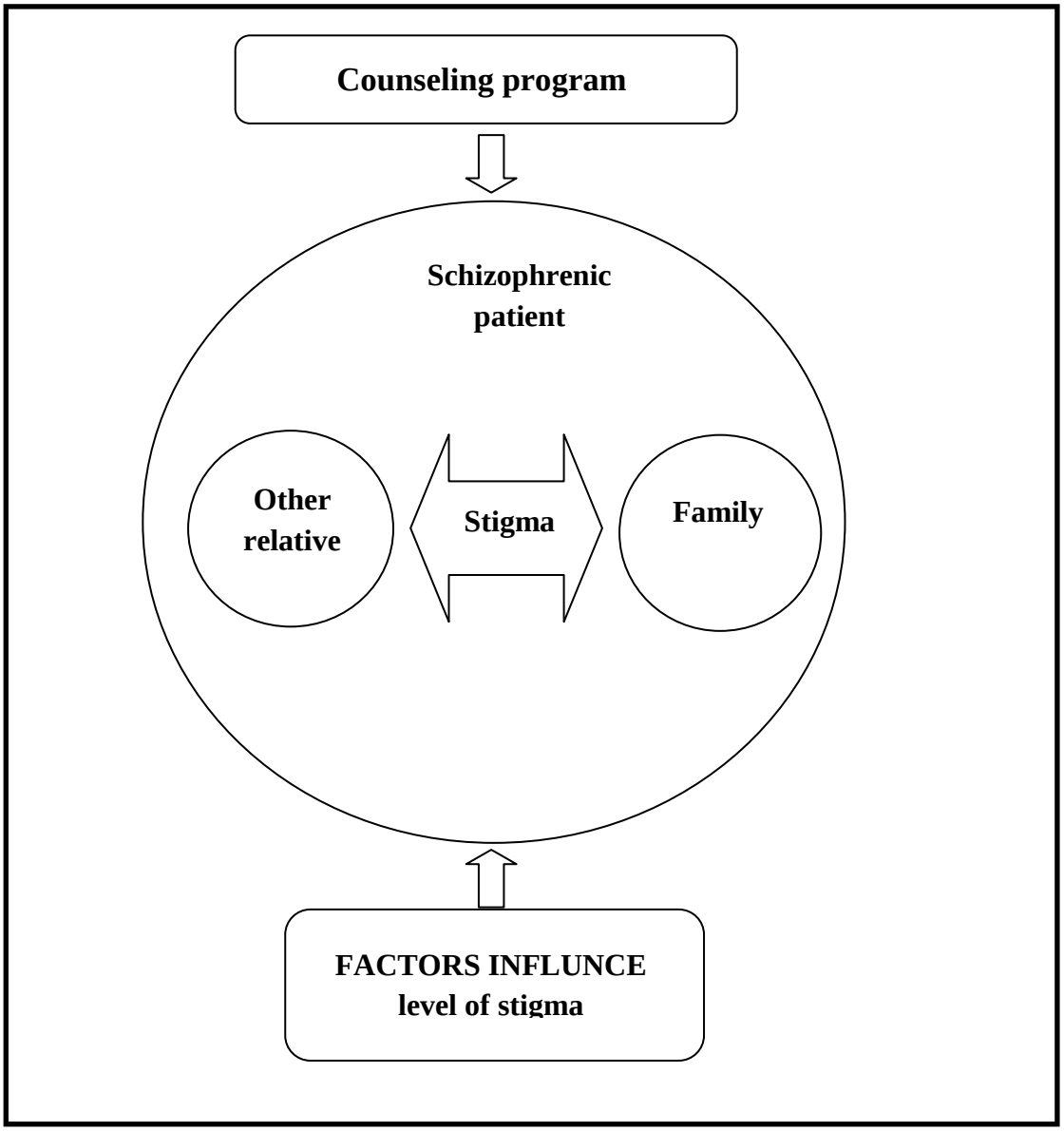

Figure (2.1): Conceptual Framework-Self developed.

The above conceptual framework is used to support, guide, and direct the research process to make research findings meaningful and applicable.

A. Schizophrenia:

2.4 Overview of Schizophrenia:

The term schizophrenia, which comes from the Greek roots ‘‘skhizein’’ and ‘‘phren,’’ was translated as ‘‘Jungshinbunyeolbyung’’ in East Asian Countries, including Japan, Korea, and China. The term literally means ‘‘mind-splitting disease.’’ This term has generated a misconception of the disorder as an untreatable chaotic personality (Lee et al, 2014).

The term schizophrenia was introduced into the medical language at the beginning of this century by the Swiss psychiatrist Bleuler. It refers to a major mental disorder, or group of disorders, whose causes are still largely unknown and which involves a complex set of disturbances of thinking, perception, affect and social behaviour. So far, no society or culture anywhere in the world has been found free from schizophrenia and there is evidence that this puzzling illness represents a serious public health problem (WHO, 2011).

Schizophrenia is one of the most heterogeneous and detrimental psychiatric disorders accompanied by major neuropsychological, social, and educational impairments. While research has shown that schizophrenia is associated with increased criminal behavior, male but not female patients have been mostly investigated. Hence, gender- specific trajectories to schizophrenia and criminal behavior are rather poorly understood (Landgraf, 2013).

Schizophrenia has fascinated and confounded healers, scientists, and philosophers for centuries. It is one of the most severe mental illnesses and is present in all cultures, races, and socioeconomic groups. Its symptoms have been attributed to possession by demons, considered punishment by gods for evils done, or accepted as evidence of the inhumanity of its sufferers. These explanations have resulted in enduring stigma for people with diagnoses of the disorder. Today the stigma persists, although it has less to do with demonic possession than with society‘s unwillingness to shoulder the tremendous costs associated with housing, treating, and rehabilitating patients with schizophrenia (Piotrowski,2005:731).

The disorder usually begins before age 25. Both patients and their families often suffer from poor care and social ostracism because of widespread ignorance about the disorder. Although schizophrenia is discussed as if it is a single disease, it probably comprises a group of disorders with heterogeneous etiologies, and it includes patients whose clinical presentations, treatment response, and courses of illness vary. Clinicians should appreciate that the diagnosis of schizophrenia is based entirely on the psychiatric history and mental status examination (Sadock, & Sadock, 2007:467).

In addition, Schizophrenia is often confused, by the layperson, with multiple personality disorder. The latter is an illness which is defined as two or more distinct personalities existing within the person. The personalities tend to be intact, and each is associated with its own style of perceiving the world and relating to others. Schizophrenia, in contrast, does not involve the existence of two or more personalities; rather, it is the presence of psychotic symptoms and characteristic deficits in social interaction that define schizophrenia (Piotrowski,2005:731).

This disease causes distorted and bizarre thoughts, perceptions, emotions, movements, and behavior. It cannot be defined as a single illness; rather, schizophrenia is thought of as a syndrome or disease process with many different varieties and symptoms, much like the varieties of cancer. For decades, the public vastly misunderstood schizophrenia, fearing it as dangerous and uncontrollable and causing wild disturbances and violent outbursts. Many people believed that those with schizophrenia needed to be locked away from society and institutionalized. Only recently has the mental health industry come to learn and educate the community at large that schizophrenia has many different symptoms and presentations and is an illness that medication can control (Videbeck, 2008:297).

The natural progression of schizophrenia is usually described as deteriorating with time, with an eventual plateau in the symptoms. Only for elderly patients with schizophrenia has it been suggested that improvement might occur. In reality, no one really knows what the course of schizophrenia would be if patients were able to adhere to a treatment regimen throughout their lives. Only recently have medications been relatively effective, with manageable side effects. The clinical picture of schizophrenia is complex; individuals differ from one another; and the experience for a single individual may be different from episode to episode (Bostrom & Boyd, 2008:266).

As with many mental disorders, the causes of schizophrenia are poorly understood. Friends and family commonly are shocked, afraid or angry when they learn of the diagnosis. People often imagine a person with schizophrenia as being more violent or out-of-control than a person who has another kind of serious mental illness. But these kinds of prejudices and misperceptions can be readily corrected. Expectations become more realistic as schizophrenia is better understood as a disorder that requires ongoing -- often lifetime -- treatment. Demystification of the illness, along with recent insights from neuroscience and neuropsychology, gives new hope for finding more effective treatments for an illness that previously carried a grave prognosis. (Landgraf, 2013).

Schizophrenia is characterized by a broad range of unusual behaviors that cause profound disruption in the lives of people suffering from the condition, as well as in the lives of the people around them. Schizophrenia strikes without regard to gender, race, social class or culture. (Landgraf, 2013).

However, recent studies have shown that people's knowledge of mental illness may be unrelated to their attitudes and perhaps even inversely related.

2.5 History of Schizophrenia:

Descriptions of illness consistent with schizophrenia date back 3400 years to 1400 BC and are found throughout history; they become frequent only after the social and industrial revolutions of the eighteenth century when physicians were given control of asylums. Emil Kraepelin, a German psychiatrist attempting to classify all subsequently described psychoses of the nineteenth century, introduced the term "dementia praecox" in 1896. He classified psychotic disorders "without known organic etiology" into three groups based on clinical presentation and course. Kraepelin used the term manic- depressive insanity for the group of disorders

characterized primarily by exacerbations and remissions in disturbances of affect rather than cognition. He linked a second syndrome, paranoia, with this group because the psychosis was limited and did not produce severe deterioration of affect or function. Dementia praecox was the term Kraepelin used for his third group, which featured severe disturbances in functioning that began in adolescence and progressively worsened and in which "failure of volition" was a prominent feature. Kraepelin did note that there were variations in course, and he considered paraphrenia to be a less severe development of dementia praecox (Goldman & Maryland, 2000:233).

In 1911, Eugen Bleuler, a Swiss psychiatrist, classified the functional psychoses into just two groups by introducing the term schizophrenia. Schizophrenia, literally translated as "splitting of the mind," remained the dominant term worldwide for the psychoses described below. Bleuler believed that four psychological processes were central to the illness: autism (a turning inward, away from the world), ambivalence (the condition of having two strong but opposite feelings at the same time), and primary disturbances in affect and associations. Like Kraepelin, Bleuler assumed that the schizophrenia syndrome was separate from manic-depressive illness and that underlying biological determinants eventually would be discovered for each (Bleuler, 1911/1950). Modern studies of manic-depressive and schizophrenic psychoses actually began after 1911, when serology had provided a means of identifying patients with tertiary syphilis, who accounted for about one-third of those considered severely mentally ill, and later when public health measures had reduced the nutritional avitaminoses (Piotrowski, one hundred years. During this time, only modest progress has been made in research on its etiology. Some significant advances 2005:731).

Finally, the word "schizophrenia" is less than 100 years old. However the disease was first identified as a discrete mental illness by Dr. Emile Kraepelin in the 1887 and the illness itself is generally believed to have accompanied mankind through its history. Eugene Bleuler first introduced the term "schizophrenia" in 1911.In a layman's language; schizophrenia can be defined as a mental sickness, which affects the entire human personality (but without a reduction of the human intellectual potentials). The main root of schizophrenia is still unknown.

2.6 Definition of schizophrenia

Gold (2012:233) defined this disease as a severe and prolonged mental disturbance manifested as a wide range of disturbed thought, speech, and behavior. Though discussed as one disease, schizophrenia may be more appropriately considered a group of disorders of uncertain cause with similar clinical presentations, invariably including thought disturbances in a clear sensorium, often with characteristic symptoms such as hallucinations, delusions, bizarre behavior, and deterioration in the general level of functioning.(Gold, 2012).

In another definition the NARSAD‘s (2009) identify Schizophrenia is a severe and debilitating brain disorder affecting how one thinks, feels and acts. People with schizophrenia can have trouble distinguishing reality from fantasy, expressing and managing normal emotions and making decisions. Thought processes may also

be disorganized and the motivation to engage in life‘s activities may be blunted. Those with the condition may hear imaginary voices and believe others are reading their minds, controlling their thoughts or plotting to harm them. (NARSAD‘s, 2009: 1).

The National Alliance on Mental Illness defined schizophrenia is "A mental illness that interferes with a person‘s ability to think clearly, manage emotions, make decisions, and relate to others. Most people living with schizophrenia have hallucinations and delusions, meaning they hear or, less commonly, see things that aren‘t there and believe things that are not real or true. Organizing one‘s thinking, performing complex memory tasks, and keeping several ideas in mind at one time may be difficult for people who live with the illness (NAMI, 2008:1).

Another definition of by Stuart(2009), was identifies schizophrenia as a confusing disease because we have only causal factors for these conditions, the causes of schizophrenia still unknown but have many factors such as hereditary, biological changed in brain, psychosocial problem, viruses and stress. Schizophrenia is probably best viewed as an umbrella term for number of disorders which case significant level of distress and many cases lifelong handicap for sufferer, also produces a considerable burden on both family and health care system (Stuart, 2009).

In addition, Gur & Johnson (2006) identified schizophrenia is a chronic and severe mental disorder that is characterized by a disintegration of the process of thinking, of emotional responsiveness, and of contact with reality. Early in the twentieth century, schizophrenia was known as dementia praecox (premature dementia), because of the disintegration or fragmenting of mental functions typically observed in people with the disorder. The term schizophrenia itself means "fragmented mind," referring to the schisms between thought, emotion, and behavior that characterize the disease. It is not the same as "split personality, "which is an altogether different illness now known as dissociative identity disorder. People with schizophrenia do not alternate between "good" and "bad" personalities (Gur & Johnson, 2006:4).

Also, Sadock (2007) was identified Schizophrenia as a clinical syndrome of variable, but profoundly disruptive, psychopathology that involves cognition, emotion, perception, and other aspects of behavior. The expression of these manifestations varies across patients and over time, but the effect of the illness is always severe and is usually long lasting. Persists throughout life, and affects persons of all social classes (Sadock, 2007:467).

The controversy about the definition of "schizophrenia" has led to many different conclusions about its natural course and treatment outcome. The varied conclusions have, in turn, confused the researchers as much as have the varied symptomatic behaviors of patients with schizophrenia with whom they interact. No matter how narrow the initial diagnostic criteria there are marked variability's in both the final outcome and the clinical presentations seen at different times over any individual patient's lifetime. Different observers, even within a single diagnostic system, seeing the patient at different times, attain contradictory impressions and gain a dissimilar perspective (NARSAD‘s, 2009: 1).

From all definition of schizophrenia, researcher sum up define of schizophrenia is one of the terms used to describe a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behavior. Individuals who develop schizophrenia will each have their own unique combination of symptoms and experiences, that shows marked disturbance in thought, mood, and behavior that lead to impaired functioning and deterioration of personality. Difficulties may include memory and concentration problems, social withdrawal, unusual and uncharacteristic behavior, disturbed communication and affect, bizarre ideas and perceptual experiences, poor personal hygiene, and reduced interest in and motivation for day-to-day activities. During this prodromal period, people with schizophrenia often feel that their world has changed, but their interpretation of this change may not be shared by others.

2.7 Onset of Schizophrenia:

One of the difficulties in reading the early warning signs of schizophrenia is the easy confusion with some typical adolescent behaviors. Schizophrenia can begin to affect an individual during the teen years, a time when many rapid physical, social, emotional, and behavioral changes normally occur. There is no easy method to tell the difference. It‘s a matter of degree. Family members tell of different experiences. Some sensed early on that their child, spouse, or sibling was not merely going through a phase, a moody period, or reaction to the abuse of drugs or alcohol. Others did not feel their relative‘s behavior had been extraordinary. If you have any concerns, the best course of action is to seek the advice of a trained mental health specialist (Montgomery & Dawe, 2003:23).

Although schizophrenia usually has its onset when the person is in the teens or early 20s, there clearly is a continuum of onset with cases occurring early (before puberty) and late (after age 45). Schizophrenia beginning in childhood often indicates a more severe disease process that is more difficult to treat. Autism and childhood schizophrenia are no longer considered to be the same disorder. Schizophrenia can begin later in life and is sometimes called late paraphrenia; clinically the typical patient is a suspicious person with delusions of persecution and hallucinations but with little formal thought disorder and affective flattening. In the majority of cases, the onset of schizophrenic symptoms occurs in late adolescence or early adulthood. The major risk period is between twenty and twenty-five years of age, but the period of risk extends well into adult life. For some patients, there are no readily apparent abnormalities prior to the development of illness. For others, however, the onset of schizophrenia is preceded by impairments in social, academic, or occupational functioning. Some are described by their families as having had adjustment problems in childhood. Childhood schizophrenia is relatively rare. It is estimated to occur in about one out of every ten thousand children. When schizophrenia is diagnosed in childhood, the same diagnostic criteria and treatments are applied (Piotrowski, 2005:736).

The onset of schizophrenia typically occurs between the late teens and mid-30s. Onset before adolescence is rare. Men and women are affected equally by schizophrenia, but men usually develop the illness earlier than women. If the illness develops after the age of 45, it tends to appear among women more than men, and

they tend to display mood symptoms more prominently (Canadian Alliance on Mental Illness and Mental Health, 2002:51).

The fact that onset is early will affect functioning in different ways. At this age the person is not only adapting to the odd perceptions which generally accompany the onset of schizophrenia, but because acute episodes often mean spending time in hospital and away from family and friends, they also miss out on the widening of social roles. There will also be effects on cognition solely due to early onset, as the development of memory systems, social cognition and executive functioning can continue into late adolescence. The cognitive systemic therefore less of an expert system and the development of cognitive schemas is delayed or disrupted (Wykes & Reeder, 2005: 71).

The onset of schizophrenia in most people is a gradual deterioration that occurs in early adulthood -- usually in a person's early 20s. Loved ones and friends may spot early warning signs long before the primary symptoms of schizophrenia occur. During this initial pre-onset phase, a person may seem without goals in their life, becoming increasingly eccentric and unmotivated. They may isolate themselves and remove themselves from family situations and friends. They may stop engaging in other activities that they also used to enjoy, such as hobbies or volunteering (Michael Bengston, 2013).

Warning signs that may indicate someone is heading toward an episode of schizophrenia include:

- Social isolation and withdrawal
- Irrational, bizarre or odd statements or beliefs
- Increased paranoia or questioning others' motivations
- Becoming more emotionless
- Hostility or suspiciousness
- Increasing reliance on drugs or alcohol (in an attempt to self-medicate)
- Lack of motivation
- Speaking in a strange manner unlike themselves
- Inappropriate laughter
- Insomnia or oversleeping
- Deterioration in their personal appearance and hygiene(Michael Bengston, 2013).

While there is no guarantee that one or more of these symptoms will lead to schizophrenia, a number of them occurring together should be cause for concern, especially if it appears that the individual is getting worse over time. This is the ideal time to act to help the person (even if it turns out not to be schizophrenia) (Michael Bengston, 2013)

2.8 Prevalence of Schizophrenia:

Schizophrenia Spreads at a rate of 1% of the general public, and schizophrenia occurs between fifteen and the age of fourty, with an increased incidence in the late twenties, and prevalence of schizophrenia In males as females, and spread evenly among all races and frequent among unmarried and last Rebirth children in the family, and is widely spread in crowded big cities, and among the poorer classes, Increasingly it appears at the beginning of summer and in the fall, and

half of September, and increasingly between the boat and the proportion and 50-60% of the total patients admitted psychiatric hospital (El-Sarraj, 2013).

The incidence of schizophrenia in industrialized countries is in the region of 10–70 new cases per 100000 populations per year1, and the lifetime risk is 0.5–1%. The geographical distribution of schizophrenia is not random: recent studies have shown that there is an increased first-onset rate in people born or brought up in inner cities. There is also a significant socioeconomic gradient, with an increased prevalence in the lower socioeconomic classes. ‗Social drift', both in social class, and into deprived areas of the inner cities, may account for part of this, but specific environmental risk factors (e.g. overcrowding, drug abuse) may also be operating (Stefan et al., 2002:30).

Schizophrenia Spreads at a rate of 1% of the general public, and schizophrenia occurs between fifteen And the age of forty, with an increased incidence in the late twenties, and prevalence of schizophrenia In males as females, and spread evenly among all races and frequent among unmarried and last Rebirth children in the family, and is widely spread in crowded big cities, and among the poorer classes, Increasingly it appears at the beginning of summer and in the fall, and half of September, and increasingly between the boat and the proportion and 50-60% of the total patients admitted psychiatric hospital .

The prevalence of schizophrenia is considerably higher in the unmarried of both sexes. There is a small excess of patients born during the late winter and early spring months in both northern and southern hemispheres (and a less well known decrement in late summer. People with schizophrenia have a twofold increase in age-standardized mortality rates, and are more likely to suffer from poor physical health. Much of the increased mortality occurs in the first few years after initial admission or diagnosis. Contributing factors early in the course include suicide, with later factors, such as cardiovascular disorders, due in part to the poor lifestyle of many patients, with heavy cigarette smoking and obesity being common(Videbeck.2008:307).

Schizophrenia occurs in all cultures and countries. Its economic costs are enormous. Direct costs include treatment expenses, and indirect costs include lost wages, premature death, and incarceration. In addition, employment among people with schizophrenia is one of the lowest of any group with disabilities. The costs of schizophrenia in terms of individual and family suffering probably are inestimable (Bostrom & Boyd, 2008:267).

2.9 The risk factor of schizophrenia

It is often said that schizophrenia is a disease of unknown etiology. This is no longer true. Schizophrenia is like other complex disorders such as ischemic heart disease, which have no single cause but are subject to a number of factors that increase the risk of the disorder (Byrne et al., 2003:678).

Also add, risk factors for schizophrenia include stresses in the prenatal period (starvation, poor nutrition, and infections), obstetrical complications, and genetic and family susceptibility. There has been recent evidence that parental age may also be a risk factor (Byrne et al., 2003:678). Birth cohort studies suggest that the incidence

may be higher among individuals born in urban settings than those born in rural ones and may be somewhat lower in later-born birth cohorts. Infants affected by these maternal stressors may have conditions that create their own risk, such as low birth weight, short gestation, and early developmental difficulties. In childhood, stressors may include central nervous system infections (Harrison et al., 2003).

2.9.1 Individual Factors:

How schizophrenia develops is uncertain but research suggests that brain abnormalities, birth complications, and neurotransmitter dysfunction may be important risk factors. Studies examining neurological anomalies in persons with schizophrenia indicate that ventricular enlargement, gross reduction of cerebral gray matter, and reduced metabolism in the frontal lobes may be related to the development of positive and negative symptoms (Schaeffer & Ross, 2002: 538). Prenatal stressors during the second trimester of pregnancy have also been implicated. These stressors may include exposure to a viral infection during a critical period of brain development, delivery complications, and poor maternal nutrition. In adults, inadequate levels of dopamine have been associated with the development of psychosis .Other neurotransmitters such as the serotonin, noradrenergic and glutamate systems are also being considered. However, few brain imaging or neurochemical studies have been done with children and adolescents so these theories must be considered conservatively (Gullotta & Adams, 2005: 351).

2.9.2 Family Factors:

Another aspect of the vulnerability-stress model is consideration of an inherited genetic predisposition to schizophrenia. Research studies examining the concordance rates of schizophrenia in families provide compelling evidence that genetics play an important role in the development of this disease. First-degree relatives of schizophrenic patients are ten times more likely to develop schizophrenia than the rate in the general population. Additionally, the risk of developing schizophrenic spectrum disorders including schizoaffective disorder, non affective psychoses, and schizotypal and paranoid personality disorder is much higher in families of persons with schizophrenia than in unaffected families (Kendler et al., 1993: 645).

Twin studies allow researchers to explore the roles of genetic and environmental factors in the development of schizophrenia. Monozygotic twins share 100% of their genetic material. If genetic factors are solely responsible for the development of schizophrenia, both twins should always develop the disease. However, studies have demonstrated that concordance rates for monozygotic twins vary from 33% to 78%. Furthermore, concordance rates for same-sex dizygotic twins range from 8% to 28%. These findings suggest that while vulnerability for schizophrenia is indeed inherited, environmental factors are also important; if not the controlling influence in some cases (Cancro & Lehman, 2000:1170).

2.9.3 Social and Community Factors:

Since environment seems significantly to influence the risk of developing schizophrenia, several studies have explored social and community factors that may be related with this disorder. Again, few studies of early-onset cases are available but

some longitudinal research provides important data on the impact of environmental stress on schizophrenic expression. Some recent prospective study tracked the occurrence of stressful life events of subjects who developed schizophrenia for one year after the onset of schizophrenic symptoms, that's results revealed that 37% of the participants experienced a significant relapse following stressful life events (Gullotta & Adams, 2005: 353).

What constitutes life stress may vary considerably from person to person, but one area that seems to be important is the family environment. Early psychoanalytic theories presented the concept of the schizophrenogenic mother and suggested that maladaptive mother–child relationships caused the onset of schizophrenic symptoms. However, empirical studies have demonstrated that there is no support for these ideas and this theory is no longer accepted today (Gullotta & Adams, 2005: 353).

