Islamic University – Gaza
Dean of High Studies
Faculty of Education
Master Degree of Community Mental Health.

The relationship between stigma and recovery among depressed patients in Gaza Strip.

Prepared by

Osama J. Emad
2009/3465

Supervised by

Dr.Abdal Karim Radwan

Dr.Atef Al- Agha

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master in Community Mental Health (nursing Sciences).

2012-1433

Dedication

I dedicate this work to

my parents,

my wife,

my brothers,

my children (Omar, Mohammed),

and my friends,

who has shown unconditional love and support from the

beginning to the end.

Acknowledgements

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

I am truly grateful for Dr. Abdal karim Radwan and Dr. Atef Al-Agha who have provided guidance and support throughout this process and serving as my mentor. Also, I would like to thank Dr. Mohammed EL-Helou for helping me whenever I asked him.

I would like to express my deepest gratitude to my parents, Family, my wife, my children, Friends, for their encouragement, help and 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 along and prosperous life.

Abstract

The overall aim of this study was to understand the relationship between stigma and recovery among depressed patients in Gaza Strip. The researcher used descriptive, analytical, cross-sectional design to describe and explore the relationship between stigma and recovery. The study population includes all depressed patients were treated in the governmental community mental health clinics in Gaza Strip at 2009-2010 record. The total number is 383, male (245) female (138). 180 depressed adult persons who were treated in the governmental community mental health clinics and registered in 2009-2010 record, who have participated voluntarily in this study. The participants were interviewed directly to fill questionnaires including the demographic data, stigma questionnaire and recovery questionnaire, with a response rate of 92%. Collected data was entered and analyzed by using Statistical Package for the Social Sciences (SPSS) version (14). The major findings of this study as the following: prevalence rate of stigma among depressed patients about 74%. 78.5% from the sample reported that the media play role in developing of stigma, that's means there was a significant relationship at significant level ($\alpha \leq 0.05$) between the role of media and developing of stigma among the participants in this study. 78.5% from the sample reported that there is negative effect of stigma on their daily life, that's means there was a significant relationship at significant level ($\alpha \leq 0.05$) between stigma and daily life of depressed patients. The study shows that the recovery level among depressed patients was 49.5%, that's means the level of recovery among the participants in this study is low. And the study shows there was a significant relationship at significant level ($\alpha \leq 0.05$) between stigma and recovery, that's means if the stigma increases the recovery level decreases among the participants in this study and indicates that the stigma is the main barrier to achieve recovery process. And showed there were no significant differences at significant level ($\alpha \leq 0.05$) in developing of stigma among the participants in this study due to age. While there were a significant differences at significant level ($\alpha \leq 0.05$) in developing of stigma due to gender and differences in favor of female. And showed that there were no significant differences at significant level ($\alpha \leq 0.05$) in developing of stigma due to education level. Also the study showed that there were no significant differences at significant level ($\alpha \leq 0.05$) in developing of stigma due to income level and 35% from the sample their family income sources are social affairs. And 44.4% from the sample the value of monthly income Less than 500 NIS ", that means that the stigma negatively affects on the economic level of the psychiatric patient. In contrast, there were a significant differences at significant level ($\alpha \leq 0.05$) in developing of stigma due to marital statue and differences in favor of married, that means that some demographic data negatively affected by stigma of mental illness as education and income level and some demographic data play a role in developing of stigma as gender favor of female and marital status favor of married. And there was no relationship between stigma and age among the participants in this study. The study recommended that fighting the stigma of mental illness and improving the way of communication and interaction between mental health care providers and psychiatric patients are important factors for improving the recovery level and developing the community mental health services in Gaza Strip.

Key words: Depression, Stigma, Recovery.

ملخص عن الدراسة باللغة العربية

الهدف العام لهذه الأطروحة هو فهم العلاقة بين الوصمة والتعافي بين مرضى الاكتئاب في قطاع غزة. قام الباحث بإجراء هده الدراسة الوصفية التحليلية التقاطعية لوصف واستكشاف العلاقة بين الوصمة والتعافي. مجتمع الدراسة عبار ة عن مرضى الاكتئاب الذين يتلقون العلاج في عيادات الصحة النفسية المجتمعة الحكومية، ومسجلين في سجل ٢٠٠٩-٢٠١٠ وكان عددهم ٣٨٣ مريضا منهم ٢٤٢ ذكور و١٣٨ إناث.أما عينة الدراسة تتكون من ١٨٠ شخص بالغ لديه الاكتئاب، يتلقون العلاج في عيادات الصحة النفسية المجتمعة الحكومية، ومسجلين في سجل ٢٠٠٩-٢٠١٠ ويعيشون في قطاع غزة. بعد إعطاء الموافقة علي المشاركة في الدراسة، تم تعبئة الاستبيانات عن طريق إجراء مقابلات وجها لوجه متضمنة البيانات الشخصية واستبانه الوصمة واستبانه التعافي، حيث بلغت نسبة تجاوب المرضى مع الدراسة ٩٢%. تم إدخال وتحليل البيانات المجمعة باستخدام الحزمة الإحصائية للعلوم الاجتماعية نسخة (١٤).

وقد كانت النتائج الرئيسية لهذه الدراسة على النحو التالي: معدل انتشار الوصمة بين مرضى الاكتئاب حوالي ٧٤% من المشتركين في الدراسة. ٧٨.٥%من العينة أكدوا أن وسائل الإعلام تلعب دوراً في تطور الوصمة لديهم، وهذا يعني وجود علاقة ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين دور وسائل الإعلام وتطور وصمة المرض النفسي بين المشتركين في هذه الدراسة. ٧٨.٥%من العينة أكدوا أن للوصمة تأثيراً سلبياً علي حياتهم اليومية، وهذا يعني أنه توجد علاقة ذات دلالة إحصائية عند مستوي عند مستوي الدلالة ($\alpha \geq 0.05$) بين الوصمة والحياة اليومية لمرضى الاكتئاب.أظهرت الدراسة أن مستوي التعافي بين مرضي الاكتئاب كان ٤٩.٥% من المشتركين في الدراسة، وهذا يعني أن مستوي التعافي بين المشتركين في هذه الدراسة منخفض. وقد أظهرت الدراسة وجود علاقة ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين الوصمة والتعافي، وهذا يعني لو زادت الوصمة فإن مستوي التعافي ينخفض بين المشتركين في هذه الدراسة ويشير إلى أن الوصمة هي المانع الرئيسي لإتمام عملية التعافي. وأظهرت الدراسة أنه لا توجد فروق ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين تطور الوصمة والعمر. بينما توجد فروقذات دلالة إحصائية عند مستو ي الدلالة ($\alpha \geq 0.05$) بين تطور الوصمة والجنس لصالح الأنثى. وأظهرت الدراسة أنه لا توجد فروق ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين تطور الوصمة والمستوي التعليمي. وأيضا أظهرت الدراسة أنه لا توجد فروق ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين تطور الوصمة والمستوي الاقتصادي وأن ٣٥% من العينة مصادر دخل الأسرة لديهم من الشؤون الاجتماعية و٤٤% من العينة قيمة الدخل الشهري لديهم أقل من ٥٠٠ شيقل، وهذا يعني أن الوصمة تؤثر سلبيا علي المستوي الاقتصادي للمريض النفسي. بالمقابل، توجد فروق ذات دلالة إحصائية عند مستوي الدلالة ($\alpha \geq 0.05$) بين تطور الوصمة والحالة الاجتماعية لصالح المتزوج، وهذا يعني أن بعض البيانات الشخصية تتأثر سلبياً بوصمة المرض النفسي مثل المستوي التعليمي والاقتصادي، و أن بعض البيانات الشخصية تلعب دوراً في تطور الوصمة مثل: الجنس لصالح الانثي، والحالة الاجتماعية لصالح المتزوج وأنه لا توجد علاقة بين وصمة المرض النفسي والعمر بين مرضى الاكتئاب المشتركين في الدراسة.وقد أوصت الدراسة أن محاربة وصمة المرض النفسي و تحسين طريقة التواصل والتفاعل مع المرضى النفسيين، تعتبر عوامل مهمة لتحسين مستوى التعافي وتطوير خدمات الصحة النفسية المجتمعية في قطاع غزة.

الكلمات الدالة: الاكتئاب، الوصمة، التعافي.

Contents

Chapter 1: Background

Chapter 2: Conceptual Framework

Chapter 3 Literature Review

Chapter 4 Methodology of the study

Chapter 5 Data analysis and results

Chapter 6 Discussion, Conclusion, and Recommendations

List of tables

List of figures

List of Annexes

List of Abbreviations

APA	American psychiatric association.
ATSPPH	Attitudes toward seeking professional psychological help.
BPRS	Brief psychiatric rating scale.
DSM-IV	Diagnostic and statistic manual of mental disorder 4th edition.
DD-NOS	Depressive disorder not otherwise specified.
DALYs	Disability-adjusted life years.
ECT	Electroconvulsive therapy.
GAS	Global assessment scale.
HIV	Human immunodeficiency virus.
HRSD	Hamilton rating scale for depression.
MOH	Ministry of Health.
NGOs	Nongovernmental organizations.
NAMHC	National advisory mental health council.
PCBS	Palestinian central of bureau of statistics.
PTSD	Post traumatic stress disorders.
RBD	Recurrent brief depression.
RAS	Recovery assessment scale.
SAD	Seasonal affective disorder.
SPSS	Statistical package for the social sciences.
SAS-SR	Social adjustment scale-self report.
SAS	Social adjustment scale.
SMI	Severe mental illness.
SADS-L	Schedule for affective disorders and schizophrenia, lifetime version.
VNS	Vagal nerve stimulation.
WHO	World health organization.
WPA	World psychiatric association.
WMR	Wellness management and recovery.

Chapter one

Background

Chapter 1

Background

1.1. Introduction:

The mental health problems are so special due to the unusual circumstances that the Palestinian people are living under. there are many forms of the suffering that the Palestinian people experience such as unemployment, poverty, security instability, and siege. All of these factors when combine together increases the mental health problems, additionally, to other factors may also contribute to increase the mental health problems, such as genetic, social, economic and biological factor ....etc. The percentage of mental health problems considered one of the highest percentages. the final annual report in the year 2010 by The Palestinian Ministry of Health (MOH) presents the incidence rate of new cases diagnosed with mental health problems in the mental health clinics is 593case (MOH, 2010:1).

The Palestinian community in particular has specialty when it comes to the percentage of mental health problems, as it is obviously higher than the standard percentage due to the present situation and the political conflicts. Adding to this, the bad economic situation in Gaza strip due to the closure and siege, which increase unemployment and poverty. According to Palestinian central of bureau of statistics (PCBS) in mid year 2009 the unemployment rate in Gaza strip is 43.8% (PCBS, 2010:16).The researcher consider this situation surely affects the psychiatric patients, as it is well known that they are the weakest group in the Palestinian community, although they are usually exposed to such crises.

The above mentioned data shows how much care should be given to this group of people by helping them to have normal life through the integration to all fields of the society. This requires improving mental health services and protections of psychiatric patient's rights.

It is well-known that mental health is often said to be a state of well-being associated with happiness, contentment, satisfaction, achievement, optimism and hope (Stuart, 2009:46).

It is well-known that mental illness is an illness with psychiatric or behavioral manifestations and or impairment in functioning due to social psychological, genetic, physical, chemical or biological disturbance (Stuart, 2009:46). The present study deals with depressed patients in trying to identify the relationship between stigma and recovery among them.

Rates of depression are increasing rapidly and particularly in developing countries. Jumaian (2004) said: Depression is highly stigmatized in the Arab world. The Surgeon General's report (1999) on mental health noted that stigma "*is among the many barriers that discourage people from seeking treatment for their condition"* (Nasir and Qutob, 2005: 126).

The global burden of disease identifies major depression as the fourth leading cause of disease burden in the world. Estimated that by 2020 major depression will be the second leading cause of disease burden (newell and Gournay, 2009: 80). stigma defined as a social cognitive process that is situational. This process consists of four components: the signal, stereotypes, prejudice, and discrimination (Kondrat, 2008:15).

Mental health recovery is a journey of healing and transformation enabling a person with mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her potential(US department of health and human services, 2004:1).

1.2. Problem statement:

Stigma is dangerous because it interferes with understanding, obtaining support from friends and family, and it delays getting help (sometimes for years). It can lead to:

Denial of signs of mental illness in self, Secrecy and failure to seeking help, Self-blame, Substance abuse or problem gambling to control symptoms and isolation (Everett, 2006:13).

Many psychiatric patients told the researcher that they are frightened because they may be labeled or seen as "crazy." People who live with mental illness and their families often said that the stigma associated with their diagnosis was more difficult to bear than the actual illness; they have Negative attitudes toward mental illness which can come from all areas peers, schools, work and even mental health care providers. Psychiatric patients are afraid of both the reactions which caused by stigma and the resulting discrimination that can occur, including loss of employment, housing, friends and respect.

The problem of stigma is a global one and crosses geographical, linguistic, cultural and religious boundaries and often based on misunderstanding and lack of knowledge about mental illness.

In Palestine: there are no previous studies about the relationship between stigma and recovery, and no surveys had been done to assess the relationship between the stigma and the attitudes towards searching for the psychological help and intentions to seek counseling yet, in Gaza strip according to researcher knowledge. So it is important to conduct this study to determine the prevalence rate of stigma and recognize the recovery level among depressed patients in Gaza strip.

In Egypt: 75% of relatives of the mentally ill thought that mentally ill people cannot work and are likely to be dangerous. Most would not consider marrying a mentally ill person. El Defrawi et al found that only 37.5% of families of patients with psychoses reported having used psychiatric services for the treatment of their ill relative. Almost 60% reported visiting Sheikhs, traditional healers, or using special traditional ceremonies involving incantations and rituals to attempt to treat the mental illness (world psychiatric association) ,(WPA, 2005:62).

In United Arab Emirates: 62% of parents would not preferentially seek help from mental health specialists if their children developed psychiatric illness, stating the stigma attached to attending mental health services as one of the reasons for non-consultation(WPA, 2005:60).

In USA: As the American psychiatric association (APA) reported that "20% of Americans don't seek help from a mental health professional because they feel there is a stigma associated with therapy (Hobson, 2008:7).

The stigma attached to mental illnesses is among the most serious problems facing people with mental illness in Gaza Strip. Arising from superstition, lack of knowledge and empathy, old belief systems, and misunderstanding of mental illness, stigma was existed throughout history. They result in stereotyping, fear, embarrassment, anger and avoidance behaviors. They force people to remain quiet about their mental illnesses, often causing them to delay seeking mental health care, discontinue treatment abruptly, and avoid sharing their concerns with family, friends, mental health providers and others in the community.
It is known that stigmatization of depression leads depressed persons to discontinue treatment abruptly and it may affects on the recovery process. from all this comes up this study will give answers about the level of stigma, level of recovery and relationship between stigma and recovery among depressed patients in Gaza strip. It also gives solutions and recommendations to reduce the stigma problem and improve recovery level among depressed patients in Gaza strip. And the results of this study will lead to improve the community mental health services in Gaza strip and the body of mental health knowledge will increase due to this study.

1.3. General objective:

The main objective of this study is to understand the relationship between stigma and recovery among depressed patients in Gaza strip.

1.4. Specific objectives:

- To determine the prevalence rate of stigma among depressed patients in Gaza strip.
- To recognize the recovery level among depressed patients in Gaza strip.
- To find the relationship between stigma and recovery among depressed patients in Gaza strip.
- To identify the relationship between socio-demographic data (age, gender, education level, income level and marital status) and developing of stigma among depressed patients in Gaza strip.
- To assess the relationship between the role of media and developing of stigma among depressed patients in Gaza strip.
- To describe the effect of stigma on the daily life of depressed patients in Gaza strip**.**

1.5. Research Questions:

The main question of the study

- What is the relationship between stigma and recovery among depressed patients in Gaza strip?

The branched questions as the following

- What is the prevalence rate of stigma among depressed patients in Gaza strip?
- What is the level of recovery among depressed patients in Gaza strip?
- Are there statistical differences in developing of stigma among depressed patients in Gaza strip due to socio-demographic data (age, gender, education level, income level and marital status)?
- What is the relationship between the role of media and developing of stigma among depressed patients in Gaza strip?
- What is the effect of stigma on the daily life of depressed patients in Gaza strip?

1.6. Justification:

The Justification of this study may be related to many factors such as the percentage of psychiatric disorders in Gaza strip is high, It makes it necessary to think of this population and to try to minimize barriers and obstacles in order to help them getting better quality of life, It is well-known that the problem of stigma is a global one and it crosses geography, linguistic, cultural and religious boundaries. So it is important to determine the prevalence rate of stigma and recognize the recovery level in Gaza strip, lack of researches particularly in this field., and no surveys had been done to assess the relationship between the stigma and the attitudes towards searching for the psychological help and intentions to seek counseling yet, in Gaza strip according to researcher knowledge, and it is important to pay attention to mental health problems in Gaza strip in order to adjust to the increased number of the psychiatric persons this study will Provides information and data for all concerned people. In the other hand, this study will contribute in increasing the mental health body knowledge in Palestine and provide guidelines for other researchers to conduct future studies related to this field. Finally, it also provides recommendations to reduce the stigma problem and improve the recovery level among depressed patients in Gaza strip.

1.7. Context of the study:

The study was conducted in Gaza, Palestine; therefore the researcher presents some background information about the geographical context, political and economical context, Palestinian population, and mental health problems population.

1.7.1. Geographical context:

Gaza Strip is a very crowded area with the Size of 360km2, the concentration of Population in cities, small villages and 8 Refugee camps that contain two thirds of Population, Gaza Strip is divided into Five Governorates as follows: Gaza city, North Gaza, Mid-area, Khanyounis, and Rafah Governorate (PCBS, 2011:1). Palestine map is attached in (Annex 7).

1.7.2. The Palestinian Population in Palestine:

The projected number of Palestinians in the world is 11.22 million, of who 4.23 million are in the Palestinian Territory, 1.37 million in Israel, 4.99 million in Arab countries and around 636 thousand in other countries at the end of 2011.
The projected number of Palestinians living in the Palestinian Territory at the end of 2011 is 4.2 million, of whom around 2.6 million reside in the West Bank and 1.6 million in the Gaza Strip. Of every 100 persons in the Palestinian Territory, about 44 are refugees: 42 per 100 in the West Bank and 58 per 100 in the Gaza Strip. (PCBS, 2011:1).