Although no evidence exists that family environment directly leads to the development of schizophrenia, several studies have noted the correlation between conflicted home environments and relapse. One particular area of interest looks at a family communication style known as expressed emotion and how it might contribute to environmental stress (Gullotta & Adams, 2005: 353).

2.10 Symptoms of Schizophrenia:

There are many myths and misconceptions about schizophrenia. Schizophrenia is not a multiple or split personality, nor are individuals who have this illness constantly incoherent or psychotic. Although the media often portray individuals with schizophrenia as violent, in reality, very few affected people are dangerous to others. In fact, individuals with schizophrenia are more likely to be victims of violence than violent themselves (Bengston, 2006).

The symptoms of schizophrenia fall into three broad categories: positive symptoms, negative symptoms, and cognitive symptoms

2.10.1 Positive symptoms:

Positive symptoms are also known as "psychotic" symptoms, because the person has lost touch with reality in certain important ways. The term "positive" symptom refers to mental experiences that are added to the person by the illness. The most common positive symptoms include hallucinations and delusions. Hallucinations cause a person to hear voices or, less commonly, to see things that do not exist. People living with schizophrenia also commonly experience delusions, which means they believe ideas that to others are clearly false, such as that people are reading their thoughts or that they can control other people's minds. Medications are crucial to symptom control, and other psychological strategies are also gaining acceptance to augment their impact (Boulevard & Arlington, 2008:2).

Positive symptoms are psychotic behaviors not seen in healthy people, People with positive symptoms often "lose touch" with reality. These symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment (Boulevard & Arlington, 2008:2).

2.10.1.1 Hallucinations:

Are things a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. "Voices" are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices. The voices may talk to the person about his or her behavior, order the person to do things, or warn the person of danger. Sometimes the voices talk to each other. People with schizophrenia may hear voices for a long time before family and friends notice the problem.

Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is near. (Boulevard & Arlington, 2008:2).

2.10.1.2 Delusions:

Are false beliefs that are not part of the person's culture and do not change. The person believes delusions even after other people prove that the beliefs are not true or logical. People with schizophrenia can have delusions that seem bizarre, such as believing that neighbors can control their behavior with magnetic waves. They may also believe that people on television are directing special messages to them, or that radio stations are broadcasting their thoughts aloud to others. Sometimes they believe they are someone else, such as a famous historical figure. They may have paranoid delusions and believe that others are trying to harm them, such as by cheating, harassing, poisoning, spying on, or plotting against them or the people they care about. These beliefs are called "delusions of persecution." (John M. Grohol, 2013).

2.10.1.3 Thought disorders:

Are unusual or dysfunctional ways of thinking. One form of thought disorder is called "disorganized thinking." This is when a person has trouble organizing his or her thoughts or connecting them logically. They may talk in a garbled way that is hard to understand. Another form is called "thought blocking." This is when a person stops speaking abruptly in the middle of a thought. When asked why he or she stopped talking, the person may say that it felt as if the thought had been taken out of his or her head. Finally, a person with a thought disorder might make up meaningless words, or "neologisms." (John M. Grohol,2013).

2.10.1.4 Movement disorders:

May appear as agitated body movements. A person with a movement disorder may repeat certain motions over and over. In the other extreme, a person may become catatonic. Catatonia is a state in which a person does not move and does not respond to others. Catatonia is rare today, but it was more common when treatment for schizophrenia was not available. (John M. Grohol,2013).

2.10.2 Negative symptoms:

Negative symptoms are not as dramatic as positive symptoms, but they can interfere greatly with the patient‘s ability to function day to day. Because expressing emotion is difficult for them, people with schizophrenia laugh, cry, and get angry less often. Their affect is flat, and they show little or no emotion when personal loss occurs. They also suffer from ambivalence, which is the concurrent experience of equally strong opposing feelings so that it is impossible to make a decision. The a

volition may be so profound that simple activities of daily living, such as dressing or combing hair, may not get done. Anhedonia prevents the person with schizophrenia from enjoying activities. People with schizophrenia have limited speech and difficulty saying anything new or carrying on a conversation. These negative symptoms cause the person with schizophrenia to withdraw and suffer feelings of severe isolation (Bostrom & Boyd, 2008:268).

Negative symptoms are called "negative" not because of the person‘s attitude, but because these are symptoms that take away from the person‘s usual way of being in the world. Negative symptoms often include emotional flatness or lack of expressiveness, an inability to start and follow through with activities, speech that is brief and lacks content, and a lack of pleasure or interest in life. Difficulties with social cues and relationships are common. These symptoms challenge rehabilitation efforts, as work and school goals require motivation as well as cognitive and interpersonal capacity. Negative symptoms can also be confused with clinical depression (NAMI, 2008:3).

Include loss or reduction in the ability to initiate plans, speak, express emotion or find pleasure in life. They include emotional flatness or lack of expression, diminished ability to begin and sustain a planned activity, social withdrawal, and apathy. These symptoms can be mistaken for laziness or depression.(NARSAD‘s, 2009:1)

Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions.

People with negative symptoms need help with everyday tasks. They often neglect basic personal hygiene. This may make them seem lazy or unwilling to help themselves, but the problems are symptoms caused by the schizophrenia. (National Institute of Mental Health, 2009:3)

According to the researcher by reviewing previous studies that are limited to negative symptoms include :(Poor eye contact, Anhedonia attitude, poor grooming and hygiene, flat or inappropriate affect, lack of expressive gestures, apathy, and inattentiveness). (John M. Grohol, 2013).

2.10.3 Cognitive symptoms:

Cognitive symptoms pertain to thinking processes. People living with schizophrenia often struggle with executive functioning (prioritizing tasks), memory, and organizing their thoughts. Other cognitive problems may also occur in the illness. These are quite challenging, as cognitive function is involved in many tasks of daily living, and especially in work or school settings. A common cognitive deficit associated with this condition can be a "lack of insight," or lack of awareness of having an illness. This difficulty in understanding is based in the brain, is not a choice, and adds many challenges to working with people coping with this problem (NAMI, 2008:3).

It becomes harder to concentrate probably patient can‘t (finish an article in the newspaper or watch a TV programmed to the end, keep up with your, studies at college, keep your mind on the job at work). The patient thoughts seem to wander. You drift from idea to idea without any obvious connection between them. After a minute or two, patient can‘t remember what you were originally trying to think about. Some people describe their thoughts as being "misty" or "hazy" when this is happening (Timms, et al, 2004:6)

Although the above symptoms must be present for at least one (1) month, there also needs to be continuous signs of the disturbance that persist for at least six (6) months. During this period, the signs of the disorder may be present in a milder form, for instance as just odd beliefs or unusual perceptual experiences. During this 6 month period, at least two of the above criteria must be met, or only the criteria of Negative Symptoms must be present -- if even just in milder form. (John M. Grohol, 2013).

For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset of the symptoms (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement). (John M. Grohol, 2013)

2.11. Types of Schizophrenia

Schizophrenia is a term given to a complex group of mental disorders. However, different types of schizophrenia may have some of the same symptoms. There are several subtypes of schizophrenia based on symptoms:

2.11.1. Paranoid schizophrenia:

People with this type are preoccupied with false beliefs (delusions) about being persecuted or being punished by someone. Their thinking, speech, and emotions, however, remain fairly normal. (John M. Grohol,2013).

2.11.2. Disorganized schizophrenia:

People with this type often are confused and incoherent and have jumbled speech. Their outward behavior may be emotionless or flat or inappropriate, even silly or childlike. Often they have disorganized behavior that may disrupt their ability to perform normal daily activities such as showering or preparing meals. (John M. Grohol,2013).

2.11.3. Catatonic schizophrenia:

The most striking symptoms of this type are physical. People with catatonic schizophrenia are generally immobile and unresponsive to the world around them. They often become very rigid and stiff and unwilling to move. Occasionally, these people have peculiar movements like grimacing or assume bizarre postures. Or, they might repeat a word or phrase just spoken by another person. At times, the opposite may be true and these individuals appear to engage in restless ongoing activity with no specific purpose or desired outcome (for example, walking a straight line over and over; repeatedly jumping in place). People with catatonic schizophrenia generally go back and forth between more sedentary behaviors and the restless, purposeless

behaviors and are at increased risk of malnutrition, exhaustion, or self-inflicted injury (John M. Grohol, 2013).

2.11.4. Undifferentiated schizophrenia:

This subtype is diagnosed when the person's symptoms do not clearly represent one of the other three subtypes (John M. Grohol, 2013).

2.11.5. Residual Schizophrenia:

In this type of schizophrenia, the severity of schizophrenia symptoms has decreased. Hallucinations, delusions, or other symptoms may still be present but are considerably less than when the schizophrenia was originally diagnosed. In addition, there must still be evidence of the disturbance as indicated by the presence of some negative symptoms (for example, inexpressive faces, blank looks, monotone speech, seeming lack of interest in the world and other people, inability to feel pleasure). (John M. Grohol, 2013).

Researcher view although there continues to be wide heterogeneity in cognitive functioning in individuals with schizophrenia, a number of recent studies from the West have suggested that cognitive deficits once established are relatively stable over time.

2.12. Subtypes of schizophrenia:

The classical subtypes of schizophrenia relate back to Kraepelin and Bleuler. They are defined by the predominant symptomatology at the time of evaluation. The first three classical subtypes of schizophrenia (dementia paranoids, hebephrenic and catatonia) were described as separate illnesses until Kraepelin brought them together under the name dementia praecox. Together with schizophrenia simplex or simple schizophrenia, which was introduced by Bleuler, Kraepelin‘s paranoid, hebephrenic and catatonic subtypes formed Bleuler‘s group of schizophrenias. Over the years, additional subtypes, such as latent, undifferentiated, or residual schizophrenia, have been added to the four main types included in Bleuler‘s original description; some of the subtypes have been renamed, and others have been redefined using slightly different criteria (Maj & Sartorius, 2002:15).

2.13. Diagnosis of Schizophrenia:

In the absence of biological marker, diagnosis of schizophrenia relies on examination of mental state, usually through a clinical interview, and observation of the patient’s behavior. The two major current classification systems to diagnosis of schizophrenia, diagnostic and statistical manual of mental disorders "DSM-IV" and International Classification of Diseases "ICD -10". No wide differences between two systems, there are put some criteria for diagnosis. Both ICD-10 and DSM-IV agree on the symptom clusters that confirm a diagnosis of schizophrenia. There are three main domains, including: psychotic symptoms, such as certain types of auditory hallucinations (hearing voices), delusions (‘paranoia’ and‘telepathy’) and thought disorder (incomprehensible speech); negative symptoms, such as poor self-care, reduced motivation, reduced ability to experience pleasure, alogia (reduced production of thought), affective blunting (lack of emotional expression) and reduced social functioning and the rarer symptom of catatonia. ICD- 10 requires that at least

one such diagnostic symptom from one of the three domains should be clearly present for 1 month. ICD-10 also confirms the diagnosis if two of these symptoms have been present in a less clear manner over the same time frame. The diagnosis is not made in the presence of prominent mood symptoms, such as depression or mania. In DSM-IV there is agreement with ICD-10 that diagnostic symptoms need to be present for at least 1 month. It also stipulates that there should be evidence of ongoing symptoms persisting for at least six months. Schizophrenia (National Collaborating Centre for Mental Health, 2010:19).

The definitions and criteria used to establish the diagnosis of schizophrenia have under gone important and wide changes over the years despite the fact that the definition and descriptions of the symptoms themselves have remained rather stable. The different diagnostic concepts used over time have been influenced by various factors outside the specific symptoms of the disorder and have introduced a significant amount of variability in the way schizophrenia has been diagnosed. Some of these factors are:

1. The number and type of symptoms included in the diagnosis.
2. Short versus extended duration of symptoms.
3. Inclusion of cross-sectional versus longitudinal course aspects of the disorder.
4. Inclusion versus exclusion of negative symptoms (Lieberman et al., 2006:187).

2.14 Stages of Schizophrenia:

By Canadian Psychiatric Association "CPA", (2007) the medical and research communities have agreed that there are three distinct phases' people go through when they have schizophrenia:

Phase 1: Acute this is when major symptoms make it clear that the individual needs medical help. It may come on very gradually or quite suddenly.

Phase 2: Stabilization this is the time when the illness is out of the acute stage and symptoms are reduced.

Phase 3: Stable or chronic the acute symptoms are being managed but there may be difficulty with ability to function and periodic relapses into Phase 1 and 2 (CPA، 2007:4)

2.15 Management of Schizophrenia:

The consequences of schizophrenia are painful and unacceptable both to the patient and to the surrounding community. The magnitude of these consequences has led to a wide range of treatments and protective strategies. Even before the development of a conceptual framework to explain schizophrenia, physical methods were used to protect society and to help families and caretakers minimize the disruption caused by schizophrenia. Treatments in the nineteenth and early twentieth centuries involved sedation, restraint, and confinement. Hospital treatment often resulted in continuous institutionalization until death, usually hastened by nutritional and infectious diseases. Occasionally, a combination of psychological, social, and biological treatments was followed by remission sufficient for discharge. These cases served as the bases of both hope and clinical reports throughout much of this century (Goldman & Maryland, 2000:244).

The probability of eventual discharge from hospitals for patients who have developed schizophrenia for the first time has increased over each decade of this century. The psychosocial therapies developed since the 1920s have played a major role in this process. Until the 1950s patients were removed from society to an institution; there they could be observed and treated, and society could avoid contact with people they considered to be frightening and disturbed. The dramatic increase in release rates since the late 1950s could not have occurred without the introduction of neuroleptic earlier in the decade. Neuroleptic treatment controls acute symptoms, allows the reduction of hospitalization from years to days, prolongs remission, and helps make the current outcome for patients treated for schizophrenia much better than the untreated natural course (Gur & Johnson, 2006:87).

Until the 1930s the only somatic treatments that were actually beneficial involved either the induction of prolonged coma/sleep by chemical means or forced, very prolonged immobilization using restraints, jackets, and sheet packs. Convulsive treatments, originally induced by chemicals but electrically induced (electroconvulsive treatment or ECT) since the 1940s, became the treatment of choice for acute schizophrenia until being displaced by the neuroleptic in the 1960s. At present, the use of ECT in the treatment of schizophrenia is limited to the occasional patient. It is typically used after pharmacotherapy has failed to treat a patient's severe psychosis or if there is severe suicidality or presentation of life-threatening catatonia. The response to ECT is often rapid and dramatic. It should be noted that ECT was supplanted by pharmacotherapy not because ECT is inferior or involves risks but for a variety of other factors including ease of administration of drugs and stigma attached to ECT. In recent years, there has been renewed interest in ECT as a treatment for schizophrenia based on the concern that prolonged psychosis might be neurotoxin and the belief that aggressive treatment could prevent deterioration (Fink & Sackeim, 1996:23).

Contemporary treatment of schizophrenia always involves a combination of biological, psychological, and social methods called combined treatment. The psychiatrist usually works as part of a treatment team, and in many cases the family is actively incorporated into the treatment plan.

The course of schizophrenia varies, but in most cases it involves recurrent episodes of symptoms. Although available pharmacological treatments can relieve many of the symptoms, most people with schizophrenia continue to suffer some symptoms throughout their lives. Appropriate treatment early in the course of the disease and adherence to continued and adequate treatment are essential to avoiding relapses and preventing hospitalization. During periods of remission, whether spontaneous or due to treatment, the individual may function well. Newer medications (and improved dosage guidelines for older medications) have substantially reduced the prevalence of severe neurological side effects that were once commonly associated with long-term pharmacological treatment of schizophrenia. Optimizing the functional status and wellbeing of individuals with schizophrenia requires a supportive family and wide range of services, including institutional, community, social, employment and housing services. Ideally, multidisciplinary community treatment teams provide these services. Social skills training strives to improve social functioning by working with individuals to resolve

problems with employment, leisure, relationships and activities of daily life. Occasionally, however, timely admission to hospital to control symptoms may prevent the development of more severe problems (CAMIMH, 2002:54).

2.16. Treatment option of Schizophrenia

The natural progression of schizophrenia is usually described as deteriorating with time, with an eventual plateau in the symptoms. Only for elderly patients with schizophrenia has it been suggested that improvement might occur. In reality, no one really knows what the course of schizophrenia would be if patients were able to adhere to a treatment regimen throughout their lives. Only recently have medications been relatively effective, with manageable side effects. The clinical picture of schizophrenia is complex; individuals differ from one another; and the experience for a single individual may be different from episode to episode (Bostrom & Boyd, 2008:266).

Because the causes of schizophrenia are still unknown, treatments focus on eliminating the symptoms of the disease. Treatments include antipsychotic medications and various psychosocial treatments (Walsh et al, 2008).

2.16.1 Antipsychotic medications:

Antipsychotic medications have been available since the mid-1950's. The older types are called conventional or "typical" antipsychotics. Some of the more commonly used typical medications include:

- Chlorpromazine (Thorazine)
- Haloperidol (Haldol)
- Perphenazine (Etrafon, Trilafon)
- Fluphenazine (Prolixin).

In the 1990's, new antipsychotic medications were developed. These new medications are called second generation, or "atypical" antipsychotics (Bell et al, 2007).

One of these medications, clozapine (Clozaril) is an effective medication that treats psychotic symptoms, hallucinations, and breaks with reality. But clozapine can sometimes cause a serious problem called agranulocytosis, which is a loss of the white blood cells that help a person fight infection. People who take clozapine must get their white blood cell counts checked every week or two. This problem and the cost of blood tests make treatment with clozapine difficult for many people. But clozapine is potentially helpful for people who do not respond to other antipsychotic medications (Gogtay et al, 2008).

Other atypical antipsychotics were also developed. None cause agranulocytosis. Examples include: (Bell et al, 2007).

- Risperidone (Risperdal)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)
- Aripiprazole (Abilify)
- Paliperidone (Invega).

2.16.2 Psychosocial treatments:

Psychosocial treatments can help people with schizophrenia who are already stabilized on antipsychotic medication. Psychosocial treatments help these patients deal with the everyday challenges of the illness, such as difficulty with communication, self-care, work, and forming and keeping relationships. Learning and using coping mechanisms to address these problems allow people with schizophrenia to socialize and attend school and work. (Gogtay et al, 2008).

Patients who receive regular psychosocial treatment also are more likely to keep taking their medication, and they are less likely to have relapses or be hospitalized. A therapist can help patients better understand and adjust to living with schizophrenia. The therapist can provide education about the disorder, common symptoms or problems patients may experience, and the importance of staying on medications (NIMH, 2009)

2.16.2.1 Illness management skills:

People with schizophrenia can take an active role in managing their own illness. Once patients learn basic facts about schizophrenia and its treatment, they can make informed decisions about their care. If they know how to watch for the early warning signs of relapse and make a plan to respond, patients can learn to prevent relapses. Patients can also use coping skills to deal with persistent symptoms. (NIMH, 2009)

2.16.2.2 Integrated treatment for co-occurring substance abuse:

Substance abuse is the most common co-occurring disorder in people with schizophrenia. But ordinary substance abuse treatment programs usually do not address this population's special needs. When schizophrenia treatment programs and drug treatment programs are used together, patients get better results. (NIMH, 2009)

2.16.2.3 Rehabilitation:

Rehabilitation emphasizes social and vocational training to help people with schizophrenia function better in their communities. Because schizophrenia usually develops in people during the critical career-forming years of life (ages 18 to 35), and because the disease makes normal thinking and functioning difficult, most patients do not receive training in the skills needed for a job. (NIMH, 2009)

Rehabilitation programs can include job counseling and training, money management counseling, help in learning to use public transportation, and opportunities to practice communication skills. Rehabilitation programs work well when they include both job training and specific therapy designed to improve cognitive or thinking skills. Programs like this help patients hold jobs, remember important details, and improve their functioning. (Gogtay et al, 2008).

2.16.2.4 Family education:

People with schizophrenia are often discharged from the hospital into the care of their families. So it is important that family members know as much as possible about the disease. With the help of a therapist, family members can learn coping strategies and problem-solving skills. In this way the family can help make sure their

loved one sticks with treatment and stays on his or her medication. Families should learn where to find outpatient and family services. (NIMH, 2009).

2.16.2.5 Cognitive behavioral therapy:

Cognitive behavioral therapy (CBT) is a type of psychotherapy that focuses on thinking and behavior. CBT helps patients with symptoms that do not go away even when they take medication. The therapist teaches people with schizophrenia how to test the reality of their thoughts and perceptions, how to "not listen" to their voices, and how to manage their symptoms overall. CBT can help reduce the severity of symptoms and reduce the risk of relapse. (NIMH, 2009).

2.16.2.6 Self-help groups:

Self-help groups for people with schizophrenia and their families are becoming more common. Professional therapists usually are not involved, but group members support and comfort each other. People in self-help groups know that others are facing the same problems, which can help everyone feel less isolated. The networking that takes place in self-help groups can also prompt families to work together to advocate for research and more hospital and community treatment programs. Also, groups may be able to draw public attention to the discrimination many people with mental illnesses face. (NIMH, 2009)

B. Stigma

2.17 Introduction to stigma of mental health:

The lives of people living with mental illness are often drastically altered by the symptoms of the illness and society's reaction to them. While symptoms can usually be mitigated by a number of measures, the inherent stigma and discrimination associated with mental illness may persist for a lifetime and can manifest themselves in a number of subtle and not so subtle ways. Typically, stigma takes the form of stereotyping, distrust, fear, or avoidance and can negatively impact pursuit of treatment, employment and income, self worth, and families. Individuals with mental illness are commonly labeled as a result of their appearance, behavior, treatment, socioeconomic status, and also due to the negative depiction of mental illness so prevalent in the media (Scheffer, 2003).

The second part of the second chapter discusses the stigma of mental illness. It covers the definitions, types, and the relationship between stigma and recovery. Many people with serious mental illness are doubly challenged. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness.

Individuals with mental illness are stereotyped as dangerous, unpredictable, and as weak willed. Along with the stigma faced by the individual, associative stigma can impact the family and friends of that person. It is now widely accepted that education, particularly in the childhood years, can significantly increase understanding among the public and lessen discrimination against the mentally ill. Educational material capable of engaging its audience emotionally as well as intellectually has shown to be the most effective. Certain programs also encourage

their audience to increase their levels of contact with people who are mentally ill. This has been shown to increase favorable attitudes and also to decrease perceived dangerousness (Scheffer, 2003).

People who live with mental illness and their families often state that the stigma associated with their diagnosis was more difficult to bear than the actual illness. Stigma has a considerable influence on whether people seek treatment, take prescribed medications and follow through on treatment plans.

2.18 Definition of Stigma:

O'Reilly et al, (2013) identifies the stigma of mental illness is described as a negative attitude based on prejudice and misinformation triggered by a marker of illness and has often been described as the main barrier to receiving effective mental health care (O'Reilly, 2013).

Manal Gaith (2013) identifies stigma as bad negative feeling that label with epileptic individual and stand an obstacle in community life way that measure the degree of stigma by stigma scale which consist of two dimensions, self and social stigma (Manal Gaith, 2013).

Another definition by Burke & Parker, (2007) whom identifies stigma as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders" (Burke & Parker, 2007:16).

Another definition by Barney et al (2006) identifies Stigma that are appears to come from health care professionals as well as the public and has been linked to a person's reluctance to seek help when mental health symptoms first appear (Barney et al, 2006).

Zartaloudi and Madianos (2010) was identifies stigma as a combination of perceived dangerousness and social distance (Zartaloudi and Madianos ,2010).

From all the previous definitions the researcher in this study identifies the stigma as: every person feels shyness or discrimination due to mental illness especially schizophrenia lead to bad negative feeling that label with schizophrenic patient and stand an obstacle in community life way that measure the degree of stigma by stigma scale which consist of three dimensions, self ; family and social stigma.

2.19 Nature and Forms of Stigma:

That stigma is not in question. It is known that stigma negatively affect the treatment and recovery of people with mental illness. There are moves to combat these but such interventions themselves require evaluation so that we can learn what has an effect and what does not. What need to be more clearly elucidated are ways to measure stigma and discrimination and then ways to determine which treatment strategies are most effective. Scales to measure stigma have to be devised and tailored to measure this social construct among the stigmatizers, which might be the

whole of the society, including even the mentally ill themselves (for self-stigma is a major block to recovery). Four intervention methods are commonly recognized. Literacy campaigns, protest actions, contact enhancements and political activism to protect the civil and political rights of patients. The impact and effectiveness of these methods need to be evaluated (Burke & Parker, 2007:15).

Disability theorists have criticized the focus on individuals. Functional limitations and micro-level social interaction as it diverts attention away from the social environment and social oppression. From a .social oppression. Perspective, the focus shifts away from stigma and the individual towards processes of social exclusion and the political realities of power differentials. This shift is also being replicated in the more recent sociological literature. In response to these movements, the stigma concept has shifted dramatically and is now much broader in scope (Green, 2009: 14).

Today the stigma persists, although it has less to do with demonic possession than with society‘s unwillingness to shoulder the tremendous costs associated with housing, treating, and rehabilitating patients with schizophrenia.