1.7.3. Political and economic context:

The nature of people's life in the Gaza strip is stumpy, and their daily lives are constantly threatened by daily traumatic events. The Life in Gaza Strip have full of factors that affect their mental health and developed the triggers to occurrence of mental illness such as Israel occupation , the siege, unemployment, political conflict, and poverty. The war against Palestinians, the strict siege imposed on the whole people of Gaza, which is another cycle of violence lead to ideas of no-solution except violence. The war has idealized power as the only solution for contracted problems, has strengthened powerlessness, loss of hope and the feeling of no safety. All these factors are great contributing factors to develop mental health problems.

The devastating and catastrophic situation in the Gaza Strip including destruction of the infrastructure such as health services, pharmaceuticals, water supply, electricity, agriculture and unemployment problem hasn't excluded anyone for physical and psychological sufferings (Jesoor for Trauma Recovery, 2009: 2).

The Palestinian people suffer from the effect of economical war represented in preventing the workers from reaching out their work place, this lead to spread of unemployment and poverty and low of daily living level, this made the extent of mental health problems in Gaza Strip reach unprecedented levels. Unemployment is concentrated among the youth aged 15-24 years with 38.9%, followed by Persons aged 25-34 years with 24.9% in 2009. The percentage of Gazan people who live in deep poverty 43.0% in 2007(PCBS, 2010:17). With the continued economic decline and the implementation of even stricter closures on Gaza strip. This deterioration in economic situation might have its impacts on financial access to mental health care facilities.

1.7.4. Persons with mental health problems in Gaza strip:

The annual health report in the year 2010 MOH presents the incidence rate of new cases diagnosed with mental health problems in the community mental health clinics is 593case and indicate increases in most mental disorder categories (MOH, 2010:1).

According to khamis (2008) increased risk of mental health problems was also found among injured young Palestinians and children experiencing family loss and home demolition in Gaza Strip during the second intifada.

In Study by Punamaki et al (2005) found women and families lacking support from relatives and community to be more vulnerable to anxiety when exposed to military violence (Giacaman et al, 2010:4).

Samour (2002) reported that 69% of postpartum women (n=364) met the criteria for caseness 4 weeks after their delivery when assessed by the Edinburgh Postnatal Depression Scale and that prevalence of depression in these women was associated with political violence and other physical and psychosocial stressors(Mental Health Atlas, 2005 :537).The following table no. (1.1) shows the estimated numbers of new cases diagnosed with mental health problems in 2010 represented in the type of mental health problems, region and sex**.**

Diagnosis	Rafah clinic		Abusheback clinic		Khanyouns clinic		Alnusirate clinic		West Gaza clinic		Alsuraney clinic		Total
SEX	M	F	M	F	M	F	M	F	M	F	M	F	
ORGANIC	5	4	1	2	3	3	1	6	3	1	1	13	43
SCHIZOPHRENIA	7	6	4	4	2	5	16	3	6	2	17	12	84
NEUROSIS	27	17	7	2	16	3	6	3	8	5	10	3	107
PERSONALITY DISORDER	5	3	0	0	2	0	4	1	0	0	3	1	19
ADDICTION	2	1	4	0	3	0	2	0	2	0	6	2	22
EPILERSY	20	21	9	4	2	0	12	3	3	3	5	1	83
AFFECTIVE	15	8	4	3	0	1	12	7	7	2	11	6	76
MENTAL RETARDATION	12	8	8	2	7	6	14	7	8	6	27	23	128
OTHERS	3	1	3	0	5	0	4	0	4	5	4	2	31
Total	96	69	40	17	40	18	71	30	41	24	84	63	593

(MOH, 2010: 1).

Community 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.

1.8. General view of the study chapters

This study consists of six 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 results and its table. These results will be discussed in details in the six chapter followed by a conclusion about the study as well as a recommendations and study limitations in same chapter.

Chapter Two

Conceptual framework

Chapter 2

Conceptual Framework

2.1. Introduction

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

2.2. Overview of mental health

World health organization (WHO,2001) defined health as a state of complete physical, mental, and social wellness, not merely the absence of disease or infirmity.
Mental health is a state of emotional, psychological, and social wellness evidenced by satisfying interpersonal relationships, effective behavior and coping, positive self-concept, and emotional stability (Videbeck, 2003:3).

Common wealth Department of Health and Aged Care (2000) defined mental health as The capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice (barkway, 2005:99).

APA (2001) defined a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom, General criteria to diagnose mental disorders include dissatisfaction with one's characteristics, abilities, and accomplishments; ineffective or nonsatisfying relationships; dissatisfaction with one's place in the world; ineffective coping with life events; and lack of personal growth. In addition, the person's behavior must not be culturally expected or sanctioned, nor does deviant behavior necessarily indicate a mental disorder (Videbeck, 2003:3).

2.2.1. Mental Health Promotion:

Defined by WHO (2001) is an umbrella term that covers a variety of strategies, all aimed at having a positive effect on mental health. The encouragement of individual resources and skills and improvements in the socio-economic environment are among them (Vickers & Masri, 2005:9).

Figure (1) Conceptual Framework Diagram

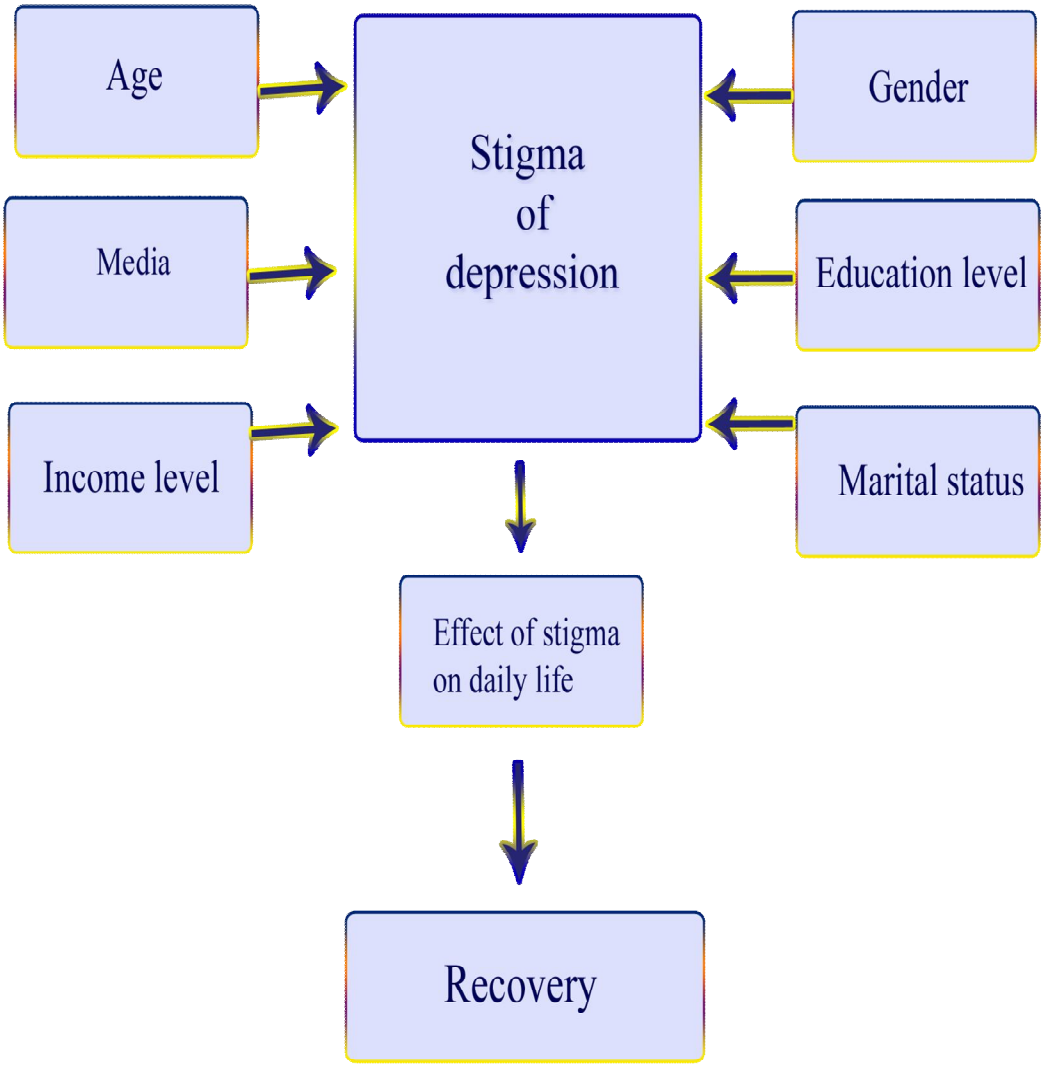


Figure (2.1): Conceptual Framework-Self developed**.**

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

2.3. Operational definitions of terms:

Before the beginning of this study, the researcher clarifies and defines the variables under investigation. The independent variable is (stigma), and the dependent variable is (recovery).

2.3.1. Stigma:

The researcher identifies stigma as: every person feels shyness or discrimination due to mental illness.

2.3.2. Recovery:

The researcher identifies recovery as: the process in which patients are able to live and do normal daily living skills despite of mental illness.

2.3.2. Depression:

Patients who will participate in this study should have the following criteria: depression diagnosis confirmed by psychiatrist, all depressed patients more than one year, both sexes are included; all depressed pts treated in the governmental community mental health clinics in Gaza strip at 2009-2010 and depression not co morbid by medical problem.

Chapter three

Literature review

Chapter 3

Literature Review

In this chapter the researcher will review the literature review in three broad categories; The first is about depression, the second is about stigma, where the third is about recovery. This chapter reviews the previous studies that related to the relationship between stigma and recovery, there are commentaries on each group in addition to the commentary on the previous studies as a whole.

Depression

3.1. Introduction:

The first part of the second chapter discusses the depression in general. It covers Theories of depression, causes, classification and treatment of depression.

Normal mood: every person experiences from time to time a change in his mood, which is related to everyday life events. This is considered normal as long as it is appropriate to the event.
Mood is considered abnormal when it is excessively depressible or related out of proportion to the life experience.

Mood disorders (affective disorders): are a group of disorders characterized by disturbance in regulation of emotion, ranging from intense elation or irritability to severe depression., These disorders often result in personal suffering, family distress, interpersonal and occupational impairment, an untold social costs (alhajar; 2005:45).

3.2. Definition of Depression:

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a person has a depressive disorder, it interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her. Depression is a common but serious illness, and most that experience it need treatment to get better.

- Depression is a set of feelings of sadness, loss of pleasure, helplessness, and hopelessness that persist over time, for at least 2 weeks. Depression can be associated with alcohol and other drug abuse and can lead to school failure as well as suicide attempts (National Institutes of Health, 2008:3).

Depression is more than just the sad mood that most people might experience when they have had a bad day. Major depression is a medical disorder that lasts at least two weeks and that produces a combination of physical and emotional symptoms that makes it very difficult to function in life. At the heart of clinical depression is a loss of pleasure in activities that used to be fun or exciting. Also, people often have feelings of sadness, hopelessness, and pessimism. These symptoms are accompanied by a wide variety of physical symptoms, such as difficulties sleeping, poor concentration and memory, low energy, and changes in appetite (National Alliance on Mental Illness, 2008:5).

3.3. Theories of Depression:

The researcher views in this study 5 etiological theory for depression (Biological, psychodynamic, behavioral, interpersonal, and cognitive).

3.3.1. Biologic Theory:

Neurotransmitter involvement:

Varcarolis (2002) indicated there is much evidence to support the view that depression is a biologically heterogeneous disorder. This indicates that many neurotransmitters are implicated and the mechanisms of their interactions are not fully understood. Neurotransmitter dysregulation may result from environmental stressors, drug use, some medical conditions and/or an inherited vulnerability.

Keltner & Warren (2003) describe three neurotransmitters that have attracted most medical research attention in relation to mood disorders are the catecholamine's, serotonin, norepinephrine and dopamine. Also, acetylcholine and gamma-aminobutyric acid are likely to have modulating effects on those biogenic amines.

It is known that stressful events overtax norepinephrine, serotonin and acetylcholine systems and lead to depletion of these neurotransmitters**,** Serotonin is an important regulator of sleep, appetite and libido; and decreased levels may account for lowered energy levels, concentration difficulties and the inability to feel pleasure **(**Elder et al, 2005:245).

Neuroendocrine influences:

According to Thase (2000): Hormonal fluctuations are being studied in relation to depression. Mood disturbances have been documented in people with endocrine disorders such as those of the thyroid, adrenal, parathyroid, and pituitary. Elevated glucocorticoid activity is associated with the stress response, and evidence of increased cortisol secretion is apparent in about 40% of clients with depression with the highest rates found among older clients. Postpartum hormone alterations precipitate mood disorders such as postpartum depression and psychosis. About 5% to 10% of people with depression have thyroid dysfunction, notably an elevated thyroid-stimulating hormone. This problem must be corrected with thyroid treatment or treatment for the mood disorder will be affected adversely (Videbeck, 2003:334).

3.3.2. Psychodynamic theory of depression:

The psychodynamic understanding of depression defined by Sigmund Freud and expanded by Karl Abraham is known as the classic view of depression. That theory involves four key points: (1) disturbances in the infant mother relationship during the oral phase (the first 10 to 18 months of life) predispose to subsequent vulnerability to depression; (2) depression can be linked to real or imagined object loss; (3) introjection of the departed objects is a defense mechanism invoked to deal with the distress connected with the object's loss; and (4) because the lost object is regarded with a mixture of love and hate, feelings of anger are directed inward at the self (Sadock, & Sadock, 2007:534).

3.3.3. Behavioral theory of depression:

The predominant behavioral theory of depression postulates that major life stressors can result in a depressive episode because they disrupt normal behavior reinforcement patterns.

This theory views depression as the consequence of a lack of or decrease in the efficiency of positively reinforced behavior and perhaps overt punishment for behavioral initiation. This may be a result of a decrease in the availability of reinforcing events, one's personal skills to act on the environment, the impact of certain types of events, or a combination of these. In addition, the mobilization of support from family and other social networks may result in a negative feedback loop of social reinforcement for depressive behaviors (eg, social withdrawal, positive social reinforcement for withdrawal, further withdrawal). In other words, in times of major stress from unexpected events, people may experience a low rate of positive reinforcement for mood-enhancing behavior and a higher rate of positive reinforcement for depressive behavior (Davidson et al, 2004:168).

Learned helplessness.

Stuart (2001): defined learned helplessness is 'both a behavioral state and a personality trait of one who believes that control has been lost over the environment'.

Learned helplessness also relates to hopelessness and powerlessness—that is, the inability to escape an intolerable situation leads to the ultimate mode of adaptation: subjugation and acceptance (Elder et al, 2005:244).

3.3.4. Interpersonal theory of depression:

The interpersonal theory of depression is based on theories emanating from the interpersonal school of psychiatry and empirical data related to attachment theory and social roles. Interpersonal psychotherapy, developed by Klerman et al., is a focused, short-term, time-limited therapy that emphasizes the current interpersonal relations of the depressed patient. The efficacy of interpersonal psychotherapy treatment for major depression has been demonstrated in several controlled comparative depression treatment trials. According to Glassman and Shapiro(1998): The patient and therapist agree on the following 4 interpersonal problem areas that will be the focus of the depression treatment: a) grief or complicated bereavement, b) role dispute or ongoing disagreements with a significant person in the patient's life, c) a recent role transition that results in major interpersonal role changes or alterations (eg, retirement, moving, being diagnosed with a major medical illness), and d) interpersonal deficits (recurrent difficulties in social interactions, in their extreme form classified as personality disorders) (Davidson et al, 2004:167).

3.3.5. Cognitive Theory:

The cognitive theory of depression developed by Beck (1963). According to cognitive theory, depression results from specific cognitive distortions present in persons susceptible to depression. Those distortions, referred to as depressogenic schemata, are cognitive templates that perceive both internal and external data in ways that are altered by early experiences. Aaron Beck postulated a cognitive triad of depression that consists of (1) views about the self a negative self-precept; (2) about the environment a tendency to experience the world as hostile and demanding, and (3) about the future the expectation of suffering and failure (Sadock and Sadock, 2007: 535).

Stuart (2001) said: people become depressed because their thinking is negatively distorted, Cognitions are disturbed in depressed people; however, this may be a consequence, not a cause. Depressive thinking involves the triad of negative views of self, others and the world; it is pessimistic and clients often overgeneralise, catastrophise, and think superstitiously and dichotomously, viewing everything as either black or white **(**Elder et al, 2005:245).

From the researcher's view, all theories relating to the etiology of depression, whether biological, psychological or social, are hypotheses and cannot be considered to be causative for mental illness. No theory is fully explanatory and they only offer partial guidance, or support for specific intervention. And there is no single known cause of depression. The researcher believes that despite theories relating to the etiology of mood disorders being able to provide explanations for specific behaviors in both normal and abnormal contexts, no theory alone is sufficient to explain all human behavior, or a single behavior in all circumstances. Depression is most often caused by the influence of more than just one or two factors. As social, biological, environmental, personal, interpersonal, and cultural factors, and there is risk factors play a more important role in personality development, human behavior and mental illness.

3.4. Epidemiology of depression:

- % 2 of the general population develops a mood disorder.
- 21% of women and 13% of men develop major depression. Ratio M: F ≈ 1:2
- Age of onset for major depression disorder ≈ 25
- Depression occurs more frequently in lower socioeconomic groups.
- Bipolar disorders occur more frequently in higher socioeconomic groups.
- Age of onset of bipolar disorder ≈ 20
- Prevalence of bipolar disorder ≈ 1%. Ratio M: F ≈ 2:3 (newell and Gournay, 2009: 80).

WHO estimates that depression will become the second most important cause of disability worldwide (after ischemic heart disease) by 2020. Major depressive disorder affects 1 in 20 people during their lifetime. Both major depression and dysthymia seem to be more common in women.

3.4.1. Onset

About 50 percent of patients having their first episode of major depressive disorder exhibited significant depressive symptoms before the first identified episode. Therefore, early identification and treatment of early symptoms may prevent the development of a full depressive episode. Although symptoms may have been present, patients with major depressive disorder usually have not had a premorbid personality disorder. The first depressive episode occurs before age 40 about 50 percent of patients. A later onset is associated with the absence of a family history of mood disorders, antisocial personality disorder, and alcohol abuse.

3.4.2. Duration

An untreated depressive episode lasts 6 to 13 months; most treated episodes last about 3 months. The withdrawal of antidepressants before 3 months has elapsed almost always results in the return of the symptoms. As the course of the disorder progresses, patients tend to have more frequent episodes that last longer. Over a 20-year period, the mean number of episodes is five or six (Sadock and Sadock, 2007: 550).