Unfortunately, pejorative terms such as “nuts,” “cracked,” and “retarded” still abound in everyday conversation and in the media. These derisive attitudes often influence the behaviour of mentally ill individuals. They might choose not to talk about their illness and not seek or further pursue treatment for fear of becoming a social pariah (Health Canada, 2002). There is also the stigma related to housing labelled as “Not In My BackYard,” or NIMBYism. Residents of a community might want to exclude individuals with mental illness from moving into their areas as a result of phobias. This discrimination often takes the form of zoning bylaws designed to discourage supportive housing (Canadian Senate Committee on Social Affairs, Science and Technology, 2006).

Stigma reduction is one of the great challenges facing mental health organizations. Intentional or not, naïve assumptions, stereotyping, and downright prejudice can have damaging effects on the course of recovery from a mental illness. The prevailing attitude in the literature on stigma reduction is that education is the best means of preventing and eliminating discrimination. Typically, successful educational campaigns have drawn upon facts and personal experiences. While facts can give the audience an overarching understanding of the impact of stigma, the stories of individuals who have mental illness can serve as a poignant reminder of the impact not only of the symptoms of mental illness, but also the negative associations tied to it (Canadian Mental Health Association, 2006).

Several components of stigma can be distinguished. According to Rensen, Bandyopadhyay, Gopal & Van Brakel (2010), stigma can be categorized from the perspective of the non-affected person into perceived and enacted stigma, and from the perspective of the affected person into internalized, perceived, and experienced stigma (Rensen *et al.*, 2010). These different aspects are all interrelated and may have an impact on the self-efficacy of the affected person, his or her participation in the community, personal well-being, and self-esteem (Rensen *et al.*, 2010).

2.20 Causes of stigma in mental health:

Thus, stigma could be conceived of as a relational construct that is based on attributes, which may change with time and from one culture to another. Stigma develops within a social matrix of relationships and interactions so that new conditions could become stigmatizing and conditions that may be stigmatizing at one time or within a given culture could come to be accepted later so that their bearers stop being stigmatized.

The researcher believes that the stigma in patients with schizophrenia vary from person to person depending on the severity of disease, age, gender, environment and way of life experienced by the patient, and needs a patient with schizophrenia special care because his outlook on life changed because of his illness, which leads to the inability to continue to live properly.

2.20.1 There are a number of reasons for stigma:

Self-stigma or internalized stigma is the process in which people with mental health problems turn the stereotypes about mental illness adopted by the public, towards themselves. They assume they will be rejected socially and so believe they are not valued (Livingston and Boyd, 2010).

1. One is that people are ignorant about mental illness. Because they know so little they can fear it and its effect, and in turn pass on this lack of understanding to those who are experiencing it themselves.
2. Another reason is that stigma is a part of our culture. It is the subject of numerous silly phrases such as "they are coming to take you away ", which all in turn influence how we are seen. There are inaccurate myths associated with mental illness (Morgan, 2003:5).
3. The history of psychiatric treatment has provoked great anxiety and fear in the population. Old hospitals were well known and very much feared. In the past admission to such places could mean that people would be unlikely to return to their community again.
4. For others organized religions play a part too. A few people still hold with the idea that mental illness is a visitation of "the sins of the father on the next generation" while other religions see acts such as suicide as being against the principles of their faith. The fact that people with a mental illness can, as part of their illness, come to feel intensely about spirits, devils, evil and demons can further confuse the subject.
5. Stigma is also seen as a sign of human frailty. Most of people know that stigma is illogical, damaging and unjustified and yet it still exists.

The effects of medication, especially older forms of medication, can affect people by slowing their down, making their shuffle, twitch or tremble or having to walk around constantly. These visible signs can influence how people see psychiatric patients. The subject of mental illness and mental health is seldom talked about in schools so successive generations are brought up with inaccurate images of mental illness. (Morgan, 2003:6).

- There is also a feeling that, unlike most other illnesses, there are aspects of judgment associated with mental illness - a feeling that if a person is mentally ill then they are at fault or flawed in some way.
- The artificial division of mental health and physical health also helps to make mental illness seem different.
- Some of psychiatric patients may behave bizarrely, and when people witness this without a proper understanding they may come to fear what they are seeing.
- The main culprit is seen as the media. There are numerous films, thrillers and horror movies that all create an inaccurate image of people who kill or frighten because they have a mental illness. The media also routinely use jokes about mental illness in lighter programmes and use words such as "schizophrenic", "mad" "nutter" or "loony" inaccurately and thoughtlessly (Morgan, 2003:7), (Scheffer, 2003: 4).

From the researcher's view, stigma connected with our culture, our misconception and misunderstanding about mental illness, stigma has negative impact on the psychiatric patients lives, stigma lead to isolate psychiatric patients from their community, often because of their illness or sometimes because of their shyness about their illness.

2.21 The experience of stigma:

Stigma includes marks and stereotypes that lead to prejudice and discrimination. Prejudice yields anger, fear, blame, and other emotional responses toward individuals with mental illness. Discrimination diminishes the quality of life of individuals with mental illness. Stigma may rob individuals of important life opportunities, including gainful employment, safe and comfortable housing, relationships, community functions, and educational opportunities (Corrigan et al, 2008: 880).

Examples of stigma experience:

- Shame
- Blame
- Secrecy
- The “black sheep of the family” role
- Isolation
- Social exclusion and discrimination.
- Stereotypes (Byrne, 2000:65).

2.22 Component of stigma:

- Labeling people with a condition.
- Stereotyping people with that condition.
- Creating a division – “us” and “them”.
- Discriminating against people based on their label (Sherman, 2007: 10).

Stigma is experienced and seen by many of us as:

- Being seen as different.
- Being regarded as socially unacceptable.
- Being alienated.
- Being discriminated against and abused.

- Being verbally harassed.
- Worrying too much about what other people will say.
- Being the subject of a set of unreasonable generalizations that may be passed from generation to generation.
- Being the subject of a range of negative views and perceptions by other people (for Instance that we are always 'down' and unhappy).
- Being seen as an unknown quantity - as another species.
- Being a group that other people do not know how to talk to or act with.
- Not being normal.
- Feeling ashamed and weak because we cannot cope.
- Being avoided.
- Being seen as failures and as weak.
- Having a condition that we have to hide and lie about.
- Being seen as unpredictable.
- Not being seen as part of social conversations. People often don't speak about illness, as the intensity of emotion is not acceptable to them.
- Being seen as 'mad' or 'nuts'.
- Being labelled and stereotyped and defined by mental illness.
- Not being understood (Morgan, 2003:5).

From the researcher's view, there is a relationship between shyness and avoiding treatment. So, the potential of self-stigma can yield label avoidance and decreased treatment participation. Stigma of schizophrenia leads schizophrenic person family to avoid treatment. Stigma is dangerous because it interferes with understanding, asking for help and support from friends and family, and it delays recovery process (sometimes for years). All of the above show an important evidence that the stigma adversely effect on the recovery of persons with mental illness. These concerns affect self-esteem and adaptive social functioning outside the family. These effects are not limited to one diagnosis.

2.24 Impact of stigma:

Psychiatric disorders have catastrophic effects on the lives of people with these disorders because of their associated distress and disability. Goffman (1963) originally adopted the term stigma from the Greeks who used it to represent bodily signs indicating something bad about the moral character of the bearer marked with the stigma (Zeev, 2010: 318).

In reality, mental illness is a poor predictor of violence. The majority of people who are violent do not suffer from mental illnesses. As a group, mentally ill people are no more violent than any other group. In fact, people with mental illnesses are far more likely to be the victims of violence than to be violent themselves. But media depictions of persons with a mental illness attacking a stranger do much to shape public opinion.

The saliency of such high-profile crimes, despite their infrequency, makes it appear as though violent crimes committed by individuals with a psychiatric diagnosis are common and that the general public has reason to fear people with mental illness (Baun,2009: 3).

2.24 The Production of Stigma:

Stigma includes marks and stereotypes that lead to prejudice and discrimination. Prejudice yields anger, fear, blame, and other emotional responses toward individuals with mental illness. Discrimination diminishes the quality of life of individuals with mental illness. Stigma may rob individuals of important life opportunities, including gainful employment, safe and comfortable housing, relationships, community functions, and educational opportunities. Stigma occur when the co-occurrence of its components as labeling, stereotyping, separation, status loss, and discrimination. And further indicate that for stigmatization to occur, power must be exercised (Manal Gaith, 2013).

To elaborate further, the stigma trajectory consists of the following:

- Labeling: human differences are noted and labeled.
- Stereotyping: the labels are imbued with negative stereotypes.
- Othering: labelled persons are clearly categorized as .other. or .them. in order to clearly separate .them. from .us..
- Status loss: labelled persons are perceived by others and by themselves as devalued and inferior.
- Discrimination: labelled persons experience discrimination leading to rejection and exclusion.
- Power: stigma will only emerge if there is a clear power differential between .us. and.them.. (Mnal Gaith, 2013).

2.25 Effects of Stigma:

Public stigma and discrimination have pernicious effects on the lives of people with serious mental illnesses, although public awareness of mental disorder, motivation for policy change, and attempts to reduce associated stigma have increased significantly over the past few decades, stigma against mental illness remains a significant barrier to positive outcomes across cultures and nations, related to the threat value of mental symptoms, intolerance for diversity, and inaccurate conceptions of mental disorder (Corrigan et al, 2012).

The mentally ill face many challenges in adapting to life in a society that does not fully understand them. Often, the effects of the stigma that they face are overwhelming (Zartaloudi anf Madianos, 2010).

The effects of stigma are:

- Cause feelings of isolation, hopelessness, and low self-esteem.
- Create problems with employment.
- Negatively impact housing.
- Cause Harassment.
- Cause physical violence.
- Negatively impact community participation.
- Reduce resource & opportunity access.
- Cause a person to deny the illness.
- Cause a person to refuse treatment.

- Cause there to be inadequate coverage of mental health treatment by health insurance companies (Manal Gaith, 2013).

2.26 Measuring the stigma:

The role of supernatural, religious and magical approaches to mental illness was prevailing in the past. Individuals with mental illness are still being stigmatized despite modern medicine and more humane treatment. People with mental illness are considered as dangerous and aggressive which in turn increases the social distance. The pathway to care is often shaped by skepticism towards mental health services and the treatments offered. Stigma experienced from family members is pervasive. Moreover, social disapproval and devaluation of families with mentally ill individuals are an important concern (Zartaloudi anf Madianos, 2010).

Researchers commonly suggest that the stigma attached to mental illness is one of the major confounding factors in help seeking from mental health professionals (Zartaloudi anf Madianos, 2010).

The researcher proposes that the stigma can be measured by two ways:

2.26.1 Direct methods:

- Attitudes
- Among rehabilitation staff or health care staff
- Internalized (or self-)stigma
- Discrimination (enacted stigma)
- Media
- Legislation
- Structural

2.26.2 Indirect methods:

- Participation
- Psychological well-being
- Self-esteem
- Quality of life.

2.27 Steps to reducing stigma

Stigma can be a barrier to seeking early treatment; often people will not seek professional help until their symptoms have become serious. Others disengage from services or therapeutic interventions or stop taking medication, all of which can cause relapse and hinder recovery. If mental illness is treated early enough, it can reduce further ill health, and ultimately the risk of suicide. By intervening at the earliest possible opportunity, people may be able to avoid a full episode of mental ill heath, and retain their jobs, relationships or social standing. (Parle S, 2012).

The steps to reducing stigma are:

- Be Supportive
- Monitor the Media
- Be an advocate – individually or as part of a group- and share experiences
- Give praise when someone including yourself seeks help.

Overall, both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults. For adolescents, the opposite pattern was found: education was more effective. Overall, face-to-face contact was more effective than contact by video. Conclusions: Future research is needed to identify moderators of the effects of both education and contact. (Corrigan et al, 2012).

C. Counseling

2.28 Counseling overview:

Counseling psychology is a broad specialization within professional psychology concerned with using psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community. Counseling psychologists bring a collaborative, developmental, multicultural, and wellness perspective to their research and practice. They work with many types of individuals, including those experiencing distress and difficulties associated with life events and transitions, decision-making, work/career/education, family and social relationships, and mental health and physical health concerns (CPA, 2009).

Counseling has become one of the most important challenges when treating patients with schizophrenia. In the past, according to the problem solving framework, this social dysfunction was described as the conjunction of disabilities in social cognition ((which refers to the mental operations and capacities that underlie social interactions) and social competence (which refers to communication skills, e.g., the verbal and nonverbal communication skills that allow successful execution of interpersonal interactions) (Calafell, 2013).

Counseling psychology adheres to an integrated set of core values: (a) counseling psychologists view individuals as agents of their own change and regard an individual's pre-existing strengths and resourcefulness and the therapeutic relationship as central mechanisms of change; (b) the counseling psychology approach to assessment, diagnosis, and case conceptualization is holistic and client-centered; and it directs attention to social context and culture when considering internal factors, individual differences, and familial/systemic influences; and (c) the counseling process is pursued with sensitivity to diverse sociocultural factors unique to each individual (CPA, 2009).

Since the patient and the family are often under enormous emotional strain, it may be advantageous to obtain counseling from professionals who understand the illness. A more integrated mental health system must also be linked to, rather than isolated from, all parts of the community and other service systems. Family doctors, teachers, police personnel, and long-term care workers are among those who should work with each other and with mental health service providers to address people's mental health needs. A more coordinated and integrated system will make available multiple resources to help facilitate recovery: timely access to medications and to adequate and affordable housing; professional counseling, as well as readily available peer support; and help in setting and meeting educational and employment goals.

2.29 Counseling definition:

UNESCO identifies counseling as a process by means of which the helper expresses care and concern towards the person with a problem, and facilitates that person's personal growth and brings about change through self-knowledge. (UNESCO, 2012)

Canadian Psychological Association (2009) identifies counseling is a broad specialization within professional psychology concerned with using psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community (CPA, 2009).

Counseling psychologists practice in diverse settings and employ a variety of evidence based and theoretical approaches grounded in psychological knowledge. In public agencies, independent practices, schools, universities, health care settings, and corporations, counseling psychologists work in collaboration with individuals to ameliorate distress, facilitate well-being, and maximize effective life functioning (CPA, 2009).

The researcher identifies counseling as a type of psychological therapy that can help people with emotional difficulties and problems in relating to people. it is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology.

2.30 Counseling process:

The counseling process is influenced by several characteristics that help it become a productive time for the client & counselor. Counseling involves the following:

- Interactive relationship
- Collaboration
- Set of clinical skills & teaching techniques
- Positive reinforcement
- Emotional support and
- Formal record

The purpose of counseling is to establish:

- Goals of treatment
- Treatment modality
- Treatment plan
- Scheduling of sessions
- Frequency and length of treatment
- Potential involvement of others and
- Termination of treatment (UNODC, 2011).

2.31 Types of counseling:

There are several types of counseling that follow similar lines to the various different types of psychotherapy. Each model has its own theory of human development and its own way of working. Some practitioners work in an ‘eclectic’

way, which means that they draw on elements of several different models when working with clients. Others practice a form of 'integrative' counseling, which draws on and blends two or more specific types (NAMI, 2011).

From the client's point of view, perhaps the most obvious difference between the types of counseling is whether the counselor is directive (suggesting courses of action and perhaps giving 'homework' exercises) or non-directive (with the client taking the lead in what's discussed). While it's not possible to include all the various types available, the most popular are discussed below. They are all non-directive, except for gestalt and cognitive behavioral counseling.

2.31.1 Psychodynamic counseling:

This is based on the idea that past experiences have a bearing on experiences and feelings in the present, and that important relationships, perhaps from early childhood, may be replayed with other people later in life. It translates the principles and insights of psychoanalysis and psychoanalytic psychotherapy into once-a-week counseling.

The counselor usually aims to be as neutral a figure as possible, giving little information about him or herself, making it more likely that important relationships (past or present) will be reflected in the relationship between the client and the counselor. This relationship is therefore an important source of insight for both parties, and helps the client to 'work through' their difficulties.

Developing a trusting and reliable relationship with the counselor is essential for this work. Client-centered or person-centered counseling.

This is based on the principle that the counselor provides three 'core conditions' (or essential attributes) that are, in themselves, therapeutic. These are:

- empathy (the ability to imagine oneself in another person's position)
- unconditional positive regard (warm, positive feelings, regardless of the person's behavior)
- congruence (honesty and openness)
- Again, the counselor uses the relationship with the client as a means of healing and change.

2.31.2Transpersonal counseling:

This is an integrative and holistic approach that utilizes creative imagination. It assumes a spiritual dimension to life and human nature. It also presupposes the interconnectedness of all beings with a higher spiritual power, and specifically addresses the bridge between the two.

Transpersonal counseling emphasizes personal empowerment. It takes account of the client's past experiences, but also looks to the future and what is likely to unfold for them, the challenges they may face and the qualities that need to emerge in them to meet those challenges. Its basic belief is that whatever the hardships of human experience, the core essence, or soul, remains undamaged.

2.31.3Transactional analysis counseling:

Transactional Analysis counseling emphasizes people's personal responsibility for their feelings، thoughts and behavior. It believes people can change, if they actively decide to replace their usual patterns of behavior with new ones.

The counselor offers:

- 'permission' (for new messages about yourself and the world)
- 'protection' (when changing behavior and thoughts feels risky)
- 'potency' (to deliver what he or she promised)

Planning the goals of the counseling is part of the process. The focus is on uncovering the 'life scripts' (life plans) that reflect the messages the client was given as a child. The counseling teaches the client to identify in which of the following modes he or she is operating, at any given time:

- The 'child' (replaying their childhood)
- The 'parent' (copied from parents or parent-figures)
- The 'adult' (appropriate to the present situation)

2.31.4 Existential counseling:

This helps people to clarify, think about and understand life, so that they can live it well. It encourages them to focus on the basic assumptions they make about it, and about themselves, so they can come to terms with life as it is. It allows them to make sense of their existence.

The counseling focuses the client on how much they already take charge of their life, and not on what they are doing wrong. At the same time, it takes note of any real limitations, so that they can make choices based on a true view of the options available.

2.31.5 Personal construct counseling:

This is based on the idea that nobody can know absolute truth. Instead, each person constructs their idea of the truth from their own experiences, and this affects the way they see the world.

The problem is that people can get stuck with a view of things that prevents them from living life to the full, because they can't find any alternative ways of seeing things. Personal Construct counseling helps people to look at different ways of behaving that may be useful in changing the way they see the world.

2.31.6 Gestalt counseling:

This is a more directive type of counseling, focusing on gestalten (patterns of thought, feeling and activity). It encourages people to have an active awareness of their present situation, and also incorporates communication that goes beyond words. A key part of gestalt counseling is the dramatization, or acting out, of important conflicts in a person's life. This could involve using two or more chairs, for instance, so that they can physically take up different positions to represent different aspects of themselves.

2.31.7 Rational-emotive behavioral counseling:

This takes the view that people have two main goals in life: to stay alive and to be happy. It aims to remove the obstacles that people place in their own way, and also to achieve a healthy balance between short-term and long-term goals.

2.31.8 Cognitive-behavioral counseling:

This is another directive model, concerned with the way people's beliefs about themselves shape how they interpret experiences. The objective is to change self-defeating or irrational beliefs and behaviors by altering negative ways of thinking.

Clients learn to monitor their emotional upsets and what triggers them, to identify self-defeating thoughts, to see the connections between their beliefs, feelings and behavior, to look at the evidence for and against these thoughts and beliefs, and to think in a way that is more realistic and less negative.

The counselor usually gives the client tasks or homework to do between sessions. This could mean recording thoughts and feelings, or doing something that tests out a basic assumption about themselves. This might mean, for instance, going to the shops when their fear is that they may panic. (See Mind's booklet, Making sense of cognitive behavior therapy)

2.31.9Brief Solution Focused Therapy:

A structured therapy, usually carried out over one to five sessions. Unlike most other talking therapies, therapist and client usually spend little time on details and causes of the problem. The client is helped to define their own goals and therapy focuses on finding the best way towards the goals in the briefest time possible. It helps the client to recognize their own strengths, resources and abilities. To focus on what is getting better and to build on this.

2.31.10 Interpersonal Therapy (IPT):

A semi-structured therapy which examines how problems in relationships contribute to emotional difficulties such as depression and vice versa. IPT primarily focuses on working and improving relationships with the aim of bringing about change, leading to improvements in mood, or other troubling symptoms. IPT is usually offered over the course of up to 16 sessions. Available mainly through the NHS.

2.31.11Dialectical Behavior Therapy (DBT):

DBT was developed from CBT and adapted to suit the specific needs of people with Borderline Personality Disorder. Available mainly through the NHS.

2.31.12 Psycho synthesis:

A holistic approach to self-realization and the development of potential. Includes creative approaches such as artwork, metaphor and imagery, visualization, therapeutic writing etc.

2.31.13 Core Process (Karuna Institute):

A gentle contemplative approach to exploring our life struggles, relationships, and inner process. Usually includes Mindfulness Meditation; underpinned by Buddhist principles.

In Core Process work, a depth awareness of what is happening in the present moment is used to explore our inner process. This awareness encompasses our energies, sensations, feelings, mental processes and their expressions in the body. The aim is not to alter our experience, but to sense how we relate to it, so that it becomes possible to move with greater creativity and flexibility in our lives. Core Process work is based on the understanding that within the conscious mind there is a deeper wisdom that moves naturally towards healing.

Integration and healing come from insight into the ways in which we hold onto our suffering, and from a deeper connection with the openness, compassion and wisdom at the heart of our human condition.

2.31.14 Integrative:

Combines ideas from more than one theoretical approach (usually including person centered and psychodynamic, and others), drawing on elements of each as appropriate for the client/ issues.

Process Work (Process Oriented Psychology – developed by A. Mindell):

An emphasis on awareness over specific interventions. Process Work, developed by Arnold Mindell, has roots in Jungian Psychology and Taoism. Its methods reflect a dedication to accurately following the way of nature, while bringing awareness into the patterns structuring our lives; including those parts normally unseen, unappreciated, disturbing or marginalized. Bringing awareness into this interaction, a surprising wisdom emerges and a creative way forward in even the most difficult situations.

2.31.15 Counseling Psychology:

Integrating psychological theory with therapeutic practice. An active collaborative relationship which can both facilitate the exploration of underlying issues and can empower people to confront change.

The researcher believes that the counseling process is an important point in psychological therapy that can help people with emotional difficulties and problems in relating to people with mental illnesses.

It is the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology.

Chapter three

Literature review

A. Overview:

The researcher took advantage of these previous studies and used it to build questionnaire, selecting study design, and writing the conceptual framework, definition of terminologies and explanation of issues and recommendations. This related studies used different tests and questionnaires about stigma and counseling in separated studies. In other hand, the researcher improves most aspects of stigma and counseling for schizophrenic patients in one study.

In this chapter the researcher show the literature reviews in three main domain the first about schizophrenia, the second about stigma, where the third is about counseling and stigma among schizophrenic patients, and was exposures of discussion and comments around the researches, in the end this is show of discussion and comments around the studies.

3.1 Study of Schizophrenia:

3.1.1 Previous studies:

1. **Denial of illness in schizophrenia as a disturbance of self-reflection, self-perception and insight. A study of (Bedford and David, 2014).** aimed to find the denial of illness in schizophrenic patients as a disturbance of self-reflection, self-perception and insight. The methods included 26 schizophrenia patients with either an overall acceptance or denial of their illness and 25 healthy controls made timed decisions about the self-descriptiveness, other-person-descriptiveness and phonological properties of mental illness traits, negative traits and positive traits, before completing surprise tests of retrieval for these traits.

   The study results found that the acceptance patients and denial patients were particularly slow in their mental illness-related self-evaluation, indicating that they both found this exercise particularly difficult. Both patient groups displayed intact recognition but particularly reduced recall for self-evaluated traits in general, possibly indicating poor organizational processing during self-reflection. Lower recall for self-evaluated mental illness traits significantly correlated with higher denial of illness and higher illness-severity. Whilst explicit and implicit measures of self-perception corresponded in the healthy controls (who displayed an intact positive N negative ‘self-positivity biases) and acceptance patients (who displayed a reduced self-positivity bias), the denial patients' self-positivity bias was explicitly intact but implicitly reduced.

   The study conclusions to schizophrenia patients, regardless of their illness-attitudes, have a particular deficit in recalling new self-related information that worsens with increasing denial of illness. This deficit may contribute towards rigid self-perception and disturbed self-awareness and insight in patients with denial of illness.