3.4.3. Prognosis

Major depressive disorder is not a benign disorder. It tends to be chronic, and patients tend to relapse. Patients who have been hospitalized for a first episode of major depressive disorder have about a 50 percent chance of recovering in the first year. The percentage of patients recovering after repeated hospitalization decreases with passing time. Many unrecovered patients remain affected with dysthymic disorder. About 25 percent of patients experience a recurrence of major depressive disorder in the first 6 months after release from a hospital, about 30 to 50 percent in the following 2 years, and about 50 to 75 percent in 5 years. The incidence of relapse is lower than these figures in patients who continue prophylactic psychopharmacological treatment and in patients who have had only one or two depressive episodes. Generally, as a patient experiences more and more depressive episodes, the time between the episodes decreases and the severity of each episode increases (Sadock and Sadock, 2007: 550).

3.4.4. Course

Symptoms of major depression usually arise within days or weeks and prodromal symptoms may include anxiety symptoms and mild depressive symptoms, which can be present for weeks to months. Duration of the depressive episode is variable. Most patients recover within 1-2 years, some will have a second depressive episode or a partial remission or become chronically depressed. Up to 15% of the patients with severe major depression may commit suicide. a new recurrent episode will arise in half of the patients after a first episode of major depression and this risk increases even further after more depressive episodes. Recurrent depression is mostly seen in younger persons (Kaptien, 2008:12).

3.4.5. Disability and mortality

According to World Bank (1993) Depression is the most common mental disorder in community settings and is a major cause of disability across the world. In 1990 it was the fourth most common cause of loss of disability-adjusted life years (DALYs) in the world, and it is projected to become the second most common cause by 2020. In 1994, it was estimated that about 1.5 million DALYs were lost each year in the West as a result of depression. Ormel et al (1999) said: onsets of depression are associated with onsets of disability, with an approximate doubling of both social and occupational disability. According to Moussavi et al (2007) a part from the subjective experiences of people with depression, the impact on social and occupational functioning, physical health and mortality is substantial. Depressive illness causes a greater decrement in health state than the major chronic physical illnesses: angina, arthritis, asthma and diabetes. Depression can also exacerbate the pain, distress and disability associated with physical health problems as well as adversely affecting outcomes (National Collaborating Centre for Mental Health, 2010:21).

3.5. Causes and Risk Factors

The researcher believes that we are all at risk for developing a depressive illness. People of all ages, races, and social class can become clinically depressed. No one is completely immune and protected from depression.

Depressive illness is strongly associated with physical disease. Up to a third of physically ill patients attending hospital have depressive symptoms. Depression is even more common in patients with:-

- Life threatening or chronic physical illness
- Unpleasant and demanding treatment
- Low social support and other adverse social circumstances
- Personal or family history of depression or other psychological vulnerability
- Alcoholism and substance misuse
- Drug treatments that cause depression as a side effect, such as antihypertensive, corticosteroids, and chemotherapy agents. (Peveler et al, 2003:10).
- Anger turned inward - This can happen when we have the feeling that it is better for us to suffer in silence than offend someone else or make them angry.
- Medical problems - Thyroid illness and other medical problems can cause depression.
- Addictions - The use of addicting substances can increase risk of depression.
- Stress versus interpersonal support - Stress can cause unhealthy relationships, thus contributing to depression.
- Poor diet and lack of exercise - Inactivity is depressing. Eating well and physical activity are natural anti-depressants and focusing aids.
- Financial stress or job loss - Financial strains, burdens and debt can wear on us emotionally and can result in an enormous amount of stress.
- Lack of humor or fun - We are all at risk of taking ourselves too seriously. If we are not finding or doing fun things each day.
- Trauma and abuse issues - Depression can some times point to a need to deal with and resolve past traumas.
- Unresolved issues of grief and loss - It is not uncommon for bereaved individuals to become depressed. Holidays and anniversaries, in particular, serve as reminders of our loss, and many people experience a deepening of their grief at these times.
- Having excessive high expectations versus reality – When we have excessively high expectations for ourselves, our partners, our children, or our jobs, and when we do not meet our expectations, it can take an emotional toll on us.
- Lack of assertiveness - We can get depressed if we end up doing things we do not want to do because we cannot or do not say no. We cannot and should not do everything (Coyle, 2011:1).

There is no single cause of depression. There are many reasons why a woman may become depressed:

- Genetics (family history) – If a woman has a family history of depression, she may be more at risk of developing it herself. However, depression may also occur in women who don't have a family history of depression.
- Chemical imbalance – The brains of people with depression look different than those who don't have depression. Also, the parts of the brain that manage your

mood, thoughts, sleep, appetite, and behavior don't have the right balance of chemicals.

- Hormonal factors – Menstrual cycle changes, pregnancy, miscarriage, postpartum period, perimenopause, and menopause may all cause a woman to develop depression.
- Stress – Stressful life events such as trauma, loss of a loved one, a bad relationship, work responsibilities, caring for children and aging parents, abuse, and poverty may trigger (depression in some people.
- Medical illness – Dealing with serious medical illnesses like stroke, heart attack, or cancer can lead to depression (Roca, 2010:2).

3.6. Classification Depressive Disorders:

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder.

- **Major depressive disorder** Major depressive disorder. Also called major depression, this is a combination of symptoms that hurt a person's ability to work, sleep, study, eat, and enjoy hobbies. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life (Roca, 2010:1).
- **Atypical depression:** is characterized by mood reactivity (ability to react to positive stimuli) and significant weight gain increased appetite, hypersomnia, a sensation of heaviness in limbs (leaden paralysis), and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection (National Institutes of Health, 2008:4).

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

- **Psychotic depression**, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions.
- **Postpartum depression**, which is diagnosed if a new mother has a major depressive episode within one month after delivery (Roca, 2010:1).
- **Melancholic depression:** is characterized by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a worsening of symptoms in the morning hours, early morning waking, psychomotor, retardation, excessive weight loss, excessive guilt.
- **Catatonic depression**: is a rare and severe form of major depression involving disturbances motor behavior, stupor, immobile.
- **Seasonal affective disorder** (SAD), which is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy

can reduce SAD symptoms, either alone or in combination with light therapy (National Institutes of Health, 2008:4).

- **Dysthymic disorder**, also called dysthymia, is characterized by long-term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes. this kind of depression lasts for a long time (two years or longer). The symptoms are less severe than major depression but can prevent you from living normally or feeling well (Roca, 2010:1).
- **Bipolar depression** was once called manic-depressive disorder and is characterized by mood swings from mania to depression. Sometimes the mania is greater than the depression and sometimes the depression is greater than the mania. Sometimes the cycles are long and sometimes the cycles are short. Bipolar disorder is a true medical condition and medication is the treatment of choice (Dowd, 2004:415).

3.7. DSM-IV criteria for Major Depressive Episode:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. **Note**: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others) .
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a mixed episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation (Sadock and Sadock, 2007: 536).

3.8. Mental Status Examination for depression:

3.8.1 General Description

Generalized psychomotor retardation is the most common symptom of depression, although psychomotor agitation is also seen, especially in older patients. Hand-wringing and hair-pulling are the most common symptoms of agitation. Classically, a depressed patient has a stooped posture, no spontaneous movements, and a downcast, averted gaze on clinical examination, depressed patients exhibiting gross symptoms of psychomotor retardation may appear identical to patients with catatonic schizophrenia. This fact is recognized in DSM-IV by the inclusion of the symptom qualifier with catatonic features for some mood disorders.

3.8.2. Mood, Affect, and Feelings.

Depressed mood and he sees the world through dark glasses**,** Depression is the key symptom, although about 50 percent of patients deny depressive feelings and do not appear to be particularly depressed. Family members or employers often bring or send these patients for treatment because of social withdrawal and generally decreased activity.

3.8.3. Speech:

Slow, monotonous, answers in brief. Many depressed patients have decreased rate and volume of speech; they respond to questions with single words and exhibit delayed responses to questions. The examiner may literally have to wait 2 or 3 minutes for a response to a question.

3.8.4. Perceptual Disturbances

Depressed patients with delusions or hallucinations are said to have a major depressive episode with psychotic features. Even in the absence of delusions or hallucinations, some clinicians use the term psychotic depression for grossly regressed depressed patients mute, not bathing, soiling. Such patients are probably better described as having catatonic features. Delusions and hallucinations that are consistent with a depressed mood are said to be mood congruent. Mood-congruent delusions in a depressed person include those of guilt, sinfulness, worthlessness, poverty, failure, persecution, and terminal (Sadock and Sadock, 2007: 545).

3.8.5. Thought

Depressed patients customarily have negative views of the world and of themselves. Their thought content often includes nondelusional ruminations about loss, guilt, suicide, and death. About 10 percent of all depressed patients have marked symptoms of a thought disorder, usually thought blocking and profound poverty of content. Thinking is slow and difficult; the patient may take along time to answer a question.

3.8.6. Sensorium and Cognition

Orientation

Most depressed patients are oriented to person, place, and time, although some may not have sufficient energy or interest to answer questions about these subjects during an interview.

3.8.7. Memory

About 50 to 75 percent of all depressed patients have a cognitive impairment, sometimes referred to as depressive pseudodementia. Such patients commonly complain of impaired concentration and forgetfulness.

3.8.8. Judgment/Insight:

Depressed patients emphasize their symptoms, they are said to have excessive insight into their condition.