2. **Depression in schizophrenia: The influence of the different dimensions of insight. A study of (Misdrahi et al, 2014).** aim of this study is to explore the association of two dimensions of insight (cognitive and clinical) with depression, hopelessness and clinical variables in patients with psychosis. Using across-sectional design, 61 remitted out patients meeting DSM-IV criteria for schizophrenia or schizo affective disorders were included. Insight was assessed using the "Scale to Assess Unawareness of Mental Disorder" (SUMD), the

PANSS-item G12 and the Beck Cognitive Insight Scale (BCIS). Overall, 41.2% of the sample had a history of suicide attempts. Patients in the high clinical insight group had significantly higher depression scores, higher hopelessness cores, greater his to rise of suicide attempts and were more likely to have received psycho education. Compared to patients with low cognitive insight, those with high overall cognitive insight were significantly more depressed and had more often received psycho education. Greater insight may have negative consequences in terms of depressive symptoms and therefore presents a challenge to clinicians in assessing the individual risks and benefits of strategies in tended to enhance awareness of mental disorder.

3. **Attitudes of mental health private practitioners dealing with patients with schizophrenia: a qualitative study from Greece. A study of Karavia et al, (2014),** aimed to document the attitudes of psychiatrists toward psychosocial interventions for patients with schizophrenia, and to identify their knowledge regarding ongoing programs, as well as their opinion on the availability of organized support structures.
   The study included two-phase qualitative study was carried-out in representative regions of Greece. A questionnaire was administered to 26 randomly-selected psychiatrists in private practice in the context of an online survey about schizophrenia.
   The study results found that all respondents considered the role of the family as being critical and the majority (80%) highlighted the efficacy of family counseling among the psychosocial therapeutic strategies. Half of the psychiatrists reported an ineffective information network on support programs, and most of the respondents (73%) considered the available psychosocial support programs to be insufficient.
   An insufficient network of organized support structures for patients with schizophrenia is reported by Greek psychiatrists. There is consensus for the need to involve family members during psychosocial treatment.

4. **Copy number variations and 'schizophrenia'. A study of Neyndorff et al, (2014),** aimed to provide an overview of what is currently known about CNVs and to summarize the implications of this information for the conceptualization of 'schizophrenia' and for the diagnosis and treatment of psychoses.
   The researcher performed a literature search using PubMed.
   And found that from all literature consulted contains discussions of 23 CNVs that are associated with an increased risk of psychosis. However, the relationship between the two variables is heterogeneous and pluriform in the sense that CNVs are often associated with several disorders or their penetrance varies considerably under the influence of gene modifiers and environmental factors.
   Research into CNVs demonstrates that the relationship between psychosis and heredity is of even more subtle nature than the two pioneers Kraepelin and Rüdin had been able to foresee. It is to be expected that in the near future research will contribute to a deconstruction of the schizophrenia concept, to a blurring of the hitherto sharply defined boundaries between different (particularly severe) mental disorders and to the introduction of genetic counselling into regular psychiatric diagnostic procedures.

5. **The relationship between insight and theory of mind in schizophrenia. A study of George Konstantakopoulos et al, (2014),** aimed to explore the effect of ToM deficits on insight impairment independently of co-existent neurocognitive deficits and symptom severity in chronic schizophrenia.
   The samples included fifty-eight chronic patients with schizophrenia and 56 matched healthy participants were assessed with the Schedule for the Assessment of Insight (SAI–E) along with a series of ToM tasks and a comprehensive battery of neuropsychological measures. Symptoms were measured with the Positive and Negative Syndrome Scale and the Calgary Depression Scale for Schizophrenia.
   The results found that ToM impairment explained a substantial proportion of variance in overall insight and its three major components: awareness of illness, relabelling of symptoms and treatment compliance. Moreover, the effect of ToM deficits on insight remained significant even after controlling for all neurocognitive factors and symptom ratings. Regression analysis showed that symptoms and cognitive deficits also contribute to impaired insight in schizophrenia. General intellectual ability was negatively associated with both overall insight and relabeling of symptoms. Executive functions were negatively associated with relabelling.
   The researcher conclude that the results was confirm that ToM deficits negatively affect insight independently of neurocognitive deficits and symptom severity in chronic schizophrenia. The effect of ToM deficits on insight should be further examined in the broader context of the failures in metacognition and their relationships with insight impairment in schizophrenia.

6. **Facial affect recognition in symptomatically remitted patients with schizophrenia and bipolar disorder. A study of Yalcin-Siedentopf et al, (2014),** both schizophrenia and bipolar disorder (BD) have consistently been associated with deficits in facial affect recognition (FAR). These impairments have been related to various aspects of social competence and functioning and are relatively stable over time. However, individuals in remission may outperform patients experiencing an acute phase of the disorders. The Yalcin-Siedentopf study directly contrasted FAR in symptomatically remitted patients with schizophrenia or BD and healthy volunteers and investigated its relationship with patients' outcomes.
   Compared to healthy control subjects, schizophrenia patients were impaired in the recognition of angry, disgusted, sad and happy facial expressions, while BD patients showed deficits only in the recognition of disgusted and happy facial expressions. When directly comparing the two patient groups individuals suffering from BD outperformed those with schizophrenia in the recognition of expressions depicting anger.
   There was no significant association between affect recognition abilities and symptomatic or psychosocial outcomes in schizophrenia patients. Among BD patients, relatively higher depression scores were associated with impairments in both the identification of happy faces and psychosocial functioning.
   Overall, study findings indicate that during periods of symptomatic remission the recognition of facial affect may be less impaired in patients with BD than in

those suffering from schizophrenia. However, in the psychosocial context BD patients seem to be more sensitive to residual symptomatology.

7. **Cross-cultural comparisons of attitudes toward schizophrenia amongst the general population and physicians. A series of web-based surveys in Japan and the United States. A study of Richards et al, (2014).** Cross-cultural differences in attitudes toward schizophrenia are suggested, while no studies have compared such attitudes between the United States and Japan. In the previous study in Japan (Hori et al., 2011), 197 subjects in the general population and 112 physicians (excluding psychiatrists) enrolled in a web-based survey using an Internet-based questionnaire format. Utilizing the identical web-based Survey method in the United States, the present study enrolled 172 subjects in the general population and 45 physicians. Participants' attitudes toward schizophrenia were assessed with the English version of the 18-item questionnaire used in our previous Japanese survey. Using exploratory factor analysis, the study identified four factors labeled "social distance," "belief of dangerousness," "underestimation of patients' abilities," and "skepticism regarding treatment." The two-way multivariate analysis of covariance on the four factors, with country and occupation as the between-subject factors and with potentially confounding demographic variables as the covariates, revealed that the general population in the US scored significantly lower than the Japanese counterparts on the factors "social distance" and "skepticism regarding treatment" and higher on "underestimation of patients' abilities." The results suggest that culture may have an important role in shaping attitudes toward mental illness. Anti-stigma campaigns that target culture-specific biases are considered important.

8. **Quality of Life among Schizophrenic Patients in Gaza Governorates. The study of Aish (2013),** the aim of this study was to assess quality of life among schizophrenic patients in Gaza governorates. Study design, is a descriptive-analytical design to conduct this study. This study focused on the quality of life including its different domain among schizophrenic patient in Gaza governorates. Study sample: A stratified random sample of sample male and female between the ages of 20 to 45 years, who treatment in psychiatric primary care clinics in the Gaza strip 160 participants of schizophrenic patients is taken from population lists who attend 6 psychiatric primary care centers. 137 of the participant respond to the study tools. Data collection: The information was collected by questionnaire designed to measure the quality of life this questionnaire specially prepared for this purpose from the World Health Organization, as well as information collected through the files and medical reports. Study results found that with analyzing results and connect them with the QOL the percentage of the total scores of the QOL among the study sample 44%, Moreover, the highest domain was the environmental 51.5%, and the lowest domain was the social at 35.4%. There were statistical significant differences in QOL due to gender favor the female in psychological, social, and physical, at (p-value < 0.05). There were statistical significant differences in QOL due to address in all domain favor middle and Rafah at (p-value < 0.05). There were statistical significant differences in QOL due to state of housing favor owned in psychological and environmental domain at (p-value < 0.05). There were statistical significant differences in QOL due to level of education favor university in social and environmental domain at (p-value<0.05). There

were statistical significant differences in QOL due to complication of illness favor put not have complication of illness at (p-value<0.05). there were statistical significant differences in QOL due to side effect of medication favor patient not have side effect of medication at (p-value<0.05). In opposite there were no statistical significant differences related to these variable: Age, type of housing, social status, number of family, occupation, income, history of illness and time of admission. The researcher conclude to health care providers and decision makers should consider the result of this study to contribute in the promotion of health care services provided to schizophrenic patients to reduce their suffering, prevent and delay future complications as well as helping them to have and enjoy a better quality of life.

9. **Auditory Emotion Recognition Impairments in Schizophrenia: Relationship to A caustic Features and Cognition. The study of Gold R et al, (2012),** aimed to evaluated performance in schizophrenia on a novel voice emotion recognition battery with well-characterized physical features, relative to impairments in more general emotional and cognitive functioning. Schizophrenia is associated with deficits in the ability to perceive emotion based on tone of voice. The basis for this deficit remains unclear, however, and relevant assessment batteries remain limited. The authors studied a primary sample of 92 patients and 73 comparison subjects. Stimuli were characterized according to both intended emotion and acoustic features (e.g., pitch, intensity) that contributed to the emotional percept. Parallel measures of visual emotion recognition, pitch perception, general cognition, and overall outcome were obtained. More limited measures were obtained in an independent replication sample of 36 patients, 31 age-matched comparison subjects, and 188 general comparison subjects. Patients showed statistically significant large-effect-size deficits in voice emotion recognition and were preferentially impaired in recognition of emotion based on pitch features but not intensity features. Emotion recognition deficits were significantly correlated with pitch perception impairments both across and within groups. Path analysis showed both sensory-specific and general cognitive contributions to auditory emotion recognition deficits in schizophrenia. Similar patterns of results were observed in the replication sample. The results demonstrate that patients with schizophrenia show a significant deficit in the ability to recognize emotion based on tone of voice and that this deficit is related to impairment in detecting the underlying acoustic features, such as change in pitch, required for auditory emotion recognition. This study provides tools for, and highlights the need for greater attention to physical features of stimuli used in studying.

10. **Influence of self-efficacy on the interpersonal behavior of schizophrenia patients undergoing rehabilitation in psychiatric day-care services. A study by Morimoto T et al. (2012)**, examined whether the self-efficacy of interpersonal behavior influenced the interpersonal behavior of schizophrenia patients using psychiatric day-care Thirty-nine patients with services. Schizophrenia were examined with the Interpersonal Relations subscale of the Life Assessment Scale for Mentally Ill, the Self-efficacy Scale of Interpersonal Behavior, the Brief Assessment of Cognition in Schizophrenia-Japanese version,

and the Positive The Life Assessment Scale for Mentally and Negative Syndrome Scale. Ill score was significantly correlated with the self-efficacy of interpersonal behavior, and was also significantly correlated with neurocognitive functions and negative symptoms. However, the Self-efficacy Scale of Interpersonal Behavior score was not correlated with neurocognitive functions and negative symptoms. To examine the causal correlations between the above social, psychological and clinical factors, multiple regression analysis was performed with the self-efficacy of interpersonal behavior, neurocognitive functions, and negative symptoms as the independent variables and interpersonal behavior as the dependent variable. The self-efficacy of interpersonal behavior was found to contribute to interpersonal behavior as well the self-efficacy of interpersonal as neurocognitive functions. Conclusion: behavior contributed to the interpersonal behavior as well as the neurocognitive functions in the case of schizophrenia patients in the community. The researcher suggested that interventions targeting the self-efficacy of interpersonal behavior, as well as those targeting neurocognitive functions, were important to improve the interpersonal behavior of schizophrenia patients undergoing psychiatric rehabilitation in the community. These results support evidence for the efficacy of IPT independent of age. Results further indicate the need of goal-oriented specific psychological interventions for middle-aged and older patients with schizophrenia.

11. **Abnormal connectivity between attentional, language and auditory networks in schizophrenia. The study of Liemburg EJ et al,.(2012)** investigated resting state network connectivity of auditory, language and attention networks of patients with schizophrenia and hypothesized that patients would show reduced connectivity. Brain circuits involved in language processing have been suggested to be compromised in patients with schizophrenia. This does not only include regions sub serving language production and perception, but also auditory processing and attention. Patients with schizophrenia (n = 45) and healthy controls (n = 30) underwent a resting state fMRI scan. Independent components analysis was used to identify networks of the auditory cortex, left inferior frontal language regions and the anterior cingulate region, associated with attention. The time courses of the components where correlated with each other, the correlations were transformed by a Fisher's Z transformation, and compared between groups. In patients with schizophrenia, the researcher observed decreased connectivity between the auditory and language networks. Conversely, patients showed increased connectivity between the attention and language network compared to controls. There was no relationship with severity of symptoms such as auditory hallucinations. The decreased connectivity between auditory and language processing areas observed in schizophrenia patients is consistent with earlier research and may underlie language processing difficulties. Altered anterior cingulate connectivity in patients may be a correlate of habitual suppression of unintended speech, or of excessive attention to internally generated speech. This altered connectivity pattern appears to be present independent of symptom severity, and may be suggestive of a trait, rather than a state characteristic.

12. **Drug compliance and family support contribution in preventing relapse among schizophrenia clients in Gaza strip.** A study of **Abu Rahma, (2012),** aimed is to identify the levels of clients attitude towards treatment, drug compliance, family support and relapse among schizophrenia clients in Gaza strip**.** Other objectives aims to identify the relationship between of drug compliance and family support in preventing relapse and assess the effect of the economic stat, gender, age and marital status on relapse among schizophrenia in Gaza strip.

    The research was designed on a descriptive cross-sectional method that focused on distributed questionnaire. This questionnaire was used to collect the required data in order to achieve the research objectives. The purposive study sample consists of 84 clients from community mental health in Gaza strip were participated in structured interviews to explore clients attitude towered medication, drug compliance and family support. The rate of response was 77.38%. The interview with family to explore relapses. Three questioners were built by researcher, first one about drug compliance, second one about family support there are filled by clients and third one bout relapse filled by families. All questionnaires filled through interview with clients and family separately, statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis.

    The study results found that the clients attitude towards treatment was positive 65.93%, the level of drug compliance was 74.79%, the level of family support was 84.312% and the level of relapse was 27.8%. The significant and extrusive relationship between the client attitude towards medication and the drug compliance to antipsychotic drug at significant level α =0.05, the p-value equal 0.000. The relationship between drug compliance and relapses are inverted correlation at significant level α =0.05, the p value equal 0.000. The relationship between family support and relapses with behavior, social, sensory, intellectual and are inverted correlation at significant level α =0.05, the p-value equal 0.000., except family support with emotional relapse is no at significant level α =0.05, the p-value equal 0.000. No a significant differences between Drug compliance and family support contribute prevent relapse among schizophrenia clients in Gaza strip due to sex, age, social status and monthly income at significant level α =0.05

    The study showed strong correlation between drug compliance and family support in preventing relapse among schizophrenia. To engage client in treatment need to support from family and community. The client's attitude towards medication and treatment are important to drug compliance and help in continuity of treatment.

13. **Aspects of cognitive functioning in schizotypy and schizophrenia: evidence for a continuum model.** The study of **Cochrane M et al., (2012).** This research consisted of two studies, the fundamental aim of which was to delineate the pattern of relationships between measures of cognitive task performance and both symptom subtypes in schizophrenia and their corresponding schizotypal personality traits in healthy individuals. Study 1 compared these relationships in healthy individuals using the Schizotypal Personality Questionnaire (SPQ) and Study 2 assessed the relationships between symptomatology assessed using the

Scale for the Assessment of Positive Symptoms and Scale for the Assessment of Negative Symptoms (SAPS/SANS) and cognitive task performance in a group of patients with schizophrenia. The contribution of fluid intelligence to task performance was also examined. In Study 1 high levels of negative schizotypy were associated with reduced verbal fluency, and high levels of disorganized schizotypy were associated with reduced negative priming in the healthy participants. In Study 2, closely corresponding relationships between symptom measures and these tasks were found in the patients with schizophrenia. The associations between the symptom and cognitive measures were independent of the effects of fluid IQ on performance.

14. **Effects of age of onset on clinical characteristics in schizophrenia spectrum disorders.** A study of **Kao YC and Liu YP, (2010),** aimed to assess differences in demographic and clinical characteristics correlated with age of illness onset in schizophrenia spectrum disorders. Over the last few decades, research regarding the age of onset of schizophrenia and its relationship with other clinical variables has been incorporated into clinical practices. However, reports of potential differences in demographic and clinical characteristics between early- and adult-onset schizophrenia spectrum disorders have been controversial. Thus, this study Data were collected from 104 patients with schizophrenia and schizoaffective disorder. Diagnosis was made via structured clinical interviews. Assessments of psychiatric symptoms and social and global functioning were completed. The effect of age of onset on demographic and clinical variables was examined using correlation analyses and binary logistic regression models. The researcher choose 17 years of age as the cut-off for early-onset schizophrenia spectrum disorders based on a recent clinical consensus. The researcher further investigated differences in the severity of psychopathology and other clinical variables between the early- and adult-onset groups. The binary logistic regression analysis showed that age of onset was significantly related to the cognitive component of the Positive and Negative Syndrome Scale (PANSS) and Barratt Impulsiveness Scale (BIS) score. Patients with early onset of schizophrenia spectrum disorders had significantly greater levels of cognitive impairment and higher impulsivity. There were significant differences between several demographic and clinical variables, including the negative symptom component of the PANSS, cognitive component of the PANSS, BIS score, and psychological domain of quality of life (QOL), between patients with early- and adult-onset schizophrenia spectrum disorders, having controlled for the effect of the current age and duration of illness. Our findings support the hypothesis of an influence of age of onset on illness course in patients with schizophrenia spectrum disorders. This finding may in fact be part of a separate domain worthy of investigation for the development of interventions for early symptoms of schizophrenia.

3.1.2. Discussion of the studies on first axis:

The researcher will discuss previous studies of schizophrenia and another independent changing; the first one is tools were used in these studies; the second is samples of the studies, and the third about the results of the previous studies, as the following:

3.1.2.1. Tools of the previous studies

Some of research used compared between case and controls such as (Bedford and David, 2014), (Yalcin-Siedentopf et al, 2014), (Karavia et al, (2014), (Gold R et al, 2012), and (Liemburg EJ et al, 2012). But another study used Interpersonal Relations subscale of the Life Assessment Scale for Mentally Ill as (Misdrahi et al, 2014), (Morimoto T et al, 2012)**.**

The study of (Richards et al, 2014), was a cross-cultural differences in attitudes toward schizophrenia are suggested, while no studies have compared such attitudes between the United States and Japan.

Some studies make a literature review for the previous research as the study of (Neyndorff et al, 2014), (Richards et al, 2014).

The study of (Cochrane M et al, 2012) included two studies, study 1 compared the relationships in healthy individuals using the Schizotypal Personality Questionnaire (SPQ) and study 2 assessed the relationships between symptomatology assessed using the Scale for the Assessment of Positive Symptoms and Scale for the Assessment of Negative Symptoms

The study of (Aish, 2013), used a descriptive- analytical design in the study, and focused on the quality of life including its different domain among schizophrenic patient in Gaza governorates. And the study of (Kao YC & Liu YP, 2010) Assessments of psychiatric symptoms and social and global functioning were completed. The effect of age of onset on demographic and clinical variables was examined using correlation analyses and binary logistic regression models.

3.1.2.2. Samples of the previous studies:

In the field of samples of the previous studies, the study samples were ranged between small samples as the study of (Bedford and David, 2014) included 26 schizophrenia patients with either an overall acceptance or denial of their illness and 25 healthy controls made timed decisions about the self-descriptiveness. (Misdrahi et al, 2014) study included 61 schizophrenic patients. (Konstantakopoulos et al, (2014) include 56 schizophrenic patient.

(Abu Rahma, 2012) study sample consists of 84 clients from community mental health in Gaza strip, and (Misdrahi et al, 2014), included 61 schizophrenic patients, (Gold R et al, 2012) the authors studied a primary sample of 92 patients and 73 comparison subjects.

However the medium samples in the studies (Aish, 2013) the samples included male and female between the ages of 20 to 45 years, who treatment in psychiatric primary care clinics in the Gaza strip, of 137 patients with schizophrenia and their families.

3.1.2.3. Results of the previous studies:

In the previous studies of (Yalcin-Siedentopf et al, 2014), There was no significant association between affect recognition abilities and symptomatic or psychosocial outcomes in schizophrenia patients.

(Richards et al, 2014), the found that in general population in the US scored significantly lower than the Japanese counterparts on the factors “social distance” and “skepticism regarding treatment” and higher on “underestimation of patients' abilities.”

(Misdrahi et al, 2014), study found that 41.2% of the sample had a history of suicide attempts. Patients in the high clinical insight group had significantly higher depression scores, higher hopelessness cores

(Aish, 2013) study found an statistical significant differences in QOL due to state of housing favor owned in psychological and environmental domain.

(Gold R et al, 2012) found patients with schizophrenia show a significant deficit in the ability to recognize emotion based on tone of voice and that this deficit is related to impairment in detecting the underlying acoustic features.

On other hands **(**Abu Rahma, 2012) study results found the level of family support was 84.312% and the level of relapse was 27.8%. The study showed strong correlation between drug compliance and family support in preventing relapse among schizophrenia.

In addition, (Kao YC & Liu YP, 2010) findings support the hypothesis of an influence of age of onset on illness course in patients with schizophrenia spectrum disorders.

(Morimoto T et al, 2012) results support evidence for the efficacy of IPT independent of age.

3.2 Study of Stigma:

3.2.1. Previous studies:

1. **Johyeonbyung (attunement disorder): Renaming mind splitting disorder as a way to reduce stigma of patients with schizophrenia in Korea. A study of Lee et al (2014),** was Johyeonbyung (attunement disorder): Renaming mind splitting disorder as a way to reduce stigma of patients with schizophrenia in Korea. Lee was study the term schizophrenia, which comes from the Greek roots ‘‘skhizein’’ and ‘‘phren,’’ was translated as ‘‘Jungshinbunyeolbyung’’ in East Asian Countries, including Japan, Korea, and China. The term literally means ‘‘mind-splitting disease.’’ This term has generated a misconception of the disorder as an untreatable chaotic personality, thus instilling stigma and causing suffering in patients and their families. This socio-cultural connotation has impeded medical treatment of schizophrenia. Recent neuroscience research has suggested neural network dysfunction in schizophrenia. Accordingly, a new term, ‘‘Johyeonbyung (attunement disorder)’’, was coined in South Korea. This term literally refers to tuning a string instrument, and metaphorically it describes schizophrenia as a disorder caused by mistuning of the brain’s neural network. Study expect that the term Johyeonbyung will incite less prejudice and that its metaphoric description of the disorder may help patients to access medical treatment in the early phase. The name of a psychiatric disorder can influence

others' attitudes toward patients; thus, discretion is crucial in naming psychiatric disorders.

2. **Internalised Stigma in People Living with Chronic Pain. A study of Augh et al, (2014),** aimed to consider whether an individual's experience, perception, or anticipation of negative social reactions to their pain may become internalised and affect the self. To examine this issue, 92 adults with chronic pain responded to a questionnaire exploring the presence of internalised stigma and its association with a range of psychological consequences. As predicted, a large percentage of people with chronic pain (38%) endorsed the experience of internalised stigma. The results showed that internalized stigma has a negative relationship with self-esteem and pain self-efficacy, after controlling for depression. Internalised stigma was also associated with cognitive functioning in relation to pain, in terms of a greater tendency to catastrophise about pain and a reduced sense of personal control over pain. Overall, this study presents a new finding regarding the application of internalised stigma to a chronic pain population. It offers a means of extending our understanding of chronic pain's psychosocial domain. Implications are discussed in terms of the potential to inform clinical treatment and resiliency into the future.

3. **Intervening within and across levels: A multilevel approach to stigma and public health. A study of Cook et al, (2014),** uses a multilevel approach to review the literature on interventions with promise to reduce social stigma and its consequences for population health. Three levels of an ecological system are discussed.
   The intrapersonal level describes interventions directed at individuals, to either enhance coping strategies of people who belong to stigmatized groups or change attitudes and behaviors of the nonstigmatized. The interpersonal level describes interventions that target dyadic or small group interactions.
   The structural level describes interventions directed at the social-political environment, such as laws and policies. These intervention levels are related and they reciprocally affect one another. In this article we review the literature within each level. The researcher suggest that interventions at any level have the potential to affect other levels of an ecological system through a process of mutually reinforcing reciprocal processes. The researcher discuss research priorities, in particular longitudinal research that incorporates multiple outcomes across a system.