Judgment is best assessed by reviewing patients' actions in the recent past and their behavior during the interview. Depressed patients' description of their disorder is often hyperbolic; they overemphasize their symptoms, their disorder, and their life problems. It is difficult to convince such patients that improvement is possible**.**

3.8.9. Reliability:

In interviews and conversations, depressed patients overemphasize the bad and minimize the good. A common clinical mistake is to unquestioningly believe a depressed patient who states that a previous trial of antidepressant medications did not work. Such statements may be false, and they require confirmation from another source.

3.8.10. Impulse control:

About 10 to 15 percent of all depressed patients commit suicide, and about two thirds have suicidal ideation. Depressed patients with psychotic features occasionally consider killing a person as a result of their delusional systems, but the most severely depressed patients often lack the motivation or the energy to act in an impulsive or violent way. Patients with depressive disorders are at increased risk of suicide as they begin to improve and regain the energy needed to plan and carry out a suicide (paradoxical suicide) (Sadock and Sadock, 2007: 546), (alhajar; 2005:49).

3.9. Management

The main aims of treatment are to improve mood and quality of life, reduce the risk of medical complications, improve compliance with and outcome of physical

treatment, and facilitate the “appropriate” use of healthcare resources. The development of a treatment plan depends on systematic assessment that should, whenever possible, not only involve the patients but also their partners or other key family members (Peveler et al, 2003:11).

The researcher considers the main aim of treatment of depressed patients is to reduce the risk of suicide or homicide. The most important thing to do for people with depression is to help them get appropriate diagnosis and treatment, usually in the form of medication and psychotherapy, can help people who suffer from depression.

3.9.1. Hospitalization

The first and most critical decision a physician must make is whether to hospitalize a patient or attempt outpatient treatment. Clear indications for hospitalization are the risk of suicide or homicide, a patient's grossly reduced ability to get food and shelter, and the need for diagnostic procedures. A history of rapidly progressing symptoms and the rupture of a patient's usual support systems are also indications for hospitalization (Sadock and Sadock, 2007: 551).

3.9.2. Psychopharmacology:

Researchers believe that levels of neurotransmitters, especially norepinephrine and serotonin, are decreased in depression.

Evidence is increasing that antidepressant therapy should continue for longer than the 3 to 6 months originally believed necessary. Fewer relapses occur in people with depression who receive 18 to 24 months of antidepressant therapy. As a rule, antidepressants should be tapered before being discontinued.

Major categories of antidepressants include tricyclic antidepressants, monoamine oxidase inhibitors, selective serotonin reuptake inhibitors, and atypical anti-depressants. Serotonin norepinephrine re-uptake inhibitors (Videbeck, 2003:341).

Other medical treatment and psychotherapy:

3.9.3. Electroconvulsive Therapy:

Psychiatrists may use electroconvulsive therapy (ECT) to treat depression in select groups such as clients who do not respond to antidepressants or those who experience intolerable side effects at therapeutic doses (particularly true for older adults). In addition, pregnant women can safely have ECT with no harm to the fetus. Clients who are actively suicidal may be given ECT if there is concern for their safety while waiting weeks for the full effects of antidepressant medication.

According to Challiner & Griffiths (2000): ECT involves application of electrodes to the head of the client to deliver an electrical impulse to the brain; this causes a seizure. It is believed that the shock stimulates brain chemistry to correct the chemical imbalance of depression; Studies regarding the efficacy of ECT are as divided as the opinions about its use. Some studies report that ECT is as effective as medication for depression, while other studies report only short-term improvement. Likewise, some studies report that side effects of ECT are short-lived, while others report they are serious and long-term (Videbeck, 2003:334).

3.9.4. Psychotherapy:

Cognitive behavior therapy, interpersonal therapy, and problem solving have all been shown to be effective for treating depression (Peveler et al, 2003:13).
Rush (2000) considered a combination of psychotherapy and medications the most effective treatment for depressive disorders. There is no one specific type of therapy that is better for the treatment of depression. The goals of combined therapy are symptom remission; psychosocial restoration; prevention of relapse or recurrence; reduced secondary consequences such as marital discord or occupational difficulties; and increasing treatment compliance (Videbeck, 2003:334).

3.9.5. Interpersonal therapy:

Interpersonal therapy, developed by Gerald Klerman, focuses on one or two of a patient's current interpersonal problems. This therapy is based on two assumptions. First, current interpersonal problems are likely to have their roots in early dysfunctional relationships. Second, current interpersonal problems are likely to be involved in precipitating or perpetuating the current depressive symptoms.

The interpersonal therapy program usually consists of 12 to 16 weekly sessions and is characterized by an active therapeutic approach. Intrapsychic phenomena, such as defense mechanisms and internal conflicts, are not addressed. Discrete behaviors such as lack of assertiveness, impaired social skills, and distorted thinking may be addressed but only in the context of their meaning in, or their effect on, interpersonal relationships (Sadock and Sadock, 2007: 553).

3.9.6. Behavior therapy:

Behavior therapy seeks to increase the frequency of the client's positively reinforcing interactions with the environment and to decrease negative interactions. It also may focus on improving social skills (Videbeck, 2003:334).The behavioral treatment that derives from this theory of depression involves helping patients increase their frequency and quality of pleasant activities. It has been found that depressed patients have low rates of pleasant activities and obtained pleasure; their mood covaries positively with rates of pleasant activities and inversely with rates of aversive activities (Davidson et al, 2004:168).

3.9.7. Cognitive therapy:

Cognitive therapy, originally developed by Aaron Beck, focuses on the cognitive distortions postulated to be present in major depressive disorder. Such distortions include selective attention to the negative aspects of circumstances and unrealistically morbid inferences about consequences, Studies have shown that cognitive therapy is effective in the treatment of major depressive disorder. Most studies found that cognitive therapy is equal in efficacy to pharmacotherapy and is associated with fewer adverse effects and better follow-up than pharmacotherapy. Some of the best controlled studies have indicated that the combination of cognitive therapy and pharmacotherapy is more efficacious than either therapy alone, although other studies have not found that additive effect (Sadock and Sadock, 2007: 553).

Cognitive behavior therapy (CBT) has been shown to be useful in helping people to overcome or at least reduce their level of depression. CBT focused on assessing, evaluating, and changing automatic thoughts or self-statements (Dowd, 2004:417).

3.9.8. Family therapy:

Family therapy is not generally viewed as a primary therapy for the treatment of major depressive disorder, but increasing evidence indicates that helping a patient with a mood disorder to reduce and cope with stress can lessen the chance of a relapse. Family therapy is indicated if the disorder jeopardizes a patient's marriage or family functioning or if the mood disorder is promoted or maintained by the family situation (Sadock and Sadock, 2007: 555).

It is recommended if there is a relation between the symptoms with patient and reaction with his family. Also it tests the role of patient in his family and how the family affects on continuity of depression condition or not.

3.9.9. Social therapy:

Helping the patient socially and solving his social problems and establishing appropriate environmental changes to decrease his suffering **(**Alhajjar, 2005:78**).**

3.9.10. Vagal Nerve Stimulation:

Experimental stimulation of the vagus nerve in several studies designed for the treatment of epilepsy found that patients showed improved mood. This observation led to the use of left vagal nerve stimulation (VNS) using an electronic device implanted in the skin, similar to a cardiac pacemaker. Preliminary studies have shown that a number of patients with chronic, recurrent major depressive disorder went into remission when treated with VNS. The mechanism of action of VNS to account for improvement is unknown. The vagus nerve connects to the enteric nervous system and, when stimulated, may cause release of peptides that act as neurotransmitters (Sadock and Sadock, 2007: 555).

3.9.11. St. John's wort:

The extract from St. John's wort (Hypericum perforatum), a bushy, wild-growing plant with yellow flowers, has been used for centuries in many folk and herbal remedies. Today in Europe, it is used extensively to treat mild to moderate depression. In the United States, it is one of the top-selling botanical products.

Other research has shown that St. John's wort can interact unfavorably with other medications, including those used to control human immunodeficiency virus (HIV) infection. with certain medications used to treat heart disease, depression, seizures, certain cancers, and organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Because of these potential interactions, patients should always consult with their doctors before taking any herbal supplement (National Institutes of Health, 2008:15).

Stigma of mental illness

Introduction:

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.

Origins of stigma:

Ancient Greece – means "mark;" marks were placed on slaves to identify their position in the social structure and indicate they were of lesser value (Sherman, 2007:3).

3.10. Definitions of stigma:

Erving Goffman (1963): showed one of the first modern definitions of stigma. "…an attribute that makes him (sic) different from others…. He is reduced in our minds from a whole and usual person to a tainted, discounted one (Kondrat, 2008:15).

The Surgeon General of the United States (1999) has identified stigma as "Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others , Fulton and Rebecca (1999): defend the Stigma is a serious impediment to the well-being of those who experience it. It affects people while they are ill, while they are in treatment, and healing, and even when a mental illness is a distant memory. Clearly, it seems difficult to get rid of the stigmatizing labels once the stigmatizing behavior has occurred (Scheffer, 2003: 3).

The Surgeon General's Report on Mental Health (1999) identified stigma as one of today's foremost obstacles to improved mental health care, noting that "stigma tragically deprives people of their dignity and interferes with their full participation in society." Stigma in relation to people with mental illness is often a combination of a lack of relevant knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination) (Baun, 2009: 1).

Stigma is a negative attribute that marks an individual or group as being unacceptable, unworthy and inferior. Corrigan (2003) said: Mental illness engenders stigmatizing responses in others and leads to discriminatory behavior, as it carries with it labels of unreliableness, unattractiveness and dangerousness (Bromley & Cunningham, 2004:371).US Department of Health and Human Services(1999): has identified stigma as a significant impediment to the treatment of mental disorders (Couture and Penn, 2003:391).

Label:

Blankertz (2001): defined label as the formal makes the mental illness visible to society.

Label is the words that are used to diagnose mental illness such as 'anxiety', 'schizophrenia' or 'manic depression' are bound up with different assumptions. Some being more loaded with prejudice than others (schizophrenia is often regarded more negatively than stress, or post natal depression which is now more often seen as a 'natural' process conveying little shame (Morgan, 2003:12)

Self stigma:

Corrigan and kleinlein (2005): defined self stigma as the consequences of people with mental illness applying stigma to themselves.

Corrigan and kleinlein (2005): defined public stigma as the results of a native public endorsing the stereotypes of mental illness.

Discrimination:

Corrigan et al (2005) said: discrimination formed by sociopolitical forces, representing "the policies of private and governmental institutions that restrict the opportunities of stigmatized groups (Woll, 2007:6).

Implicit Bias:

According to teachman et al (2006) bias is unintentional or less strategy, often lying outside conscious control and awareness, and more likely to predict discriminatory behaviors (Woll, 2007:6).

3.11. What causes of stigma?

There are a number of reasons for stigma:

- 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.
- 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).
- 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.
- 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.
- 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.

3.11.1. The causes and consequences of stigma against older people with mental disorders:

Causes

Stigma has both cognitive and behavioral components, both of which need to be addressed by any actions designed to counter it. It arises out of normal human cognitive processes that evaluate threat and risk, organize social knowledge, and determine self-perception. In the case of older people with mental disorders**, these result in:**

- Ignorance / misconceptions of the facts regarding the nature of old age, and of mental disorders and their treatment.
- Fear of injury, contamination, the unknown, the burden of care, of one's own ageing.
- Drive for social conformity and security and the subsequent suppression of deviance.
- Internalization of stigmatizing ideas (self-stigma) by those affected (sufferers, families, professionals).

3.11.2. Stigma against older people with mental disorder is reinforced by:

- Cultural factors, such as differences in specific beliefs regarding the value of older members of society, of the causation of mental illness, and what it implies about the patient's family.

- Social and economic instability and crisis: war, migration, the influx of refugees, etc., encourage the stigmatisation of people with mental illness at all ages.
- The actual or perceived absence or inadequacy of preventive strategies and treatments for mental disorders;
- The lack of information systems to educate both professionals and the general public.
- Gender discrimination, which may be greater in older populations, where women outnumber men (i.e., there is a 'triple jeopardy' for elderly women with mental illness, so far as stigma is concerned).
- Any rewards for those who stigmatize: financial, denial of problems enhanced social status, enhanced self-esteem (WHO and WPA, 2002:10).

3.12. On How Stigma is manifested

According to Corrigan (1999) Stigma is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders.

Some of the ways in which stigma is manifested include:

- Avoidance of seeking treatment.
- Decreased employment
- Low self worth
- Stigma by association (Scheffer, 2003:3).

3.12.1. The experience of stigma

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

3.12.2. 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).

3.13. Why stigma matters?

Stigma is dangerous because it interferes with understanding, obtaining support from friends and family, and it delays getting help (sometimes for years). It can lead to:

- Denial of signs of mental illness in self.
- Failure to recognize signs in others.
- Secrecy and failure to seeking help.
- Ostracism by one's friends, family and co-workers.
- Self-blame
- Substance abuse or problem gambling to control symptoms.

- Isolation.
- Problems in relationships, school and work (Everett, 2006:13).

In the extreme, it can lead to:

- Loss of career
- Family breakdown
- Suicide (Everett, 2006:14).

3.13.1. 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).

3.14. Stigma as a Barrier to Recovery.

The researcher believes that the stigma associated with having a serious mental illness which resumes to be one of the major barriers to the recovery process. Shyness and secrecy lead people to deny distress to the point that they do not ask for help and finished with more chronic forms of illness

The Surgeon General's report on mental health (1999) determined stigma to be "the most formidable obstacle to future progress in the arena of mental illness and health .Stigma as an impediment to recovery: Stigma implies permanency – people have entered a social category from which there is believed to be no exit (Everett, 2006:17). Perlick (2001) said: Recovery from severe mental disabilities (SMD) represents an achievable goal for persons with SMD. Yet the stigma associated with having SMD is a barrier to mental health recovery, Link & Phelan(2001) noted stigma concepts have been associated with reduced life chances or opportunities for persons receiving psychiatric treatment (Kondrat, 2008:3).

Corrigan (2004) said: many relevant factors exist that play a role in a person's decision to seek mental health services. The most frequently cited reason for why people do not seek counseling and other mental health services is the stigma associated with mental illness and seeking treatment. According to Vogel et al (2006) The "stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable", While Brown & Bradley (2002) considered Stigma has consistently been cited as one of the main factors inhibiting individuals from seeking mental health care and there is a great deal of research suggestive of the strong stigma attached to mental illness and seeking psychological services (Hobson, 2008:6).Buetler (2007) said: Stigma is directed toward individuals with mental health concerns and toward mental health services. The APA states that "20% of Americans chose not to seek help from a mental health professional because they feel there is a stigma associated with therapy (Hobson, 2008:7).

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 depression leads depressed persons 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 affect 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.

3.15. The work of Jones and colleagues (1984) they propose six dimensions of stigma:

- Concealability: how obvious or detectable a characteristic is to others.
- Course: whether the difference is life-long or reversible over time.
- Disruptiveness: the impact of the difference on interpersonal relationships
- Aesthetics: whether the difference elicits a reaction of disgust or is perceived as unattractive.
- Origin: the causes of the difference, particularly whether the individual is perceived as responsible for this difference.
- Peril: the degree to which the difference induces feelings of threat or danger in others (Brohan et al, 2010:2).

3.16. Stigma by association

Goffman (1963) said: Stigma affects not only people with mental illnesses, but their families as well. The process by which a person is stigmatized by virtue of association with another stigmatized individual has been referred to as 'courtesy'.
According to Mehta & Farina (1988) being a close relative of a person with SMI creates 'a particularly difficult and delicate position if they cannot remove themselves, for they are both marker and marked'. To widen the knowledge of stigma by association in families of patients with SMI it might be valuable to measure aspects of psychological distress and psychological burden perceived by members of these families. Understanding how the situation of stigma affects family members both in connection with psychological feelings towards the ill person and in connection with psychiatric services can increase the knowledge of the situation of these families (ostman and kjellin, 2002:494).

3.17. Stigma of depression

The stigma of depression is different from that of other mental illnesses and largely due to the negative nature of the illness that makes depressives seem unattractive and unreliable. Self stigmatization makes patients shameful and secretive and can prevent proper treatment. It may also cause somatisation. A major contributing factor is that depression for those who have not had it is very hard to understand and so can be seen as a sign of weakness (Wolpert, 2001:221).

In trying to understand stigma, it is essential to recognize the effect that depression has on those associated with the depressed individual. Depressives are both negative and self involved. Other studies confirm that depressed individuals have a negative impact on those with whom they interact. The shame and stigma associated with depression can prevent those with the illness admitting they are ill. It is remarkable how it is sometimes possible to conceal one's depression. There is also the stigma of taking antidepressant medication which is perceived as mind altering and addictive. Stigma may also cause somatic symptoms as it is more acceptable to talk of stomach ache and fatigue than mental problems.

Mental illnesses, such as depression, are responsible for a growing disease burden worldwide. Unfortunately, effective treatment is often impeded by stigmatizing attitudes of other individuals, which have been found to lead to a number of negative consequences including reduced help-seeking behavior and increased social distance (Cook and Wang, 2010:1).

- Depression is seen as a natural consequence of ageing, loss and physical illness (by patients, their families and professionals), and is therefore not diagnosed or treated. Some symptoms of depression (e.g. anhedonia, social withdrawal) are particularly likely to be misinterpreted in this way.
- Certain treatments (e.g. ECT, drugs) that are perceived as more stigmatising than others (e.g. psychotherapy) are more likely to be offered to older people.
- Depressive cognitions (e.g. guilt, pessimism, hopelessness) and behaviours (e.g. suicidal acts) have a stigmatising impact on the sufferers and their families.
- Depression and anxiety are seen as marks of personal weakness, by others and by patients themselves (WHO and WPA, 2002:14).

According to Corrigan and lundin (2001) self stigma and depression share many symptoms, including:

- low self –esteem
- loss of hope
- Loss of confidence
- Feeling of helplessness
- Giving up on goals
- Denying credit for accomplishments
- Self- blame for failure
- Problems with sleep, fatigue, eating patterns
- Loss of interest in keeping on living (Woll, 2007:7).

3.18. 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).

Self-stigma is the loss of self-esteem and self-efficacy that occurs when people internalize, Corrigan (2000) defined Public stigma conceptualized as a staged process. In the first stage, the general public infers mental illness from explicit cues: psychiatric symptoms, social-skills deficits, physical appearance, and common labels.

Baldwin & Johnson (2004) considered Public stigma harms people who are mentally ill in several ways. Stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving their life goals. Studies have shown that public stereotypes and prejudice about mental illness have a deleterious impact on obtaining and keeping good jobs (Zeev, 2010: 319).

3.18.1. Impact on Help-Seeking:

Nearly more than half of all people with diagnosable mental disorders do not seek treatment. Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment, the stigmatization of mental illness and the lack of information on the symptoms of mental illness are seen as the main barriers to seeking help for mental health problems.