4. **Online support groups for mental health: A space for challenging self-stigma or a means of social avoidance?. A study of Lawlor and Kirakowski, (2014),** a mediation model was used to test two hypotheses, (1) Online Support Group (OSG) use mediates self-stigma and recovery from self-stigma and (2), recovery from self-stigma mediates OSG use and support seeking. Structural Equation Modelling (SEM) using Bayesian estimation with Monte-Carlo Markov Chain (MCMC) was used to analyses the model, based on the data collected from 99 users of OSGs for mental illness. The hypotheses were not supported. Active users were found to have higher levels of recovery from self-stigma and increased likelihood to have sought formal support. However, these

perceived benefits maybe attributable to underlying factors which encourage a user to actively participate. Frequency of visits negatively affects recovery from self-stigma, suggesting that OSGs are a form of social avoidance‹ as opposed to a method of challenging the problem of stigma. This supports a growing body of research which is highlighting the negative effects of excessive dependency on OSGs. Users, moderators and mental health professionals need to be cognizant of the potential harm that excessive dependency can cause to already vulnerable people.

5. **Self-regulatory processes underlying structural stigma and health. A study of Richman and Lattanner, (2014),** was examined self-regulatory processes that are initiated by structural stigma. To date, the literature on self-regulation as a mechanism that underlies stigma and health outcomes has focused primarily on harmful health-related behaviors that are associated with perceived discrimination.
   Numerous studies find that when people experience discrimination, they are more likely to engage in behaviors that pose risks for health, such as overeating and substance use. However, a large body of literature also finds that low power e which is also a chronic, though often more subtle, experience for stigmatized groups e is associated with a heightened activation of inhibitory processes. This inhibition system has wide-ranging influences on cognition, behavior, and affect. The researcher provide an overview of these two literatures, examine synergies, and propose potential implications for measurement and research design.

6. **Stereotype endorsement, metacognitive capacity, and self-esteem as predictors of stigma resistance in persons with schizophrenia. A study of Nabors et al, (2014),** research continues to document the impact of internalized stigma among persons with schizophrenia, little is known about the factors which promote stigma resistance or the ability to recognize and reject stigma. This study aimed to replicate previous findings linking stigma resistance with lesser levels of depression and higher levels of self-esteem while also examining the extent to which other factors, including metacognitive capacity and positive and negative symptoms, are linked to the ability to resist stigma.
   Method: Participants were 62 adults with schizophrenia-spectrum disorders who completed selfreports of stigma resistance, internalized stigma, self-esteem, and rater assessments of positive, negative, disorganization, and emotional discomfort symptoms, and metacognitive capacity.

   Results: Stigma resistance was significantly correlated with lower levels of acceptance of stereotypes of mental illness, negative symptoms, and higher levels of metacognitive capacity, and self-esteem. A stepwise multiple regression revealed that acceptance of stereotypes of mental illness, metacognitive capacity, and self-esteem all uniquely contributed to greater levels of stigma resistance, accounting for 39% of the variance.

   Conclusion: Stigma resistance is related to, but not synonymous with, internalized stigma. Greater metacognitive capacity, better self-esteem, and fewer negative symptoms may be factors which facilitate stigma resistance.

7. **The power to resist: the relationship between power, stigma, and negative symptoms in schizophrenia. A study of Campellone (2014),** Stigmatizing beliefs about mental illness can be a daily struggle for people with schizophrenia. While investigations into the impact of internalizing stigma on negative symptoms have yielded mixed results, resistance to stigmatizing beliefs has received little attention. In this study, the researcher examined the linkage between internalized stigma, stigma resistance, negative symptoms, and social power, or perceived ability to influence others during social inter actions among people with schizophrenia. Further, the researcher sought to determine whether resistance to stigma would be bolstered by social power, with greater power in relationships with other possibly buffering against motivation/ pleasure negative symptoms. Fifty-one people with schizophrenia or schizo affective disorder completed measures of social power, internalized stigma, and stigma resistance. Negative symptoms were assessed using the Clinical Assessment Interview for Negative Symptoms (CAINS). Greater social power was associated with less internalized stigma and negative symptoms as well as more stigma resistance. Further, the relationship between social power and negative symptoms was partially mediated by stigma resistance. These findings provide evidence for the role of stigma resistance as a viable target for psychosocial interventions aimed at improving motivation and social power in people with schizophrenia.

8. **Development of a scale to measure stigma related to podoconiosis in Southern Ethiopia. A study of Franklin et al, (2013),** Indicators of stigma were drawn from existing qualitative podoconiosis research and a literature review on measuring leprosy stigma. These were then formulated into items for questioning and evaluated through a Delphi process in which irrelevant items were discounted. The final items formed four scales measuring two distinct forms of stigma (felt stigma and enacted stigma) for those with podoconiosis and those without the disease. The scales were formatted as two questionnaires, one for podoconiosis patients and one for unaffected community members. 150 podoconiosis patients and 500 unaffected community members from Wolaita zone, Southern Ethiopia were selected through multistage random sampling to complete the questionnaires which were interview-administered. The scales were evaluated through reliability assessment, content and construct validity analysis of the items, factor analysis and internal consistency analysis.
   Results: All scales had Cronbach's alpha over 0.7, indicating good consistency. The content and construct validity of the scales were satisfactory with modest correlation between items. There was significant correlation between the felt and enacted stigma scales among patients (Spearman's $r = 0.892$; $p < 0.001$) and within the community (Spearman's $r = 0.794$; $p < 0.001$).
   Conclusion: The researcher report the development and testing of the first standardised measures of podoconiosis stigma. Although further research is needed to validate the scales in other contexts, the researcher anticipate they will be useful in situational analysis and in designing, monitoring and evaluating interventions. The scales will enable an evidence-based approach to mitigating stigma which will enable implementation of more effective disease control and help break the cycle of poverty and NTDs.

9. **Exploring the relationship between mental health stigma, knowledge and provision of pharmacy services for consumers with schizophrenia. The study of O'Reilly et al. in (2013),** Objectives: To explore the relationship between pharmacists' level of mental health stigma, mental health literacy and behavioral intentions in relation to providing pharmacy services for consumers with schizophrenia.

   Methods: A survey instrument containing a measure of mental health literacy, the 7-item social distance scale, and 16 items relating to the provision of pharmacy services for consumers with schizophrenia compared to cardiovascular disease, was mailed to a random sample of 1000 pharmacists registered with the Pharmacy Board of New South Wales in November 2009. Multiple linear regression models were used to assess the relationship between stigma, knowledge and behavior.

   Results: Responses were received from 188 pharmacists. Pharmacists were significantly more confident and comfortable to provide services to consumers with a cardiovascular illness than a mental illness. Social distance, b ¼ -0.11 (95% CI: -0.22, -0.01, P ¼ 0.03), and schizophrenia literacy scores, b ¼ 1.02, (95% CI: 0.54, 1.50, P! 0.001), were strongly associated with willingness to provide medication counseling. Schizophrenia literacy was also a predictor of identifying drug-related problems, b ¼ 1.09 (95% CI: 0.39, 1.79, P ¼ 0.002).

   Claire L. O'Reilly However, in their study the scale was used in the context of depression rather than schizophrenia and is hence not directly comparable. While stigma is thought to be greater toward schizophrenia than depression

   Both mental health stigma and knowledge of schizophrenia treatments were independent predictors of medication counseling scores in this study demonstrating the importance of multifaceted interventions to improve the provision of pharmacy services to consumers with schizophrenia. While health professionals seem to have improved levels of mental health literacy compared to the public, levels of mental health stigma appear to be independent of knowledge, and health professionals and the public share similar levels of social distance toward schizophrenia. Many anti-stigma campaigns have been based on the concept that improving knowledge will reduce stigma toward mental illness.

10. **Internalized stigma in schizophrenia: relations with dysfunctional attitudes, symptoms, and quality of life. A study of Park SG et al, (2013),** Internalized stigma refers to the process by which individuals with mental illness apply negative stereotypes to themselves, expect to be rejected by others, and feel alienated from society. Though internalized stigma has been hypothesized to be associated with maladaptive cognitions and expectations of failure, this relationship with dysfunctional attitudes has not been fully examined. In the present study, 49 individuals with schizophrenia or schizoaffective disorder completed the Internalized Stigma of Mental Illness Scale (ISMI; Ritsher et al., 2003) in addition to measures tapping defeatist performance beliefs, beliefs regarding low likelihood of success and limited resources, negative symptoms, depression, and quality of life. Consistent with prior research, internalized stigma was correlated with depression and quality of life but not with negative symptoms. Further, internalized stigma was correlated with both measures of dysfunctional attitudes. After controlling for depressive symptomatology, the

relationship between internalized stigma and beliefs regarding low likelihood of success and limited resources remained significant, and though the correlation between defeatist performance beliefs and internalized stigma was no longer significant, it was of a similar magnitude. Overall, these data suggest that dysfunctional attitudes play a role in internalized stigma in individuals with schizophrenia, indicating a possible point of intervention.

11. **Awareness of schizophrenia and intellectual disability and stigma across ethnic groups in the UK. A study of Scior et al, (2013),** Research has examined the public's understanding of mental illness and stigma, but there is scant evidence on intellectual disabilities. This study investigated whether the public from different ethnic groups can recognize symptoms of schizophrenia and intellectual disability depicted in a vignette, and what factors predict recognition and social distance. A survey of lay people of working age was completed in the UK (N¼1002). The sample was ethnically mixed, with the largest groups consisting of White UK residents, and people from Asian and black African/Caribbean backgrounds. Regression analyses were performed to identify predictors of recognition and social distance. A cross the whole sample, 25.7% recognized schizophrenia and 28.0% intellectual disability. Ethnicity, gender, education and prior contact predicted recognition of both vignettes. Social distance was higher for schizophrenia than intellectual disability, but overall participants were ambivalent to mildly negative about social
    Contact with individuals with either symptom at ology. Familiarity was associated with lower social distance for both conditions. Symptom recognition predicted reduced social distance for intellectual disability, but not for schizophrenia. The low levels of awareness of symptoms and high levels of stigma among some ethnic groups indicate a need for targeted public education efforts and further research.

12. **The relationship between internalized stigma, negative symptoms and social functioning in schizophrenia: The mediating role of self-efficacy. A study of Hill et al, (2013),** aim was to gain a greater understanding of the processes that contribute to negative symptoms and social functioning in schizophrenia. More specifically, a theoretical model was proposed predicting that self-efficacy would mediate the relationship between internalized stigma and both negative symptoms and social functioning in schizophrenia. Initial analyses revealed that all
    Variables were correlated. Specifically, internalized stigma was strongly correlated with negative symptoms, social functioning and self-efficacy. Furthermore, self-efficacy was strongly related to negative symptoms and moderately associated with social functioning. Further analyses show ever did not support the mediational role of self-efficacy. The theoretical and clinical implications of the findings, together with recommendations for future research, are outlined.

13. **The Psychometric Assessment of Internalized Stigma Instruments: A Systematic Review. A study of Stevelink et al, (2012),** Objective: To rate the psychometric properties of instruments to measure internalized (or self-) stigma in health conditions where stigma plays a major role.

The researcher conducted a systematic literature review by searching relevant databases and by reviewing the bibliographies of relevant papers. Quantitative studies were included if the items used, or a sample of the instrument, was included in the paper and if the studies focused on the initial development or validation of the instrument. Health conditions included were HIV/AIDS, mental health, leprosy, asthma, epilepsy, cancer, obesity, and tuberculosis. Psychometric properties of the included studies were assessed using the quality criteria proposed by Terwee *et al.* and the COSMIN consortium: content validity, internal consistency, construct validity, criterion validity, reproducibility, responsiveness, floor and ceiling effects, and interpretability.
Results: Thirty-three papers were included of which 21 were identified as actual instrument development studies. Only two instruments received three positive quality ratings, 12 received at least three indeterminate ratings, especially for the internal consistency and construct validity. At least one negative rating was given to five instruments. Content and construct validity as well as internal consistency were most often assessed, whereas agreement and responsiveness received least attention.
The researcher rated the psychometric properties of available instruments to measure internalized stigma using standard quality criteria. Only the child attitude towards illness scale and the internalized stigma of mental illness received three positive ratings indicating that the majority of the instruments need further testing.
Implications: The need was identified for a simplified testing protocol to design an instrument development study, to assess certain psychometric properties, and to specify the preferred statistical methods for testing these. In addition, researchers should be aware that re-validation of instruments is necessary before they are used in cultures and study populations other than those for which they were developed.

14. **Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies. The study of Corrigan et al, (2012),** about public stigma and discrimination have pernicious effects on the lives of people with serious mental illnesses. Given a plethora of research on changing the stigma of mental illness, this article reports on a meta-analysis that examined the effects of antistigma approaches that included protest or social activism, education of the public, and contact with persons with mental illness. Methods: The investigators heeded published guidelines for systematic literature reviews in health care. This comprehensive and systematic review included articles in languages other than English, dissertations, and population studies. The search included all articles from the inception of the databases until October 2010. Search terms fell into three categories: stigma, mental illness (such as schizophrenia and depression), and change program (including contact and education). The search yielded 72 articles and reports meeting the inclusion criteria of relevance to changing public stigma and sufficient data and statistics to complete analyses. Studies represented 38,364 research participants from 14 countries. Effect sizes were computed for all studies and for each treatment condition within studies. Comparisons between effect sizes were conducted with a weighted one-way analysis of variance. Results: Overall, both education and contact had positive

effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults. For adolescents, the opposite pattern was found: education was more effective. Overall, face-to-face contact was more effective than contact by video. Conclusions: Future research is needed to identify moderators of the effects of both education and contact.

15. **Prevalence of Internalized Stigma among Persons with Severe Mental Illness.** Study conducted by **West et al (2011**) in United States American (USA), aimed to investigate the current prevalence and demographic correlates of significantly elevated levels of internalized stigma in two samples of people with severe mental illness living in the community.
    The sample size of this study was 144 persons (79.9% males, 20.1% females) participated, completing a demographic form and the Internalized Stigma of Mental Illness scale.
    The result of study showed that overall, 36% of the sample had elevated internalized stigma scores using a cutoff criterion. Participants in the middle of the age distribution had the highest scores, and there was a site difference. No other demographic variables studied were related to overall internalized stigma.

16. **Stigma related to help-seeking from a mental health professional. A study of Zartaloudi and Madianos, (2010),** purpose to examine the relationships between stigma, mental illness and help-seeking. The researcher used a review of this body of literature was carried out. Evidence was collected through Medline database.
    The results indicated that the role of supernatural, religious and magical approaches to mental illness was prevailing in the past. Individuals with mental illness are still being stigmatized despite modern medicine and more humane treatment. People with mental illness are considered as dangerous and aggressive which in turn increases the social distance. The pathway to care is often shaped by scepticism towards mental health services and the treatments offered. Stigma experienced from family members is pervasive. Moreover, social disapproval and devaluation of families with mentally ill individuals are an important concern.
    This review revealed that the stigmatization of people with mental illness is widespread. Because of the importance of this subject, future research should be conducted to look at why mental illness is stigmatized by the general public and mainly orientate towards finding a way for individuals with mental illness to live in a world without stigma.

17. **Experiences of mental illness stigma, prejudice and discrimination: a review of measures. The study of Brohan et al, (2010).** This study aims to review current practice in the survey measurement of mental illness stigma, prejudice and discrimination experienced by people who have personal experience of mental illness. The researcher will identify measures used, their characteristics and psychometric properties.

A narrative literature review of survey measures of mental illness stigma was conducted. The databases Medline, Psych Info and the British Nursing Index were searched for the period 1990-2009.

The results indicated that 57 studies were included in the review. 14 survey measures of mental illness stigma were identified. Seven of the located measures addressed aspects of perceived stigma, 10 aspects of experienced stigma and 5 aspects of self-stigma. Of the identified studies, 79% used one of the measures of perceived stigma, 46% one of the measures of experienced stigma and 33% one of the measures of self-stigma. All measures presented some information on psychometric properties.

The review was structured by considering perceived, experienced and self-stigma as separate but related constructs. It provides a resource to aid researchers in selecting the measure of mental illness stigma which is most appropriate to their purpose.

18. **Demographic, social and clinical variables of anticipated and experienced stigma of mental illness.** Study conducted by **Cechnicki and Bielańska (2009**) aimed to describe the anticipated and experienced stigma and to analyze relationships between demographic, social and clinical factors, and anticipated and experienced stigma.

    The sample comprised 202 patients from the Malopolska region diagnosed with schizophrenia and schizotypal syndromes (ICD 10). Average age: 40, average number hospitalize ions. Angermeyer’ s questionnaire. The patients shared their opinions (part A) and experiences (part B) concerning stigma. To analyze inter-group comparisons Mann-Whitney U-test was used, complex relationships were assessed with forward stepwise regression.

    The result showed that older age and living in a large town account for anticipated stigma to a limited but significant extent; a stronger experience of stigma is explained, to a limited but significant extent, with better education, lack of employment and a higher number of earlier hospitalizations. The anticipation of stigma explains to a significant extent the experience of stigma, especially the beliefs that: contacts between healthy and mentally ill people are affected by negative stereotypes and therefore hindered; the mentally ill have fewer employment opportunities; the mentally ill and healthy people cannot be partners; the mentally ill have limited access to institutionally granted benefits, gender proved to be of no significance for the explanation of the indicators of stigma.

19. **Antipsychotic side effect, influence on stigma of mental illness.** Study conducted by **Nvak and Svab (2009)** in the Psychiatric Hospital Ljubljana, aimed to discriminate between stigmatizing effects of antipsychotics and other stigma related factors such as illness symptoms.

    The method of this study was focus group of ten patients with schizophrenia or schizoaffective disorder with severe and remitting mental illness treated with antipsychotic medication was conducted to obtain their personal views on how side effects of antipsychotic drugs affect their everyday lives and contribute to the stigmatization because of mental illness.

The result showed that the patients felt most stigmatized in areas of employment and occupation. They repeatedly skipped or discontinued regular medication due to side effects. Their families supported them throughout treatment and recovery despite problems associated with psychotropic medication.

20. **Socio-Demographic Correlates of Stigma Attached to Mental Illness.** Study conducted **by Ansari et al (2008) in Pakistan,** .aimed to identify sociodemographic correlates of stigma attached to psychiatric illnesses.
    The method of this study was a retrospective study. Data of the patients who had attended psychiatry department; either as a referral or direct consultation; and as inpatient or outpatient; at Isra University Hospital at Hyderabad during the years 2001 to 2004, were reviewed and presence or absence of stigma feelings were compared to their socio-demographic backgrounds. Demographic characteristics of a total of 1208 patients with different psychiatric illnesses were recorded. Data obtained, was subjected to analysis using SPSS 13th version.
    Result showed that Feelings of stigma was present in forty seven percent of the studied population. Males had slightly more feelings of stigma. People from urban areas were also carrying more feelings of stigma but it was statistically insignificant. Apart from people with no formal education who had maximum stigma feelings; education level was found to increase such feelings, in the population studied.

21. **Study conducted by Sharac et al (2008) in London.** aimed to identify literature on the Economic impact of mental illness stigma. The method of this study was a systematic review of the literature identified 30 papers from 27 studies by searching electronic databases and hand searching reference lists. The systematic literature review was designed to include searches of electronic databases and checking the reference lists of included studies.
    The results showed, Mental illness stigma/discrimination was found to impact negatively on employment, income, public views about resource allocation and healthcare costs.

3.2.2. Discussion of the studies on the second axis:

The researcher will discuss previous studies of schizophrenia and stigma; the first one is objective previous studies, second, tools were used in these studies, the third is samples of the studies, and the fourth is about the results of the previous studies, as the following:

3.2.2.1. Tools of the previous studies:

Number of studied was discussed the previous literature on stigma as study of (Lee et al, 2014), (Richman and Lattanner, 2014), (Richman and Lattanner, 2014), (Lee et al, 2014), (Franklin et al, 2013), (Corrigan et al, 2012), (Zartaloudi et al, 2010), (Brohan et al, (2010), (Madianos, 2010), (Sharac et al, 2008). And (Stevelink et al, 2012), (Cook et al, 2014), uses a multilevel approach to review the literature on interventions with promise to reduce social stigma and its consequences for population health.

(Brohan et al, 2010) used a narrative literature review of survey measures of mental illness stigma was conducted for the period 1990-2009.

Some of studies develop a pilot scale as (Hill et al, 2013), (Corrigan et al, 2012), (West et al, 2011). The study of (Franklin et al, 2013) formed four scales measuring two distinct forms of stigma.

Some of research used compared between case and controls such as the study (Campellone, 2014).

Some studies used a survey in a large samples as the study of (O'Reilly et al, 2013), and (Scior et al, 2013)

The study of (Nvak and Svab, 2009) used a case study for 10 patients with schizophrenia or schizoaffective disorder with severe and remitting mental illness treated with antipsychotic medication.

The study of (Ansari et al, 2008) used a retrospective study.

A study of (Sharac et al, 2008) used a systematic review of the literature identified 30 papers from 27 studies by searching electronic databases and hand searching reference lists.

3.2.2.2. Samples of the previous studies:

In the field of samples of the previous studies, the study samples were ranged between small samples as the study of (Augh et al, 2014) was 92 adults with chronic pain responded to a questionnaire exploring the presence of internalised stigma and its association with a range of psychological consequences.

(Lawlor and Kirakowski, 2014), developed a mediation model was used to test two hypotheses, (1) Online Support Group (OSG) use mediates self-stigma and recovery from self-stigma and (2), recovery from self-stigma mediates OSG use and support seeking.

The study (Campellone, 2014) consists of 51 patients with schizophrenia or schizo affective disorder completed measures of social power, internalized stigma, and stigma resistance. The study of (Borhan et al, 2010) used a literature review for 57 studies by 14 survey measures of mental illness stigma were identified.

However the medium samples in the studies as (Lawlor and Kirakowski, 2014) study that data collected from 99 users of OSGs for mental illness. The study of (Nabors et al, (2014) consists of 62 adults with schizophrenia-spectrum disorders who completed selfreports of stigma resistance, internalized stigma, self-esteem, and rater assessments of positive, negative, disorganization, and emotional discomfort symptoms, and metacognitive capacity. (Park SG et al, (2013), 49 individuals with schizophrenia or schizoaffective disorder completed the Internalized Stigma.

However the medium samples as study of (Franklin et al, (2013) consists of 150 podoconiosis patients and 500 unaffected community members from Wolaita

zone, Southern Ethiopia were selected through multistage random sampling to complete the questionnaires which were interview-administered.

While; some studies have large samples as study of (O'Reilly et al, 2013), used a random sample of 1000 pharmacists registered with the Pharmacy Board of New South Wales in November 2009. Multiple linear regression models were used to assess the relationship between stigma, knowledge and behavior.

And study of (Scior et al, 2013) which used a survey of lay people of working age was completed in the UK (N¼1002), distributed ethnically mixed, with the largest groups consisting of White UK residents, and people from Asian and black African/Caribbean backgrounds. (Ansari et al, 2008) sample was 1082 patients with different psychiatric illnesses were recorded retrospectively.

3.2.2.3. Results of the previous studies:

(Augh et al, 2014) study results indicated that internalised stigma was associated with cognitive functioning in relation to pain, in terms of a greater tendency to catastrophise about pain and a reduced sense of personal control over pain.

(Lee et al, 2014), study results suggested that the name of a psychiatric disorder can influence others' attitudes toward patients; thus, discretion is crucial in naming psychiatric disorders.

The researcher (Cook et al, (2014), suggest that interventions at any level have the potential to affect other levels of an ecological system through a process of mutually reinforcing reciprocal processes.

(Franklin et al, 2013) study found that all scales had Cronbach's alpha over 0.7, indicating good consistency, and there was significant correlation between the felt and enacted stigma scales among patients.

The study of (Park SG et al, 2013) indicated that after controlling for depressive symptomatology, the relationship between internalized stigma and beliefs regarding low likelihood of success and limited resources remained significant, and though the correlation between defeatist performance beliefs and internalized stigma was no longer significant, it was of a similar magnitude.

(Scior et al, 2013) study results found that 25.7% recognized schizophrenia and 28.0% intellectual disability.

The study of (Hill et al, 2013) indicated that internalized stigma was strongly correlated with negative symptoms, social functioning and self-efficacy.

(West et al, 2011) results found that 36% of the sample had elevated internalized stigma scores using a cutoff criterion. Participants in the middle of the age distribution had the highest scores, and there was a site difference.

The results of (Borhan et al, 2010) showed that of the identified studies, 79% used one of the measures of perceived stigma, 46% one of the measures of experienced stigma and 33% one of the measures of self-stigma.

The study of (Ansari et al, 2008) results showed that feelings of stigma was present in 47% of the studied population and males had slightly more feelings of stigma.

3.3 Study of Schizophrenia and Counseling:

3.3.1. Previous studies:

1. **A virtual reality-integrated program for improving social skills in patients with schizophrenia: A pilot study. BY Calafell et al (2014).** In this study, we report results from the application of a virtual reality (VR) integrated program as an adjunct technique to a brief social skills intervention for patients with schizophrenia. It was predicted that the intervention would improve social cognition and performance of patients as well as generalization of the learned responses into patient's daily life.
   Methods: Twelve patients with schizophrenia or schizoaffective disorder completed the study. They attended sixteen individual one-hour sessions, and outcome assessments were conducted at pretreatment, post-treatment and four-month follow-up.
   Results: The results of a series of repeated measures ANOVA revealed significant improvement in negative symptoms, psychopathology, social anxiety and discomfort, avoidance and social functioning.
   Objective scores obtained through the use of the VR program showed a pattern of learning in emotion perception, assertive behaviors and time spent in a conversation. Most of these gains were maintained at four-month follow-up.
   Limitations: The reported results are based on a small, uncontrolled pilot study. Although there was an independent rater for the self-reported and informant questionnaires, assessments were not blinded.
   Conclusions: The results showed that the intervention may be effective for improving social dysfunction. The use of the VR program contributed to the generalization of new skills into the patient's everyday functioning.

2. **Preventive Counseling for Chronic Disease: Missed Opportunities in a Community Mental Health Center. Study of Chwastiak et al, (2013).** The tremendous burden of cardiovascular risk among persons with serious mental illness underscores a critical need for prevention. Counseling by primary care clinicians increases patient smoking cessation, physical activity, and the consumption of fruits and vegetables. The extent to which community mental health clinicians counsel about cardiovascular risk factors has not been reported.
   Methods: This cross-sectional study examines the rates of counseling about cardiovascular risk factors by mental health providers at an urban community mental health center (n _ 154). Logistic regression analyses identified clinician characteristics associated with counseling more than 50% of clients about diet, exercise, and smoking.
   Results: 72% of clinical staff members responded to the survey, for a sample of 154 mental health clinicians; 26.6% of the clinicians counseled more than half of

their clients annually about all three cardiovascular disease (CVD) risk factors. Logistic regression showed that mental health providers who counseled clients about CVD risk factors were less likely to be obese, and were more likely to have received formal training about how to counsel clients about CVD risk. Discussion: This is the first study to examine the routine clinical practice of community mental health clinicians in addressing CVD risk at an urban community mental health center. Both training mental health clinicians about CVD risk and also support for improving clinician health status may improve the preventive care provided to clients at community mental health centers.

3. **Nutritional Counseling for Adults with Severe Mental Illness: Key Lessons Learned. A study of Kwan, et al, (2013).** The purpose of this article is to provide insight into the challenges RDNs face when providing nutritional counseling to individuals living with a mental illness. Case studies highlight the complexities involved in providing nutritional care and education. Although nutritional counseling was provided within the context of a research study, the lessons learned can apply to any RDN looking for practical strategies to overcome some of the challenges associated with behavior change in the SMI population.

   A randomized controlled Department of Veterans Affairs research study assessed the efficacy of a behavioral weight loss program for 120 US veterans with SMI (men and women, aged 18 to 70 years) who have gained weight as a result of their medications.

   This program has proven to be effective in preliminary findings. A multisite extension of this study is currently underway. Subjects assigned to the intervention group receive educational group lessons on nutrition and exercise, along with individual nutrition counseling weekly for the first 8 weeks and monthly thereafter, up to 1 year.

   RDNs teach the classes and perform the counseling.

   Psychotic Symptoms. Another difficult challenge involves getting information across to subjects in spite of any psychotic symptoms they might experience. As part of their illness, subjects' attention may be competing with internal stimuli, such as auditory hallucinations, that can affect their ability to focus on the dietetic counseling. These subjects may present with motoric abnormalities, such as moving lips without sound or blank stares, which might initially appear to be odd or even disrespectful to a provider without a background in mental health.

   Results : Other interventions may also be useful. Social skills training can be used by RDNs to help subjects learn how to be appropriately assertive when ordering food at restaurants, when resisting food from family members, and when navigating buffet tables at parties. Mindful eating strategies have also been practiced as a way to manage portion control. RDNs may also visit subjects' homes or assisted-living facilities to provide education to family members and caregivers. Other handson educational opportunities have included trips to grocery stores and restaurants to help subjects recognize and make healthier choices. RDNs help to locate appropriate exercise opportunities in the event that weight loss does not occur during a specified time period.

   Conclusion: RDNs are well-equipped to provide health promotional activities to prevent and manage disease and optimize nutritional health for individuals with

SMI. The use of psychotherapeutic techniques and other tools for metabolic management have all contributed to successful outcomes. These strategies, along with a hopeful attitude for the individual's wellness and recovery, are recommended for any RDN interested in working with this population.

4. **Enhancing sense of recovery and self-reflectivity in people with schizophrenia: A pilot study of Metacognitive Narrative Psychotherapy. A study of Bargenquast and Schweitzer RD, (2013)**, investigated the effectiveness of an innovative, manualized psychotherapy aimed at enhancing recovery and self-experience in people with schizophrenia, Metacognitive Narrative Psychotherapy.

   Design:

   Treatment effects were assessed using a mixed methodology. Data were quantitatively assessed using a single-sample, pre- and post-therapy design and qualitatively assessed using a case-study methodology.

   Methods:

   Eleven patients diagnosed with schizophrenia received Metacognitive Narrative Psychotherapy over the course of 11-26 months. Therapists were seven supervised postgraduate psychology students. On average patients attended 49 sessions over the course of therapy. Patients completed interview-based and self-report measures for general and treatment-specific outcomes at pre-, mid-, and post-treatment.

   Quantitative analyses showed that patients significantly improved on the general outcome of subjective recovery, as well as the treatment-specific outcome of self-reflectivity, with medium to large effect sizes. Case-study evidence also showed improvements for some patients in symptom severity, and narrative coherence and complexity.

   The results are consistent with previous case-study evidence and suggest that this manualized version of Metacognitive Narrative Psychotherapy produces general and approach-specific improvements for people with schizophrenia. Replication is needed to ascertain its effectiveness with a larger sample size and within a controlled design.

   People with psychotic symptoms experience disruptions in self-disturbance that are amenable to psychological interventions. A focus on enhancing metacognitive capacity in people with psychotic symptoms may contribute to enhancing sense of recovery. The current findings support the use of interventions that target capacity for meaningful storytelling in people with psychotic symptoms.

5. **Stigma, Agency and Recovery amongst People with Severe Mental Illness. A study of Whitley et al, (2014).**

   Evidence suggests that people with a severe mental illness still suffer high levels of stigma and discrimination. However little is known about how people with a severe mental illness manage such stigma. As such, the overall aim of this study is to document and analyze behavioral and psychological strategies of stigma management and control in a sample of people in recovery from a severe mental illness. To meet this aim, we conducted a five-year (2008-2012) qualitative longitudinal study in Washington D.C. Participants were recruited from small-

scale congregate housing units ('recovery communities') for people in recovery, provided by a public mental health agency. We conducted regular focus groups at these communities, augmented by in-depth participant observation. Analysis was propelled by the grounded theory approach. A key finding of this study is that stigma and discrimination were not perceived as commonly *experienced* problems by participants. Instead, stigma was perceived as an omnipresent *potential* problem to which participants remained eternally vigilant, taking various preventive measures. Most notable among these measures was a concerted and self-conscious effort to behave and look 'normal'; through dress, appearance, conduct and demeanor. In this endeavor, participants possessed and deployed a considered degree of agency to prevent, avoid or preempt stigma and discrimination.

These efforts appeared to have a strong semiotic dimension, as participants report their developing 'normality' (and increased agentic power) is tangible proof of their ongoing recovery. Participants also routinely discussed severe mental illness in normative terms, noting its similarity to physical illnesses such as diabetes, or to generic mental health problems experienced by all. These behavioral and psychological strategies of normalization appeared to be consolidated within the recovery communities, which provided physical shelter and highly valued peer support. This fostered participants' ability to face and embrace the outside world with confidence, pride and dignity.

6. **The impact of a counseling program for abused children. A study of Eftimie et al, (2012).** Aims to analyse the impact of an individualized and group counseling program developed with abused children integrated in an Emergency Reception Centre. Our findings have emphasized important changes regarding personal, social and prospective self of counseled children. For example the researcher found that self esteem has increased from 20% to 64% of counseled children, and prospective self have increased from 30% to 85%. The implementation of the individual and the group counseling program have developed self image of abused children and their chances to scholar and social integration.

7. **A pilot study of a weight management program with food provision in schizophrenia. A study by Jean-Baptiste et al, (2007).**
Obesity is a serious medical problem that disproportionately affects people with severe mental illness. Behavioral strategies, aimed at lifestyle modification have proven effective for weight loss in general population but have not been studied adequately among persons with schizophrenia. The researcher have conducted a randomized controlled pilot trial of an established weight loss program, modified for this specific population, and supplemented with a novel food replacement program, as well as practical, community based teaching of shopping and preparing healthy food. The program not only arrested weight gain, and produced meaningful weight loss, but also weight loss continued 6 months after the intervention is completed. Cognitive impairment had no bearing to the extent a participant benefited from the program. As a conclusion, well designed simple behavioral programs can produce lasting weight loss for patients with

schizophrenia and co morbid obesity, improve metabolic indices, and possibly decrease significant medical risks associated with obesity.

8. **Between self-clarity and recovery in schizophrenia: reducing the self-stigma and finding meaning. A study of Hasson-Ohayon et al, (2013),** Although there are extensive theoretical reviews regarding the self-experience among persons with schizophrenia, there is limited research that addresses the implications of self-clarity on the recovery of persons with schizophrenia while exploring the role of possible mediators within this process. Accordingly, the current study explored the relationship between self-clarity and recovery while examining the possible mediating role of self-stigma and sense of meaning in life. 80 persons with schizophrenia or schizoaffective disorder were administered four scales: self-concept clarity, self-stigma, meaning in life, and recovery. Results confirmed the hypothesized model in which self-clarity affects self-stigma, self-stigma affects meaning in life, and meaning in life affects recovery. No direct relationship was uncovered between selfclarity and recovery. Implications of the current study for future research and clinical practice are discussed with the emphasis on the importance of the self-experience with regard to the process of recovery.

9. **Therapeutic alliance in schizophrenia: The role of recovery orientation, self-stigma, and insight. A study of Kvrgic et al, (2013)**
The present study examined variables related to the quality of the therapeutic alliance in out-patients with schizophrenia. The researcher expected recovery orientation and insight to be positively, and self-stigma to be negatively associated with a good therapeutic alliance. The authers expected these associations to be independent from age, clinical symptoms (i.e. positive and negative symptoms, depression), and more general aspects of relationship building like avoidant attachment style and the duration of treatment by the current therapist. The study included 156 participants with DSM-IV diagnoses of schizophrenia or schizoaffective disorder in the maintenance phase of treatment. Therapeutic alliance, recovery orientation, self-stigma, insight, adult attachment style, and depression were assessed by self-report. Symptoms were rated by interviewers. Hierarchical multiple regressions revealed that more recovery orientation, less self-stigma, and more insight independently were associated with a better quality of the therapeutic alliance. Clinical symptoms, adult attachment style, age, and the duration of treatment by current therapist were unrelated to the quality of the therapeutic alliance. Low recovery orientation and increased self-stigma might undermine the therapeutic alliance in schizophrenia beyond the detrimental effect of poor insight. Therefore in clinical settings, besides enhancing insight, recovery orientation, and self-stigma should be addressed.

Chapter Four

Methodology

4.1.Overview:

The researcher, in this chapter, displays the steps and procedures applied in the field of this study in terms of the methodology.

This chapter contains the following headings; the study population, the sample that has been applied by the study, and tools used by the researcher, and statistical treatments that have been used in the analysis of data to test the validity and reliability of the questionnaire to reach the final results of this study.

4.2.Study design:

After the researcher finished the first three chapters which focused on the introduction, literature review and conceptual framework of the study, the researcher applied the proposed counseling program.

The researcher used the intervention method, pre test and post test approach, which was based on the study of facts since this approach is interested in the accurate description and is express qualitatively or quantitatively.

4.3. Study population:

All families that have schizophrenic patients in Gaza strip.
Number of registered files of schizophrenia in community mental health clinics in Gaza strip was 1000 cases.

4.3.1. The sampling process:

The samplings of families were done by simple random procedure among families with schizophrenic patient in Gaza strip who are registered mainly in mental health clinics and in psychiatric hospital.

The study sample included two samples, pilot study sample and the actual study sample, and it's illustrated by the following:

4.3.2. Pilot study sample:

The researcher distributed the questionnaire on a sample of (60) of the families of schizophrenic patients in the Gaza Strip, and after corrected scores, the researcher selected (38) participants who received the highest scores on a scale of stigma.
Then those participants were divided into two groups, namely the intervention group that will undergo the proposed counseling Program, however the other group, is the group that did not undergo any counseling program. The number of the intervention group was (17) persons while the number of the control group was (21) persons. Matching between the two groups was done to legalize stigma scale on the Palestinian environment and the results of this process will be explained later.

4.3.3The actual study sample:

The researcher divided the sample into two groups the intervention group which consist of (17) persons and the control group (21) persons. To identify the characteristics of the two groups in demographic variables and to identify the homogeneity between the two groups in the variables of the study the researcher will discuss in the following tables:

4.4. Demographic characteristics of the two groups:

To identify the characteristics of the intervention group and the control group members, the researcher verified it through schedules test and chi-squared test.

To identify the demographic characteristics between the members of the control group and members of the intervention group the results shown in the following table:

Table (4.4.1) shows the demographic characteristics (kinship) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
Kinship					1.59	0.66
Father	4	19.0	4	23.5		
Mother	5	23.8	5	29.4		
Wife	6	28.6	6	35.3		
Other relative	6	28.6	2	11.8		

Table (4.4.2) shows the demographic characteristics (father\husband job) of the control group and the intervention group according to demographic variables (n= 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
father\husband job					4.6	0.32
without	13	61.9	7	41.2		
Worker	1	4.8	4	23.5		
employee	5	23.8	4	23.5		
free works	1	4.8	2	11.8		
Other relative	1	4.8	0	0.0		

Table (4.4.3) shows the demographic characteristics (mother\wife job) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
Mother\wife job					2.6	0.27//
Employee	2	9.5	1	5.9		
free works	0	0.0	2	11.8		
without	19	90.5	14	82.4		

Table (4.4.4) shows the demographic characteristics (father\husband educational level) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
father \husband educational level					4.3	0.22
secondary	13	61.9	14	82.4		
postsecondary	3	14.3	1	5.9		
university	5	23.8	1	5.9		
higher education	0	0.0	1	5.9		

Table (4.4.5) shows the demographic characteristics (mother\wife educational level) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
mother \wife educational level					3.4	0.17
secondary	15	71.4	16	94.1		
postsecondary	2	9.5	0	0.0		
university	4	19.0	1	5.9		

Table (4.4.6) shows the demographic characteristics (patient age) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
patient age					1.55	0.45//
17-25 years	11	52.4	6	35.3		
26-33 years	4	19.0	6	35.3		
34-46 years	6	28.6	5	29.4		

Table (4.4.7) shows the demographic characteristics (arrangement of patient between kids) of the control group and the intervention group according to demographic variables (n = 38)

demographic characteristics	control group (n=21)		intervention group (n=17)		x2	P value
	N	%	N	%		
Arrangement of patient between kids					6.7	0.15//
First	3	14.3	3	17.6		
Second	3	14.3	4	23.5		
Third	9	42.9	3	17.6		
Fourth	2	9.5	4	23.5		
Fifth	4	19.0	0	0.0		

The results showed insignificant statistical differences among the members of the control group and the intervention group in demographic variables in the schizophrenic patients families as well as the demographic variables of patients themselves and the variables are as follows: (kinship patient, the job of the father / husband, the job of the mother / wife, age of the patient, arrangement of patient between children in the family), and this indicates the presence of homogeneity among the members of the control group and the intervention group regarding demographic variables.

4.5. The study tools:

4.5.1 Stigma scale: (researcher preparation):

4.5.2 Questionnaire Design and Content:

Stigma scale Consists of 35 paragraphs that measure the level of stigma among the family members of schizophrenic patients in the Gaza Strip. It also consists of three main dimensions, (psychological, social, family) dimension.

The Questionnaire contains five options to answer (strongly agree- agree - somewhat- disagree -Strongly Disagree) and the screened were asked to determine the level of satisfaction that accurately describes the level of stigma.

Ranging degrees of this scale is from 35 degrees and up to 175 degrees. Answers of the questionnaire contain five levels as show in the following table:

level	strongly agree	agree	somewhat	disagree	Strongly Disagree
scale	5	4	3	2	1

High-degree refers to the high level of stigma among the family of schizophrenic patients.

4.5.3. Permission of study:

The permission was obtained from general mental health directorate before starting this study (Annex 9).

4.6. Counseling program (researcher preparation):

4.6.1 Description of the program:

Counseling program is a group counseling program to deal with the family and relatives of patients with schizophrenia, who cause them to have a stigma of mental illness. Different teaching methods were used in the session like lectures, brain Storming, group work, role play, video tape and other things. This program consists of 12 sessions. The time of session (45 minutes). Program structure and Session's contents (Annex 5).

4.6.2 General goal of the program:

The aim of group counseling program was to reduce the level of stigma resulting from the presence of a patient with schizophrenia in the family through the implementation of several sessions of guidance and counseling to family parents or other relative.

4.6.3 Specific goals of the program:

1. Help the families of schizophrenic patients to reduce the effects of psychological, social and family resulting from the negative feeling towards mental illness.
2. Help the families of schizophrenic patients to insight their problems and exploit their potential to reach the lowest level of stigma towards mental illness.
3. Help the people of schizophrenic patients to cope with themselves and with their surrounding community.
4. Modify ideas and beliefs and irrational and distorted trends about mental illness.
5. Provide psychological support to get out of this negative feeling and get rid of the stigma of mental illness.

4.6.4 The Target group:

The researcher chooses a sample of 60 relative members of patients with schizophrenia by simple random way, who are frequently take care by the governmental community mental health clinics in Gaza Strip.

After arbitration of the tools of study, the program will be implemented on respondents mentioned in the sample to select the highest family member feeling the stigma of mental illness.

The researcher selected 17 family members (fathers, mothers, brothers, sisters, and other relatives) to be the intervention group who the counseling Program will be applied on.

4.6.5 Time of implementation:

The program was implemented during the second semester 2014.

4.6.6 Techniques used in the program:

1. Discussion and dialogue.
2. De- briefing
3. Avoiding self-judgment.
4. Style of rational and emotional psychotherapy.
5. Correction of irrational thoughts and believes.
6. Relaxation exercise.
7. Homework and feedback.
8. Religious counseling.
9. Psychodrama and Role play
10. Wishes list.
11. Questionnaire to evaluate the effectiveness of the program.

4.6.7 Monitoring and Evaluation:

The researcher monitor and follow up the application of the program to evaluate and correct the program's progress to commensurate with the levels of the participants and through the application of the questionnaire before starting the program and after completion to observe the improvement.

4.6.8 Tools used in the program:

1. Scientific materials programmed and recorded on CD.
2. Paper plates to serve sessions to achieve its goals.
3. Some documents that will help the development of thinking.

4.6.9 Ethical Consideration:

The researcher used consent form for every one of the participants, so everyone has the right to participate or not, and explanatory cover letter was attached to the questionnaire and sent for every participants which show purpose of the study confidentiality of information and instruction regarding dealing with the questions is a great importance.

4.6.10 Limitations of the Study:

1. The population in this study is related to schizophrenic patients treated in governmental mental health clinics, so this sample is not representative of Schizophrenic patients treated in the NGOs.
2. There are no Statistic resources of mentally ill persons in Palestinian territories especially about schizophrenic persons.
3. Lack of related local researches.
4. Israeli aggression and war on the Gaza Strip in July 2014.
5. Lack of logistic support (frequent power cut).

4.7. Validity of the research:

4.7.1 Validity of the questionnaire:

To ensures the validity of the questionnaire, two ways were applied, the content validity and validity of the internal consistency that will be discussed in details through the following**.**

4.7.2. Content validity of the questionnaire:

Content validity test was conducted by consulting a group of experts (psychologists, psychiatrists, professional psychiatric therapy and others)

The group was requested to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem.

The group of experts did agree that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

4.7.3. Statistical validity of the questionnaire:

To ensures the validity of the questionnaire, two statistical tests were applied.

The first test is Criterion-related validity test (Pearson test) which measures the correlation coefficient between each item in the dimension and the whole dimension. The second test is structure validity test (Pearson test) that is used to test the validity of the questionnaire structure by testing the validity of each dimension and the validity of the whole questionnaire. It measures the correlation coefficient between one dimension and all the dimensions of the questionnaire.

4.8. Internal consistency:

The researcher calculates the correlation between the degree of paragraph individually and the total score of the scale and Table (4.8.1) shows the degree of correlation coefficient of stigma scale, as well as the table shows the level of significance of each paragraph at the end.

Table (4.8.1) shows the degree of correlation coefficient of stigma scale and P-value of each item of psychological dimension.

No. of item	Pearson coefficient	p- value
1	.450**	.005
2	.744**	0.001
3	*0.359	0.03
4	.588**	0.001
5	.345*	.034
6	.246	//.136
7	.383*	.018
8	.662**	0.001
9	.379*	.019
10	.701**	0.001
11	.116	//.489
12	.458**	0.0001
13	.758**	0.0001

significant at 0.01 * significant at 0.001

Table (4.8.2) shows the degree of correlation coefficient of stigma scale and P-value of each item of social dimension.

No. of item	Pearson coefficient	p- value
14	.725**	.000
15	.474**	.003
16	.508**	.001
17	.215	//.195
18	.513**	.001
19	.650**	.000
20	.406*	.011
21	.150	//.377
22	.379*	.019
23	.494**	.002
24	.644**	.000
25	.615**	.000
26	.630**	.000
27	.653**	.000
28	.585**	.000

significant at 0.01 * significant at 0.001

Table (4.8.3) shows the degree of correlation coefficient of stigma scale and P-value of each item of family dimension.

No. of item	Pearson coefficient	p- value
29	.850**	.000
30	.692**	.000
31	.394*	.016
32	.440**	.006
33	.816**	.000
34	.686**	.000
35	.537**	.001

significant at 0.01 * significant at 0.001

The researcher calculates the correlation coefficients between the degree of each dimension and the total score of stigma scale:

The following table shows the correlation coefficients between the degree of each dimension and the total score of the stigma scale, and the results are shown in the following table:

Table (4.8.4) shows the correlation coefficient dimensions of the stigma scale with the total score of the scale

Dimensions	Pearson coefficient	p- value
psychological dimension	.809**	0.001
social dimension	.929**	0.001
family dimension	.755**	0.001

significant at 0.01 * significant at 0.001

Can be seen from the above table that the correlation coefficients of the three dimensions of stigma scale have significant value with the total score of the scale at levels of significance is less than 0.01, while correlation coefficients has ranged between (0.75- 0.92). That means achieving the internal consistency of the scale of the stigma.

Since the scale has three dimensions the researcher has to find a correlation coefficients between each items of dimension and the dimension itself, and the results will be indicated by the following table:

Table (4.8.5) shows the correlation coefficient between the items of the psychological dimension with the total score of the scale

No. of item	Pearson coefficient	p- value
1	.450**	.005
2	.744**	0.001
3	*0.359	0.03
4	.588**	0.001
5	.345*	.034
6	.246	//.136
7	.383*	.018
8	.662**	0.001
9	.379*	.019
10	.701**	0.001
11	.116	//.489
12	.458**	0.0001
13	.758**	0.0001

significant at 0.01 * significant at 0.001

Previous table shows that the correlation coefficients between the items of the psychological dimension ranged between (0.34-0.75) and this shows the items of psychological dimension enjoys a high degree of validity with the exception of the following items (6-11) which are statistically insignificant therefore they should be deleted from the dimension.

Table(4.8.6) shows the correlation coefficient between the items of the social dimension with the total score of the scale

No. of item	Pearson coefficient	p- value
14	.725**	.000
15	.474**	.003
16	.508**	.001
17	.215	//.195
18	.513**	.001
19	.650**	.000
20	.406*	.011
21	.150	//.377
22	.379*	.019
23	.494**	.002
24	.644**	.000
25	.615**	.000
26	.630**	.000
27	.653**	.000
28	.585**	.000

significant at 0.01 * significant at 0.001

The previous table shows that the correlation coefficients between the items of the social dimension ranged between (0.37-0.72) and this shows the item of the social dimension enjoys a high degree of validity, with the exception of the following items (17-21) which are statistically insignificant therefore they should be deleted from the dimension.

Table(4.8.7) shows the correlation coefficient between the items of the family dimension with the total score of the scale

No. of item	Pearson coefficient	p- value
29	.850**	.000
30	.692**	.000
31	.394*	.016
32	.440**	.006
33	.816**	.000
34	.686**	.000
35	.537**	.001

significant at 0.01 * significant at 0.001

Previous table shows that the correlation coefficients between the items of family dimension ranged between (0.39-0.81), and this shows the items of family dimension enjoys a high degree of validity.

4.9. Reliability of the research:

Reliability can be equated with the stability, consistency, or dependability of the measuring tool. The reliability of scale questions was tested immediately after data collection and it was improved by standardization of the instrument and its implementation.

4.9.1. Cronbach's Coefficient Alpha:

The questionnaire of stigma distribute on a pilot study sample of (60) members of schizophrenic patients families, and after the collection of the questionnaire, coefficient alpha Cronbach done to measure the reliability which was (0.82) this range is considered high. The result ensures the reliability of the questionnaire. While the stigma scale has three dimensions, the first (psychological) has reached by coefficient alpha Cronbach's (0.70). And the coefficient alpha Cronbach's of second dimension (social) was (0.80) and the third dimension (family) coefficient alpha Cronbach's (0.78) and this evidence is enough that the stigma scale and its items enjoy high reliability factor.

Based on this result, the scale and its dimensions fit to answer the questions and hypotheses of the study and are suitable to apply on the members of the study sample.

4.9.2.Split – half method:

The application of the scale was calculated to achieve reliability in a way of split-half method of the total. The way of split-half method is based on dividing the items of the scale into two halves, as well as dividing every items of dimension in two sections. The correlation coefficient between the total items of first half and total items of second half of the scale has reached reliability coefficient in split-half method. After correction spearman Brown coefficient the psychological dimension is (0.77) and reliability coefficient in split-half method of the social dimension is (0.79) the reliability coefficient in split –half method of the family dimension is (0.87) and total reliability coefficient in split – half method to the total is (0.79).

This is enough proof that the scale and the three dimensions have high level of reliability factor. The results are illustrated by the following table:

Table (4.9.1) Split-Half Coefficient method and Cronbach's Coefficient Alpha

No.	Dimension	No. of items	Cronbach's Alpha	Split-Half	
				person correlation Coefficient	correction Spearman-Brown Coefficient
1	psychological dimension	11	0.70	0.63	0.77
2	social dimension	13	0.80	0.65	0.79
3	family dimension	7	0.78	0.77	0.87
4	total scale	31	0.82	0.65	0.79

4.10. Statistical methods:

To achieve the research goal. The researcher used the SPSS for Manipulating and analyzing the data by the following method:

- Frequencies and Percentile.
- Alpha- Cronbach's Test for measuring reliability of the items of the questionnaires.
- Pearson correlation coefficients for measuring validity of the items of the questionnaires.
- Spearman –Brown Coefficient.
- Independent sample T test.
- Wilcoxon T-statistic test.
- Chi-square test.

Chapter 5

Result and Discussion

Introduction:

This chapter presents the results and the findings according to the pre-test and post-test analysis of the study and intervention group discussion. The researcher discussed the results and the findings of analysis in relation to research objectives to answer the research questions. Also the researcher gives interpretation of statistical analysis of the study findings.

5.1 The research questions:

1. What is the level of stigma among the families of patients with schizophrenia in Gaza Strip?

2. What is the level of stigma among the intervention group members and the control group members in the pre test and post test intervention?

To determine the level of stigma among the families of patients with schizophrenia in the Gaza Strip according to the type of group (control and, intervention) before and after the counseling program, the researcher calculated the mean and the standard deviation and the relative weight of the stigma scale and its three dimension (psychological, social, family) for each group separately in pre test and post test intervention, and the results are illustrated in table (5.1.1):

Table (5.1.1) mean, standard deviation, relative weight of the stigma scale of the control group and the intervention group in the pre and post test intervention

group	dimension	Items No.	Total score	Pre test			Post test		
				Mean	s. Deviation	%	Mean	s. Deviation	%
control group	psychological dimension	11	55	45.8	3.9	83.3	44.7	3.7	81.2
	social dimension	13	65	51.9	6.3	79.8	52.2	6.0	80.3
	family dimension	7	35	28.4	3.6	81.2	30.9	3.5	88.3
	total score	31	155	126.1	11.2	81.4	127.8	9.6	82.4
intervention group	psychological dimension	11	55	44.5	4.6	81.0	24.7	1.4	44.9
	social dimension	13	65	50.6	6.4	77.9	24.0	3.0	36.9
	family dimension	7	35	27.1	3.5	77.5	17.4	1.0	49.8
	total score	31	155	122.3	13.0	78.9	66.1	3.1	42.7

To obtaining the relative weight of the mean is achieved by dividing the mean for each dimension on the total score and then multiplied by 100.

The control group Members:

The previous table shows that the average degrees of stigma for the control group in the pre test intervention reached 126.1 degrees and a standard deviation was 11.2 degrees, and the relative weight was (81.4%) while the relative weight of the post test intervention was 82.4%.

When we talk about the dimensions, the psychological dimension has reached 83.3% in the pre test intervention while in the post test intervention it was 81.2%.

The social dimension has reached 79.8% in the pre test intervention, while in the post test intervention it was 80.3%.

The family dimension was 81.2% in the pre test intervention, while the post test intervention was 88.3%.

The intervention group Members:

In the previous table the mean scores of stigma scale of the intervention group in the pre test intervention reached 122.3 degrees and a standard deviation is 13.0 degrees. The relative weight was (78.9%), while after the post test intervention it was 42.7%, and this indicates that the level of stigma among the members of the intervention group decreased after application of the proposed counseling Program.

As for the dimensions, the relative weight of the psychological dimension reached 81.0% in the pre test intervention, and the relative weight of the post test intervention was 44.9%. The relative weight of the social dimension reached 77.9% in the pre test intervention, and the post test intervention was 36.9%. The family dimension was 77.5% in the pre test intervention while the post test intervention was 49.8%.

It is already clear from the results that the proposed counseling program has an indicative effect in reducing the level of stigma among the families of patients with schizophrenia in the Gaza Strip.

5.2 Study Hypotheses

5.2.1 First hypothesis:

"There are no statistically significant differences at the level of significance (0.05) in level of stigma among the intervention group and the control group before the application of the counseling program.

To test this hypothesis, the researcher uses a T-test to compare the mean scores of the intervention group and the control group before the application of the counseling program. This is shown in Table (5.2.1):

Table (5.2.1): The results of (T-test) by comparison between the intervention group and the control group in degrees of stigma scale before applying the program (n = 38)

dimension	type of group	No.	mean	standard deviation	T value	P value
psychological dimension	control	21	45.8	3.9	1.07	//0.29
	intervention	17	44.5	4.6		
social dimension	control	21	51.9	6.3	0.80	//0.43
	intervention	17	50.6	6.4		
family dimension	control	21	28.4	3.6	1.04	//0.30
	intervention	17	27.1	3.5		
total degree of stigma scale	control	21	126.1	11.2	1.27	//0.21
	intervention	17	122.3	13.0		

**Significant at 0.01 *significant at 0.05 //not significant

The result in the previous table shows insignificant statistical differences between the intervention group and the control group members in the total degree of stigma scale and its dimensions (psychological, social, family). This ensures that the degrees of control group members and the degrees of intervention group members are equal in the pre test of stigma scale and this shows that the degrees of control group members and the intervention group members are homogeneous in the pre test among stigma scale and its three dimensions (psychological, social, family).

5.2.2 Second hypothesis:

"There are no statistically significant differences at the level of significance (0.05) in level of stigma among the intervention group and the control group after the application of the counseling program.

To test this hypothesis, the researcher uses a T-test to compare between mean scores of the intervention group and mean scores of the control group after the application of the counseling program. This is shown in Table (5.3.1):

Table (5.3.1): The results of (T test) by comparison between the intervention group and the control group in degrees of stigma scale after application of counseling program (n = 38)

dimension	type of group	No.	mean	standard deviation	T value	P value
psychological dimension	control	21	44.7	3.7	20.86	**0.001
	intervention	17	24.8	1.4		
social dimension	control	21	52.2	6.0	17.80	**0.001
	intervention	17	23.9	2.9		
family dimension	control	21	30.9	3.5	15.22	**0.001
	intervention	17	17.4	0.9		
total degree of stigma scale	control	21	127.8	9.6	25.42	**0.001
	intervention	17	66.1	3.0		

**Significant at 0.01 *significant at 0.05 //not significant

Table (5.3.1): shows the following results:

Stigma Scale: Statistically significant differences were found between the mean scores of the control group members and the mean scores of the intervention group members in degrees of stigma scale in post- test (T-test = 25.42, P-value <0.01) and these differences were in favor of the intervention group and this shows that members of the intervention group who Underwent application of counseling Program have lower level of stigma compared by members of the control group who did not Undergo application of counseling Program. The mean scores of the intervention group members in stigma scale was (66.1) degrees while the mean scores of the control group members was (127.8) degrees. This gives an indication that the counseling program has a substantial impact in reducing the level of stigma among the intervention group members.

Dimensions of stigma scale: (psychological, social, family)

Statistically significant differences were found between the mean scores of the control group members and the mean scores of the intervention group in grades of stigma scale dimensions (psychological, social, family) in post- test.

Differences were in favor of the intervention group members and this shows that the intervention group members who underwent application of counseling Program have lower degrees of stigma in the psychological, social, and family dimensions compared to the control group members who did not undergo application of counseling Program and this gives an indication that the sessions of proposed counseling Program has big role to reduce the level of stigma among the intervention group members.

5.2.3 Third hypothesis:

"There are no statistically significant differences at the level of significance (0.05) between the scores of pre-test and post-test in stigma level among the intervention group members in the counseling program.

To check the third hypothesis, the researcher uses (Wilcoxon T-statistic) non parametric because the sample size is small and the study is about two related samples in order to detect differences between the scores of pre test and post test interventions of the stigma scale and its dimensions (psychological, social, family) among the intervention group members that underwent the counseling program. The researcher calculates the size effect of ETA square and the results are illustrated by the following table:

Table (5.4.1): Shows the mean average of the scores of pre test and post test of stigma scale and the value of (Wilcoxon T-statistic) and the value of ETA to measure the impact on the intervention group

Dimension	Pre Test		Post Test		Z. value	P. value	D. value	Efficiency value %
	mean	s. Deviation	mean	s. Deviation				
psychological dimension	44.5	4.6	24.7	1.4	-3.624	**.0001	8.6	44.6
social dimension	50.6	6.4	24.0	3.0	-3.627	**.0001	6.9	52.6
family dimension	27.1	3.5	17.4	1.0	-3.631	**.0001	5.4	35.7
total degree of scale	122.3	13.0	66.1	3.1	-3.624	**.0001	7.9	45.9

**Significant at 0.01 *significant at 0.05 //not significant

D.value: d>0.8: high efficiency value d(0.5-0.7) middle efficiency value d(0.2-0.4) low efficiency value

The previous table (5.4.1) shows the presence of statistically significant differences between the scores of pre-test and the score of post-test intervention of stigma scale and its three dimensions (psychological, social, family). The differences were in favor of the post-test intervention which indicates the effectiveness of the counseling program on reducing level of stigma among schizophrenic patients families in general as well as reducing the level of psychological, social stigma.

The table(5.4.1) shows that the total level of stigma dropped after applying the counseling program on the intervention group which has been selected from the family of schizophrenic patients in Gaza Strip and with respect to the size of the impact of the counseling program on reducing level of psychological ,social stigma among the family of schizophrenic patients of the intervention group that underwent the program we seen that the effect size was high because the D.value is about (0.8) and this means that the counseling program has a positive effect on reducing level of stigma of the intervention group while the percentage change was (45.9%) for the intervention group in level of stigma after the application of the counseling program. The effectiveness value ranged between (35.7% - 52.6%).

5.2.4 Fourth hypothesis:

There are no statistically significant differences at the level of significance (0.05) between the scores of post-test and Sequential test of stigma scale among the intervention group of the counseling program.

To check the fourth hypothesis, the researcher uses (Wilcoxon T-statistic) non parametric because the sample size is small and the study is about two related samples in order to detect differences between the scores of post- test and sequential test interventions of the stigma scale and its dimensions (psychological, social, family) among the intervention group members that underwent the counseling program and the results are illustrated by the following table:

Table (5.5.1): shows the mean average of the scores of post test and sequential test of stigma scale and the value of (Wilcoxon T-statistic)

dimension	Post-Test		sequential Test		Z. value	P. value
	mean	s. Deviation	Mean	s. Deviation		
psychological dimension	24.7	1.4	26.2	4.3	-1.37	//0.19
social dimension	24.0	3.0	25.1	5.9	-0.61	//0.55
family dimension	17.4	1.0	18.4	3.3	-1.49	//0.15
total degree of scale	66.1	3.1	69.7	12.4	-1.15	//0.27

**Significant at 0.01 *significant at 0.05 //not significant

The above table (5.5.1) shows insignificant statistical differences between the scores of post- test and the scores of sequential test of stigma scale and its three dimensions (psychological, social, family) after one month of counseling program intervention. This ensures the continuity of the positive impact of counseling program on reducing level of stigma among the intervention group of schizophrenic patients families in Gaza Strip and this gives an indication that the counseling program and its sessions works on the stability improvement of the schizophrenic patients families toward stigma of mental illness.

5.3 Conclusion:

The results of the current study revealed the presence of statistically significant differences in the stigma of the mental illness among members of the intervention group before and after applying the counseling program and this means that the scores on stigma scale of mental illness has declined after applying the counseling program. This ensures the effectiveness of the counseling program. The Researcher finds that the activities of the counseling program sessions' contents (De-briefing, psychodrama, discussion, dialogue and religious counseling) have contributed to reduce the stigma level among the members of the intervention group in post test intervention.

The results of the current study show the insignificant statistical differences in the level of stigma among members of the intervention group after one month of counseling program application and sequential test intervention.

The researcher finds that the decreasing scores of stigma scale after applying the counseling program on the intervention group were due to many experiences and social and psychological skills of people which are considered an important element in immunizing and providing them with ways to adapt to stressful situations.

One of the most important reasons that helped essentially in the response of the intervention group is their religious culture (Islamic culture) the effective influence of the religious scruples as well as the belief in fate and destiny. In addition, there are effective influences of Quran recitation and praying on decreasing stress and helping people greatly for how to deal with stressors.

The results ensure the effectiveness of the counseling program used in the recent study on decreasing stigma level among families of patients with schizophrenia. There were no statistically significant differences of stigma level between post-test and sequential test after one month there was no change in stigma scale score and this is related to the stability of the program and ensures the positive effects of counseling program.

The stigma means a sign of shame or rejection attached to individuals themselves and may result in isolation and causes of prejudice, discrimination and harassment of family members when they listen to people talking about the actions of psychiatric patients especially if they were seen in streets. Accordingly there is no doubt that the presence of patients with mental illness creates stress situation in family relations and this leads to poor relationships of family members at a time when their relationships should be stronger than ever. So, the family should know more and more about the mental illness as an organic disease and that it can be cured based on that come to know that when their patients family can avoid the stigma of mental illness so that all of them can treat their patient.
The Palestinian families affected by trends in society. For example, when a young man wants to get marred he may be affected by stigma and rejected if the people know he went to a psychiatric clinic that is because of the negative impact of the idea people bear about the patients with mental illness.

5.4 Recommendations:

The Researcher believes that society as a whole should understand that the stigma of mental illness is not the result of moral failure or false social concept but it is a real disease responding to effective treatments.

Patients with mental illness and their families are in bad need of support and advice because they are living unbearable life.

- Appling the recent counseling program on cases with problems related to stigma of mental illness.
- Training of psychiatric health workers and social workers on counseling program as a tool of treatment.
- Building other programs to treat other problems related to stigma of mental illness.
- Providing public education to fight the stigma. This involves people with mental illness and their families. Public meetings should be held to raise awareness of mental health and its prevention and promotion.
- Encouraging positive and responsible reporting and discussion of mental illness by the media and assigning to the Palestinian media the responsibility for removing the attitudinal barriers and changing behavior and attitudes towards patients with mental illness and their families.
- Increasing the spiritual support Islam plays an important role in defining health and illness as well as stigma reduction and management.
- Training and technical assistance to help create effective anti–stigma campaigns. these campaigns involved educational leaflets, booklets and videos aimed to reduce stigma level.

5.5 Suggestions for Future Studies:

- Further research is necessary to measure the level of stigma related to all different mental disorders.
- Applying such program in the community mental health clinic and social centers to reduce stigma of mental illness.

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Annexes

Annex (1)

نموذج موافقة للمشاركة في الدراسة

عزيزي المشترك :

أنا الباحث محمد البرعي أقوم بدراسة حول فعالية البرنامج الإرشادي المقترح بشأن خفض مستوى الوصمة لدي أسرة مريض الفصام في قطاع غزة.

إن المشاركة في هذا البحث هي مشاركة اختيارية حيث أن إجاباتكم علي هذه الاستبانة ستكون سرية.

نحن نقدر مشاركتك في هذا البحث وإجابتك على الأسئلة ستلعب دوراً مهماً في هذه الدراسة وسنقوم بطرح بعض الأسئلة لمعرفة بعض البيانات والعادات والممارسات والحالة الصحية حتى نستطيع الوصول لأفضل النتائج التي سوف تخدم البحث.

مهما تكن طبيعة ونوعية المعلومات تأكد تماما أنها ستكون سرية وطي الكتمان ولن يطلع عليها أحد باستثناء فريق البحث.

الاستبانة تحتوي على خمسة خيارات للاجابة (موافق بشدة- موافق – الى حد ما – غير موافق-غير موافق بشدة) فحاول اختيار مدى الرضا الذي يصف شعورك بدقة ..

شاكرين لكم حسن تعاونكم معنا،،،

الباحث

محمد البرعي

Annex (2)

استبيـــــــــان مقيـــــاس الوصمـــــــة

أولاً : المعلومات الشخصية :

1. **صلة القرابة بالمريض :** □ الأب □ الأم □ الزوج □ الزوجة □ اخرين من الأقارب
2. **مكان السكن :** □ الشمال □ غزة □ الوسطى □ خان يونس □ رفح
3. **مهنة الأب / الزوج:** □ عاطل عن العمل □ عامل □ موظف □ أعمال حرة □ أخرى
4. **مهنة الأم / الزوجة :** □ موظفة □ أعمال حرة □ ربة بيت □ أخرى
5. **المستوى الدراسي للأب / الزوج:** □ ثانوية فأقل □ دبلوم □ جامعي □ دراسات عليا
6. **المستوى الدراسي للأم/ الزوجة :** □ ثانوية فأقل □ دبلوم □ جامعي □ دراسات عليا
7. **الدخل الشهري للأسرة:** □ أقل من1400شيكل □ من 1400–2250شيكل □ من 2250– 3500 شيكل
8. **عدد أفراد الأسرة؟** □ الأبناء ..... □ البنات.....

ثانياً : المعلومات الشخصية لمريض الفصام :

1. **العمر :** _____
2. **الحالة الإجتماعية :** □ أعزب □ متزوج □ منفصل □ مطلق □ أرمل
3. **المستوى التعليمي للمريض :** □ ثانوية فأقل □ دبلوم □ جامعي □ دراسات عليا
4. **ترتيب المريض بين الأبناء :**.....

أولاً: البعد النفسي :

م	الفقــرة	موافق بشدة	موافق	الى حدما	غير موافق	غير موافق بشدة
.1	أشعر بأني أقل قيمة من الناس الاخرين بسبب وجود مريض نفسي في أسرتنا					
.2	أشعر بالأسى عندما يسألني الجيران والأقارب عن حال ابني/ابنتي المريض/ة نفسياً					
.3	أشعر بالحزن الشديد عنما أرى ابني/ابنتي المريض/ة نفسيا جالسا بمفرده بدون أصدقاء					
.4	تمنيت كثيرا أنني لم أرزق بهذا الابن / البنت المريض/ة نفسياً					
.5	أشعر بقلق شديد على مستقبل ابني / ابنتي المريض/ة نفسياً بعد موتي					
.6	أعتقد أن المريض النفسي إنسان لا يمكن شفاؤه					
.7	أشعر بأن صحتي في تدهور بسبب ابني/ابنتي المريض/ة نفسياً					
.8	أشعر بالخجل العميق عندما أسير مع ابني/ابنتي المريض/ة نفسيا في الشارع					
.9	أشعر بالضيق والحرج عندما يتحدث ابني/ابنتي المريض/ة نفسياً في السيارة					
.10	لا أحب أن يتحدث أحد مع ابني/ابنتي المريض/ة نفسياً					
.11	أعتقد ان وجود ابني/ابنتي المريض/ة نفسياً ابتلاء من الله					
.12	أشعر أن الاهتمام بابني/ابنتي المريض/ة نفسياً واجب ديني وأخلاقي					
.13	أشعر بالخجل الشديد عند أخذ ابني/ابنتي المريض/ة نفسياً لعلاجه					

ثانياً : البعد الاجتماعي :

م	الفقــرة	موافق بشدة	موافق	الى حدما	غير موافق	غير موافق بشدة
.14	أشعر بالخجل من الكلام مع الناس عن ابني/ابنتي مريض/ة نفسياً					
.15	أشعر بالحرج من كثرة ما يفعله ابني/ابنتي المريض/ة نفسياً من تصرفات غير لائقة					
.16	اعتقد بأن الدخول لمستشفى الطب النفسي أمر مخزي في مجتمعنا					
.17	اعتقد بأن الناس يجهلون أن المرض النفسي مثل المرض العضوي قابل للعلاج					
.18	أفضل الذهاب سراً إلى عيادة الصحة النفسية منعاً لأي احراج					
.19	أتجنب دعوة الأصدقاء والأقارب للبيت لكي لا يروا ابني/ابنتي المريض/ة نفسيا					
.20	لا أسمح لابني/ابنتي المريض/ة نفسيا بأن يخرج مع اخوته للشارع					
.21	اشعر ان ابني/ابنتي المريض/ة نفسيا لا يقدر أن يتزوج ويتحمل مسئولية أسرة					
.22	أشعر أن اصدقائي الذين ليس لديهم مريض نفسي أكثر مني سعادة					
.23	لا أسمح لابني/ابنتي المريض/ة نفسياً بالجلوس امام المنزل					
.24	لا أحب أن يزورني أحد حتى لا يروا ابني/ابنتي المريض/ة نفسياً					
.25	لا أحب أن اصطحب ابني/ابنتي المريض/ة نفسياً في الزيارات التي أقوم بها					
.26	أشعر بالتعاسة عندما يخاف الجيران والأقارب من ابني/ابنتي المريض/ة نفسياً على ابنائهم وبناتهم					

م	الفقــرة	موافق بشدة	موافق	الى حدما	غير موافق	غير موافق بشدة
.27	أحرص جداً على عدم اصطحاب ابني/ابنتي المريض/ة نفسياً الى الاماكن العامة					
.28	أشعر أن الأقارب والأصدقاء لايرحبون بزيارتنا عندما يكون معنا ابني/ابنتي المريض/ة نفسياً					

ثالثاً : البعد الأسري :

م	الفقــرة	موافق بشدة	موافق	الى حدما	غير موافق	غير موافق بشدة
.29	أشعر أن أبنائي يتجنبون المعاملة مع أخيهم/أختهم المريض/ة نفسياً					
.30	أشعر أن أبنائي يتمنون موت أخيهم/أختهم المريض/ة نفسياً					
.31	أشعر أن وجود ابني/ابنتي المريض/ة يثير أعصابي ويسبب مشاكل زوجية					
.32	أعتقد أن الابن/الابنة المريض/ة نفسياً يسيء لسمعة الأسرة					
.33	أشعر أن أولادي يرون أن أخاهم/أختهم المريض/ة نفسياً سببا في تعاستهم					
.34	أعتقد أن المريض نفسياً يسئ لسمعة الأولاد والبنات عند الزواج					
.35	أغضب جداً على الطريقة التي يتعامل بها أقاربي مع ابني/ابنتي المريض/ة نفسياً					

Annex (3)

Participation letter

Dear participant:

I am the researcher mohammed Elburai and my study is about

The effectiveness of proposed counseling program on reducing level of stigma among families of schizophrenic patients in Gaza Strip.

Your Participation in this study is optional and your answers to this questionnaire will be kept confidential.

We appreciate your participation in this study and your answers to the questions will play an important role in this study and we will ask some questions to collect some data, customs and practices and health status so that we can reach the best results that will serve the study.

Whatever the nature and kind of information is be absolutely sure that it will be confidential and will not be seen with the exception of the research team.

The Questionnaire contains five options to answer (strongly agree- agree - somewhat- disagree -Strongly Disagree) try to choose the level of satisfaction that accurately describes how you feel.

Thank you for your cooperation.

Researcher
Mohammed F. Elburai

Annex (4)

Stigma Scale Questionnaire

First : personal information :

9. **Kinship of patient :**
   □ father □ mother □ husband □ wife □ other relative
10. **Address:**
    □ North governorate □ Gaza governorate □ mid-area governorate
    □ Khanyounis governorate □ Rafah governorate
11. **Father \husband job :**
    □without □worker □ employee □free works □ other
12. **Mother\wife job :**
    □ employee □free works □ housewife □ other
13. **Father \husband educational level:**
    □secondary □ postsecondary □ university □ postgraduate
14. **Mother \wife educational level :**
    □secondary □ postsecondary □ university □higher education
15. **Family income source:**
    □ less than 1400 NIS □ 1400-2250 NIS □ 2250-3500 NIS
16. **Number of family:**
    □ son…….. □ daughter……..

Second : personal information of schizophrenic patient

1. **Age :……**
2. **Marital status :**
3. □single □ married □ separate □ divorced □ widow
3. patient educational level:
   □ secondary □ postsecondary □ university □ postgraduate
4. Arrangement of patient between kids: ……..……..

Stigma scale

First : psychological dimension :

#		Strongly Agree	Agree	Some what	Disagree	strongly disagree
1.	I feel less valuable than other people because we have mentally ill patient in our family.					
2.	I feel distressed when my neighbors and relatives ask me about my mentally ill son / daughter.					
3.	I feel very sad when I see my mentally ill son / daughter sitting alone without friends.					
4.	I wished so much that I did not have this mentally ill son / daughter.					
5.	I'm very worried for the future of my mentally ill son / daughter after my death.					
6.	I think that a mentally ill patient cannot recover.					
7.	I feel my wellness is deteriorating because of my mentally ill son / daughter.					
8.	I feel deeply ashamed when I walk with my mentally ill son/daughter in the street.					
9.	I feel upset and embarrassed when my mentally ill son/daughter talks in the car.					
10.	I don't like any one to talk with my mentally ill son / daughter.					
11.	I think that the presence of my mentally ill son / daughter is a test from Allah.					
12.	I believe that taking care of my mentally ill son / daughter is a religious duty.					
13.	I feel very ashamed when I take my mentally ill son / daughter for treatment.					

Second : social dimension

#		Strongly Agree	Agree	Some what	Disagree	strongly disagree
14.	I feel ashamed to talk with people about my mentally ill son / daughter.					
15.	I feel ashamed by the inappropriate action of my mentally ill son / daughter with others.					
16.	I think that the admission to the psychiatric hospital is shameful in our society.					
17.	I think that people don't know that mental illness is like the organic illness and it can be cured.					
18.	I prefer to go secretly to the mental health clinic to prevent any embarrassment.					
19.	I avoid inviting friends and relatives to my house so as not to see my mentally ill son / daughter.					
20.	I do not let my mentally ill son / daughter go out with his brothers.					
21.	I feel that my mentally ill son / daughter cannot marry and hold responsibility of family.					
22.	I feel that my friends who do not have a mentally ill patient are happier than me.					
23.	I do not let my mentally ill son / daughter to sit in front of the house.					
24.	I do not like any one to visit me so as not to see my mentally ill son/daughter.					
25.	I do not like to take my mentally ill son / daughter in visits.					
26.	I feel miserable when my neighbors and relatives feel afraid of my mentally ill son / daughter.					
27.	I am very keen not to take my mentally ill son / daughter to public places.					
28.	I feel we are not welcome by our relative and friends when my mentally ill son / daughter is with us.					

Third : family dimension

#		Strongly Agree	Agree	Some what	Disagree	Strongly disagree
29.	I feel that my kids avoid dealing with their mentally ill brother / sister.					
30	I feel that my kids wish the death of their mentally ill brother / sister					
31.	I feel that the presence of my mentally ill son / daughter cause marital problems to me and makes me irritable.					
32.	I think that mentally ill son / daughter is harmful to the reputation of the family.					
33.	I feel that my kids feel that their mentally ill brother / sister is the cause of their misery.					
34.	I think that the mentally ill patient is harmful to the reputation of the boys and girls at marriage.					
35.	I get very angry at the way my relatives deal with my mentally ill son / daughter.					

Annex (5)

Program structure

Description of the program:

Counseling program is a group counseling program to deal with the family and relatives of patients with schizophrenia, who cause them to have a stigma of mental illness. Different teaching methods were used in the session like lectures, brain Storming, group work, role play, video tape and other things. This program consists of 12 sessions. The time of session (45 minutes).

General goal of the program :

A group counseling program aims to reduce the level of stigma resulting from the presence of a patient with schizophrenia in the family through the implementation of several sessions of guidance and counseling to family parents or other relative.

Specific goals of the program:

1. Help the families of schizophrenic patients to reduce the effects of psychological, social and family resulting from the negative feeling towards mental illness.
2. Help the families of schizophrenic patients to insight their problems and exploit their potential to reach the lowest level of stigma towards mental illness.
3. Help the people of schizophrenic patients to cope with themselves and with their surrounding community.
4. Modify ideas and beliefs and irrational and distorted trends about mental illness.
5. Provide psychological support to get out of this negative feeling and get rid of the stigma of mental illness.

The Target group:

The researcher chooses a sample of 60 relative members of patients with schizophrenia by simple random way, who are frequently take care by the governmental community mental health clinics in Gaza Strip.

After arbitration of the tools of the study, the program was implemented on respondents mentioned in the sample after select the (38) case of highest family member feeling stigma of mental illness.

The researcher selected (17) family members (fathers, mothers, brothers, sisters, and other relatives) to be the intervention group who the counseling Program will be applied on and the other (21) members to be the control group.

Time of implementation:

The program was implemented during the second semester 2014.

Permission of counseling program implementation place:

The permission of counseling program implementation place was obtained from The Islamic University of Gaza (Annex 9).

Techniques used in the program:

1. Discussion and dialogue.
2. De- briefing
3. Avoiding self-judgment.
4. Style of rational and emotional psychotherapy.
5. Correction of irrational thoughts and believes.
6. Relaxation exercise.
7. Homework and feedback.
8. Religious counseling.
9. Psychodrama and Role play
10. Wishes list.
11. Questionnaire to evaluate the effectiveness of the program.

Monitoring and Evaluation:

The researcher monitor and follow up the application of the program to evaluate and correct the sessions contents to commensurate with the levels of the participants and through the application of the questionnaire before starting the program and after completion to observe the improvement.

Tools used in the program:

4. Scientific materials programmed and recorded on CD.
5. Paper plates to serve sessions to achieve its goals.
6. Some documents that help in the development of thinking.

Sessions of counseling program:

First Session Title: (counseling relationship building " action Plan "	
Session goal	• Instructing participants with the concept of group counseling program dedicated to them and its components and building expectations appropriate for the participants. • Allowing for long relationship and building trust between the participants and the counselor. • Access to an agreement between the participants and the counselor on the specific mechanism and identification of places and dates of meetings. • Commitment to attend on time. • Respecting other's opinions and not interrupting them. • Showing stimuli to those who abide by the rules and the rules agreed upon. • Filling the questionnaire
Session length	**45 minutes**
Session Description and content	• The counselors introduce himself and clarifies the nature of his work and gives an introduction to the group counseling. • He talks about the goal of the program and what can be achieved and clarifies the goal of the program is indicative. • At the end of the meeting he confirms the laws and agreements and in the need to implement homework thoroughly which helps program success • He emphasizes on confidentiality and privacy within sessions. • He gives thanks to the participants response to the call

	• He give an idea about the subject and workflow • He clarifies the importance of the program for families in helping them understand and address a lot of stressful situations that they face due to the presence of their mentally ill son's. • Brainstorming: an activity where the counselor is inspired by the participants to voice their opinions and ideas freely and spontaneously for a training topics
Homework	• The counselor asks each participant to use special file given to them for keeping the activities and reports to be completed during the period of the program and then asks the members of the group to recording their notes and impressions about their participation in the first session of the program freely.

Second Session Title: (Perceptions and expectations of participants)	
Session goal	• Enables participants to see the importance of psychological counseling and emphasizes the importance of the indicative program to reduce their feeling of stigma.
Session length	**45 minutes**
Session Description and content	• Reviewing of the previous session and confirm the key concepts • Identifying the expectations of the participants. • Discuss realistic expectations and deleting unrealistic expectations. • Developing a spirit of teamwork and acting as a teamwork • Talking about the stigma of mental illness. • Assertiveness skills. • The expression of positive emotions and negative once. • Expressing opinions. • Expression of public and private rights and defending them. • Facing pressure of others
Homework	• Counselor asked each participant to write a certain position in which he felt of stigma and shame and how to deal with it.

Third Session Title: (Social skills)	
Session goal	Clarifying the role of counseling program and its importance in the development of social skills
Session length	**45 minutes**
Session Description and content	• Reviewing of the foregoing and confirm the key concepts. • Affective skills(deep understanding of the attitudes and reaction) • Communication skills (Art of dealing with others). • Restraint Skills (help participants get rid of anger). • The guidance counselor is not to blame for the restraint and not to get angry of the actions of the mentally ill.
Homework	• Write the subject in the form of a story or expression of critical situations and try to analyze it from the perspective of the participants themselves.

Fourth Session Title: (The role of psychological counseling in the fight against stigma)	
Session goal	Clarify the importance of counseling program in the fight against stigma and discuss and refute irrational thoughts.
Session length	**45 minutes**
Session Description and content	• Reviewing of the foregoing and confirm the key concepts • Brainstorming for participants to express their opinions freely and spontaneously about the stigma. • Clarification of the counselor about the causes and the reasons for the stigma • Dividing the working groups on various aspects that have been raised about the stigma and providing an opportunity for participation by everyone. • Each participant of the group presented their findings of the concepts and proposals and recommendations to get rid of irrational thoughts and replace them with rational ideas and trends. • Insight problems suffered by participants and develop appropriate solutions using the method of problem-solving • Talking about all the offers and exit a joint idea , suggestions and recommendations .
Homework	• Identify irrational thoughts and write notes • Read a story or book about interested concern to be insight

Fifth Session Title: (The role of psychological counseling in reducing anxiety and stress)	
Session goal	Reduce the anxiety and fear of social stigma associated with mental illness.
Session length	**45 minutes**
Session Description and content	• Reviewing of the foregoing and confirm the key concepts. • Make 3 working groups composed of 6 participants per group. • Planning for the entertainment program out of the crisis and to freely express their feelings • Classification of positive feelings about negative emotions
Homework	Write notes, Suggestions and Recommendations .

Sixth Session Title: (Relaxation by breathing)	
session goal	Skill Development of positive feelings and relaxation exercises to calm the mind and body.
Session length	**45 minutes**
Session Description and content	• Relaxation exercises (Ins and Outs) to relieve the pressure and tension. • Teaching participants how to control emotions by practicing relaxation. • Assist participants in overcoming the pressure. • Discuss with the participants their feelings towards themselves and towards others. • The counselor strengthens the spontaneous expression and

	positive feelings for them. • Disclosure of negative feelings towards any of the others in order to promote serenity and positive feelings.
Homework	• Practicing relaxation and breathing exercise every day and recording feeling after exercise.

Seventh Session Title: (De- briefing)* **	
Session goal	• Expression of feelings and emotions and attitudes towards the reflexes. • Assess the extent of the suffering. • Discuss in details the symptoms experienced by the participants • Identify other individuals on the same symptoms.
Session length	**45 minutes**
Session Description and content	• Summarize the previous session and discuss homework. • The participant talk about the suffering of the most important thing and what he make his feeling upset. • Let him express what is inside without interrupting. • Take into account that he may cry during the talk, so let him unload what's inside through the tears. • Focus on ideas and beliefs that emerged after mental illness • Provide Support for the participants and show empathy of the emotional level.
Homework	• Write the most important negative emotions experienced by the participants to get rid of them and how they deal with it.

***** Many of specialists, psychologists from Palestine Center Foundation for the Care of Victims of trauma in the application of the sixth and seventh session of the program.**

Eighth Session Title: (Opinion Expression)	
Session goal	Development of Skill Dialogue: a method of learning provides an opportunity to exchange views and ideas, clarify and defend them, and the role of the counselor is to lead the dialogue and facilitate a vital role. The Counselor encourages the target group for the constructive dialogue and feed them by some ideas (without imposing on others).
Session length	**45 minutes**
Session Description and content	• Open the door of dialogue for the community Impression. • Identify priorities for the participants in terms of the most important issues affecting and threaten them. • Constant encouragement for them to talk and express an opinion.
Homework	

Ninth and tenth Sessions Title: (psychodrama)**	
Session goal	• Help participants to express their thoughts and feelings freely • Developing their skills and abilities to express and act in difficult situations. • Assist in satisfying their needs for fun and humor in an order manner (role play)

	• Providing them with a stock of knowledge and practical experience to deal with different situations in the future.
Session length	**45 minutes**
Session Description and content	• Identify the problem related to stigma that will be addressed at the psychodrama. • Distribute the roles freely and guide them correctly. • Participants are asked to prepare themselves for the implementation of roles. • During the implementation the counselor asked participants to focus on the psychological and emotional attitudes regardless of performance. • Discuss with the participants the feelings and ideas through implementation. • Identify their impressions about the proposed solutions through role play.
Homework	• Ask the Participants to record the most important feelings that negatively affected them by watching the play, and take advantages and try to write a similar story

****Theatrical Sketch Video was presented within the MDM Spain for the best awareness material to educate the community about the stigma of mental illness..**

Eleventh Session Title: (Emotional empathy with the community)(Annex 8)	
Session goal	• Working to provide activity to community integration and breaking the stigma
Session length	**45 minutes**
Session Description and content	• Preparation work for exhibition: The exhibition is one of the channels of effective communication in the transfer of knowledge and presentation skills and it's used to display products by the participant in order to provide an opportunity for others to learn much and provide feedback.
Homework	Draw graphics, Write notes, Suggestions and Recommendations.

Twelfth Session Title: (counseling program evaluation)	
Session goal	• Measuring level of improvement during program intervention. • Assessing the participants themselves to the program and exercising during sessions. • Fill the post questionnaire freely.
Session length	**45 minutes**
Session Description and content	• The Counselor welcomes participants and thanks their participation in the program. • Discuss with them the difficulties faced during participating. • Distribute the questionnaire and measure improvement and knowledge of the feasibility of the program. • The Counselor agrees with the participants on a mechanism to communicate with them in the future. • The Counselor shakes hands with the participants and wishes them success.

Annex (6)

List of arbitrators of stigma scale

1.	Dr. Ashraf Al Jidy	Assistant Prof. Faculty of nursing , The Islamic University - Gaza.
2.	Dr. Abdel Aziz Thabit	Assistant Prof. Faculty of Public Health Al -Quds University - Gaza.
3.	Dr. Fadel Ashour	Psychiatrist, Al Azhar university- Gaza.
4.	Prof. Samir Quota	Professor of Educational Psychology , The Islamic University - Gaza.
5.	Dr. samir Zaquot	Psychologist , Gaza Community Mental Health Program .
6.	Dr. Khadra Al-Amassy	Director of general mental health Administration, MOH, Gaza.

Annex (7)

List of arbitrators of counseling program

1.	Dr. Yousef Aljeesh	Associate Prof. Faculty of Nursing, The Islamic University Gaza
2.	Dr. Atef Ismail	Assistant Prof. Faculty of Nursing, The Islamic University Gaza.
3.	Prof. Mohammed Elhelou	Professor of educational psychology, The Islamic University Gaza.
4.	Prof. Samir Quota	Professor of Educational Psychology, The Islamic University Gaza.
5.	Dr. Atef Al- Agha	Assistant Prof. Faculty of Education, The Islamic University Gaza.
6.	Dr. Khitam Al-Sahar	Assistant Prof. Faculty of Education, The Islamic University Gaza.

Annex (8)

Exhibition of Counseling Program Sessions Graphics and images.

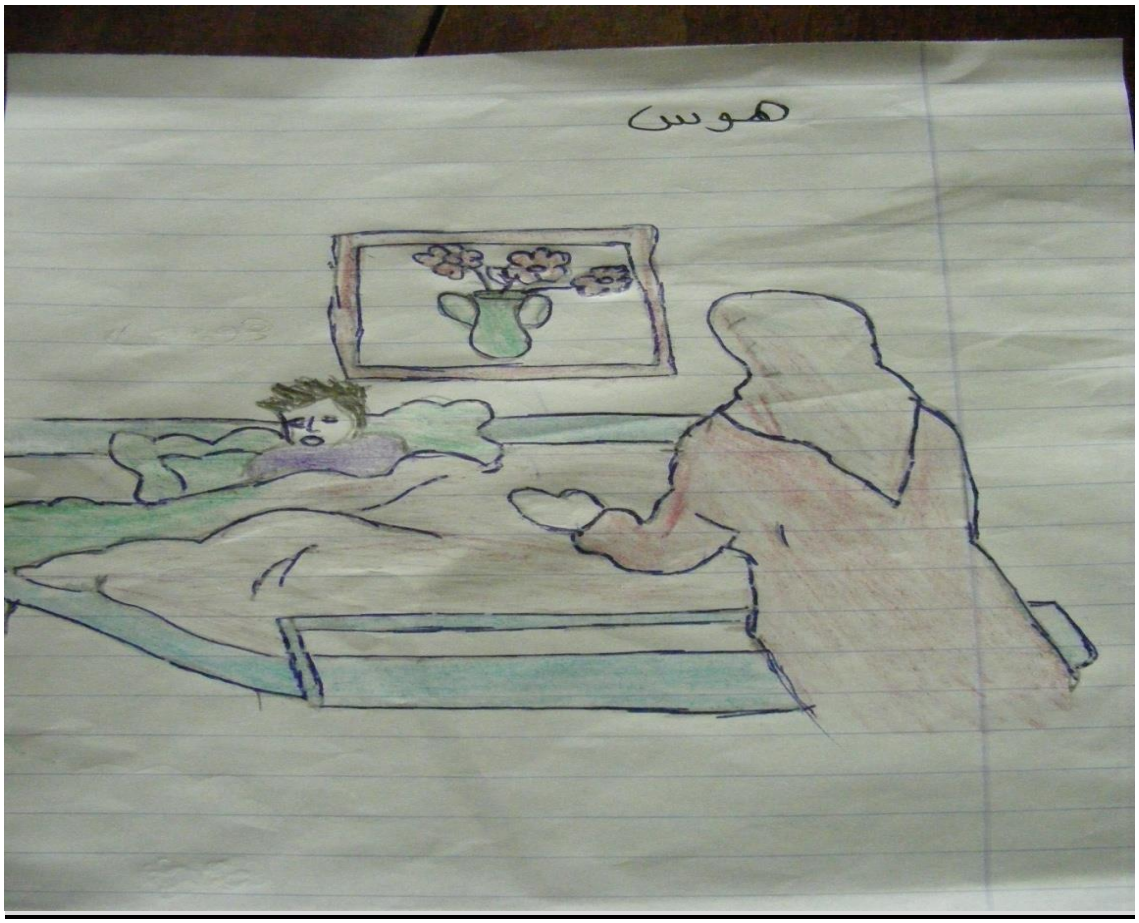

مصحة الأمراض النفسية


مشفى الأمراض النفسية


بسم الله الرحمن الرحيم
مرض
مستقبل العظام

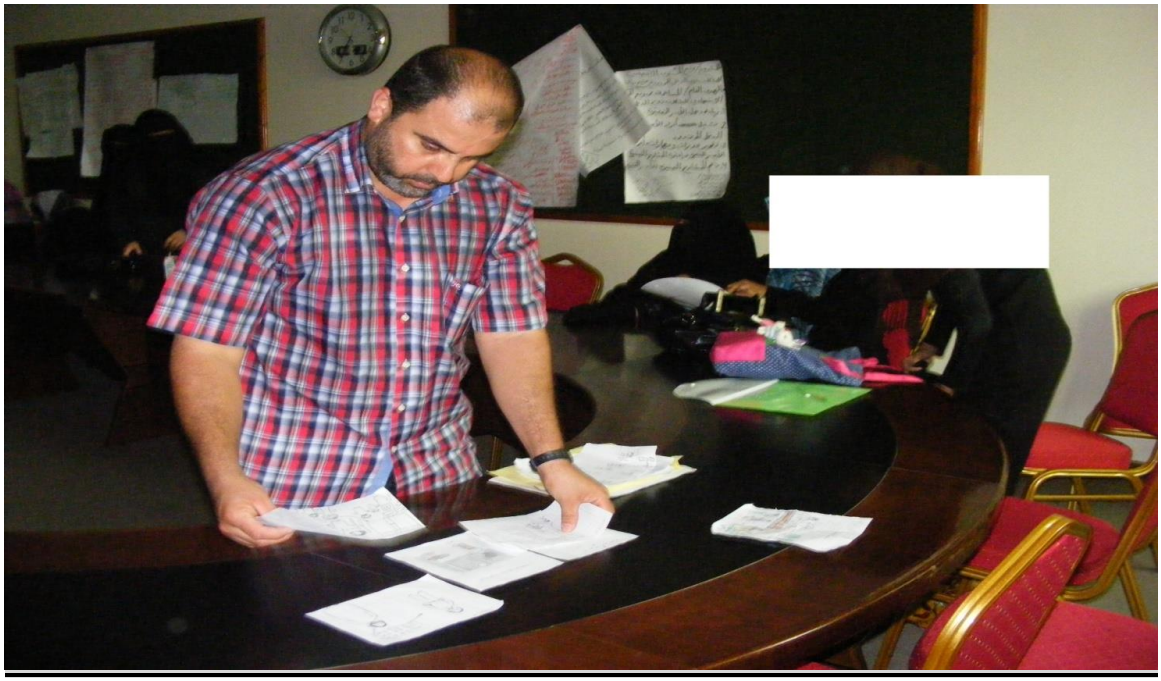

الحياة جميلة لماذا لا نعيشها...


ريم هوس
الثقة بالنفس


هوس


[redacted]
مركز لعلاج مرض الفصام
(برعاية أطباء من أسبانيا)
خبر عاجل جاءنا أطباء من أسبانيا لعلاج مرض الفصام
أب المريض
أم المريض
حبس شاب مريض في هذه الغرفة
كان يعاني من مرض الفصام
كان قليل الكلام عصبي وعنيف
كان يتهيأ له أشياء غير موجودة
عدم التركيز مع الآخرين
يكلم نفسه
وكان يعاني من الهلوسة
بعد سماع الأخبار أخذا الأب والأم ابنهم المريض وذهبا إلى المركز
رجع المريض لحالته الطبيعية بعد العلاج بالأدوية والعلاج الأسري

The Researcher during Counseling Program Sessions intervention



Annex (9)

Approval letter to implement the counseling program in the lectures room of The Islamic University – Gaza

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza

الرقم Ref .....
التاريخ Date ٢٠١٤/٦/٤ م

الأخ الفاضل / أ. علاء اللخاوي منسق الدورات بالتعليم المستمر حفظه الله
السلام عليكم ورحمة الله وبركاته

الموضوع: توفير قاعة لتطبيق برنامج إرشاد نفسي ضمن دراسة الماجستير

بداية نهديكم عاطر التحيات ونتمنى لكم دوام الصحة والعافية ...

أقوم بعمل برنامج ارشادي لتقليل الشعور بالوصمة لدى أهالي مرضى الفصام في قطاع غزة والبرنامج عبارة عن ١٢ جلسة ارشادية مدة الجلسة حوالي ٤٥ دقيقة لعدد ٢٠ شخص من أهالي مرضى الفصام وهذا الأمر يتطلب قاعة اجتماعات أو قاعة دراسية لتوفير الجو المناسب للجلسات الارشادية لذا أرجو منكم المساعدة بتوفير هذه القاعة لتنفيذ البرنامج علما بأن مدة البرنامج أربعة أسابيع بواقع ٣ أيام بالأسبوع تبدأ من يوم السبت القادم الموافق ٢٠١٤/٦/٧ وذلك من الساعة الخامسة مساءا حتى السابعة مساءا..

آملين منكم المساعدة خدمة لمسيرة العلم وطلاب العلم بالجامعة الاسلامية

وبارك الله فيكم،،،

مقدمه// محمد فايز البرعي
طالب ماجستير الصحة النفسية المجتمعية
الجامعة الاسلامية

لا مانع لدينا
علما بأن القاعة خارج حرم الجامعة
2014/6/8

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Annex (10)

Approval letter to the studied in community mental health clinics

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza

مكتب نائب الرئيس للبحث العلمي والدراسات العليا هاتف داخلي: 1150

الرقم.....ج س غ/35/ Ref
2014/04/23
التاريخ..... Date

الأخت الدكتورة/ خضرة العمصي حفظها الله،،
مدير عام الصحة النفسية – وزارة الصحة

السلام عليكم ورحمة الله وبركاته،

الموضوع/ تسهيل مهمة طالب ماجستير

تهديكم شئون البحث العلمي والدراسات العليا أعطر تحياتها، وترجو من سيادتكم التكرم بتسهيل مهمة الطالب/ **محمد فايز عبد الرحمن البرعي**، برقم جامعي **120093106** المسجل في برنامج الماجستير بكلية التربية تخصص الصحة النفسية المجتمعية التمريض وذلك بهدف تطبيق أدوات دراسته والحصول على المعلومات التي تساعده في إعداد رسالة الماجستير والتي بعنوان:

The effectiveness of proposed counseling program on reducing level of stigma among family of schizophrenia patient in Gaza strip

والله ولي التوفيق،،،

مساعد نائب الرئيس للبحث العلمي والدراسات العليا

أ.د. فؤاد علي العاجز

صورة إلى:-
- الملف.

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