3.18.2. Impact on Employment:

Stigmatization is generally associated with decreased employment. Consumer Experience with Stigma.

3.18.3. Impact on Self-Worth:

Stigma leads to low self-esteem, isolation, and hopelessness., Further, low self-worth in response to stigmatization is found to be a predictor of poorer social adjustment.

3.18.4. Impact on Families:

Stigma effects aren't only on people with mental illnesses, but also on their families as well. Families commonly report ‘stigma by association’ resulting in discriminatory and prejudicial behaviors towards them (Scheffer, 2003:3).

Many people who would benefit from mental health services opt not to pursue them or fail to fully participate once they have begun. One of the reasons for this disconnect is stigma; people decide not to seek or fully participate in care. Stigma yields 2 kinds of harm that may impede treatment participation: It diminishes self-esteem and robs people of social opportunities (Corrigan, 2004:614).

3.19. Public Stigma: Harm to Social Opportunities:

Stigma harms people who are publicly labeled as mentally ill in several ways. Stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving life goals.

The negative impact of public stigma is also observed in the general health care system; people labeled mentally ill are less likely to benefit from the depth and breadth of available physical health care services than people without these illnesses.

People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities: employers and landlords (Corrigan, 2004:616).

3.20. Self-Stigma: Harm to Self-Esteem:

According to Link & Phelan (2001) people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued because of their psychiatric disorder (Corrigan, 2004:618).

3.21. The Media's Impact on Public Perceptions of Mental Illness:

Media depiction of individuals with mental illness is commonly referred to as a challenging source of depression. Stigma due to negative media coverage impedes recovery, triggers discrimination and prejudice, and creates barriers to seeking and finding decent housing, employment, and education. The effects of stigma are therefore both cyclical and burdensome. Lack of safe, affordable, available housing contributes to homelessness, thereby adding to the burden of mental illness, and increasing the challenge of daily survival. Inadequate, unhealthy living conditions and increased stress are hardly conducive to improved mental functioning. Reduced employment opportunities lead to poverty.

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 (Banu, 2009: 3).

Recovery

3.22. Introduction:

The third part from second chapter discusses the recovery; It covers the definitions, components, and the relationship between recovery and stigma.

Any illness may involve significant changes in a personal level of functioning. People who have been seriously ill are more likely to have problems resuming their usual life and activities.

The goal of mental health care should promote an optimal level of wellness and full recovery from the illness. The stigmatization of people who have a mental illness not only adds to difficulties in their daily life: it also prevents them from getting access to treatment and care, thus further worsening their usually very difficult position (WPA, 2005:1).

3.23. Definitions of Recovery:

According to Webster's Dictionary (1984) the formal definition of the word recovery means "to get back: regain" or "to restore (oneself) to a normal state (Onken et al, 2002:7).

Recovery has been defined as: a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any limitations imposed by their condition (Kirby et al, 2009:5).

Stocks (1995) defined Recovery as an ongoing process of growth, discovery, and change. While Deegan (1988) defined Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again. The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution".

Chamberlin (1997) said: "One of the elements that make recovery possible is the regaining of one's belief in oneself (Ralph, 2000:7). Beale & Lambric (1995) indicated Recovery includes personal empowerment and a spirituality/philosophy, which gives meaning to life. It is accomplished one step at a time. It is deeply personal, and can be done only by the individual who is recovering .According to DeMasi (1996) recovery It includes physical and mental health, and economic and interpersonal well-being (Ralph, 2000:8).

According to Anthony(1993) Recovery has been defined as a person with serious mental illness living a satisfying life within the constraints of his/her mental illness, and he said recovery is a continuing, deeply personal, individual effort that leads to growth, discovery and the change of attitudes, values, goals and perhaps roles. (Potokar, 2008:27).

Deegan (1996) said: The goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human (Roberts and Wolfson, 2004:37). While Long (1994) said: a recovery paradigm is each person's unique experience of their road to recovery. Recovery paradigm included reconnection which included the following four key ingredients: connection, safety, hope, and acknowledgment of my spiritual self. Blanch (1993) said: recovery it involves hope, courage, adaptation, coping, self esteem, confidence, a sense of control (Ralph, 2000:8).

Mental health recovery is a journey of healing and transformation enabling a person with mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her potential (US department of health and human services, 2004:1).

According to Spaniol et al (1994) Recovery is the process by which people with psychiatric disability rebuild and further develop these important personal, social, environmental, and spiritual connections, and confront the devastating effects of stigma through personal empowerment. Recovery is the process of adjusting one's attitudes, feelings, perceptions, beliefs, roles, and goals in life. It is a process of self-discovery, self-renewal, and transformation (Johnson, 2000:6).

Andresen et al (2003) defined Psychological recovery as the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination" Psychological recovery differs from the aforementioned, and has been found to be most compatible with consumer beliefs, because it makes no statement about the cause of mental illness, the necessity of medication, does not define recovery by roles valued by society, or define whether the illness is still present during recovery—it actually allows for the presence of symptoms and ongoing management of the illness in the midst of recovery. Markowitz (2001) said: The recovery process is involve symptom control, dealing with discrimination and stigma by society, regaining a positive sense of self, and attempting to lead a satisfying and productive life (Hupp, 2008:15).The concept of recovery emphasizes a person's capacity to have hope and lead a meaningful life, and suggests that treatment can be guided by attention to life goals and ambitions. It recognizes that patients often feel powerless or disenfranchised, that these feelings can interfere with initiation and maintenance of mental health and medical care; it focuses on wellness and resilience and encourages patients to participate actively in their care, particularly by enabling them to help define the goals of psychopharmacologic and psychosocial treatments. The concept of recovery values include maximization of 1) each patient's autonomy based on that patient's desires and capabilities, 2) patient's dignity and self respect, 3) patient's acceptance and integration into full community life, and 4) resumption of normal development. The concept of recovery focuses on increasing the patient's ability to successfully cope with life's challenges, and to successfully manage their symptoms. The application of the concept of recovery requires a commitment to a broad range of necessary services and should not be used to justify a retraction of resources. The concept of recovery is predicated on a partnership between psychiatrist, other practitioners, and patient in the construction and direction of all services aimed at maximizing hope and quality of life (APA, 2005:1).

3.24. The History of Recovery and the Consumer-Survivor Movement.

Recovery as a concept arose from and is deeply rooted in the consumer movement. Starting in the 1930's, there has been a burgeoning first person narrative by people living with mental illness describing their journey towards recovery, Recovery as an ideal gained significant traction in the 1970's when it was associated with "liberation" as state hospitals closed their doors and people were moved with minimal support into the community. Early leaders such as **Judy Chamberlain** describe consumer-focused recovery as a fundamental challenge to "mentalism", or second class citizenship and discrimination, which was based on a belief that people with mental illness are unable to make their own decisions, function independently, or take care of themselves, Thereby requiring the support and assistance of well-intentioned others to meet their needs (Martin 2008:5).

Beginning in the 1950s, escalating in the 1960, and becoming solidified in the 1970s, these consumers (who were originally groups organized of lay persons) have organized into consumer-oriented organizations that exist on all governmental and societal levels**.** These organizations insist that each consumer has a voice in the delivery and decision-making processes of their mental health services.

Frese & Davis (1997) noticed the pioneers and followers of this movement support the principle that no person shall be hospitalized involuntarily, as well as agreeing upon the government's right to subject dangerous (even though mentally unstable) individuals to the criminal justice system, The consumer-survivor movement began in the United States immediately following the Civil War. McLean (1995) described Empowerment is an important concept in the consumer-survivor movement, as well as in recovery research. To the mental health consumer, empowerment embodies self-determination and control over their lives, in addition to their treatment, and has become the fundamental goal of many consumers (Hupp, 2008:12).

Anthony (1993) said: after the period of psychiatric deinstitutionalization, the ideas of recovery began to grow. While Corrigan & Phelan (2004) said the consumer-survivor movement served to give hope to those diagnosed with severe mental illness (SMI), and as a result the recovery vision from the consumer-survivor perspective is most concerned with the process of recovery. According to Ellis & King (2003) The idea of a recovery vision for mental health consumers has resulted from both the consumer-survivor movement's gains in patient rights, as well as the mental health profession's gains in knowledge about the prognosis of SMI (Hupp, 2008:13).

3.25. Stages of Recovery

According to Andresen et al (2006) some people may take years for the light of hopefulness to penetrate the darkness of despair or denial. Although not a linear process, people recovering from serious mental illness describe going through a series of stages on their journey to recovery. These include:

- **Moratorium** – A time of withdrawal characterized by a profound sense of loss and hopelessness;
- **Awareness** – Realization that all is not lost and that a fulfilling life is possible.
- **Preparation** – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills.
- **Rebuilding** – Actively working towards a positive identity, setting meaningful goals and taking control of one's life.
- **Growth** – Living a meaningful life, characterized by self-management of the illness, resilience and a positive sense of self (Martin, 2008:13).

3.26. Key themes in recovery include the following:

Deegan, (1988), Leete, (1989); Unzicker, (1989) determine common themes of recovery as the following.

- Recovery is the reawakening of hope after despair.
- Recovery is breaking through denial and achieving understanding and acceptance.
- Recovery is moving from withdrawal to engagement and active participation in life.
- Recovery is active coping rather than passive adjustment.
- Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.
- Recovery is a complex journey from alienation to purpose.
- Recovery is not accomplished alone–it involves support and partnership. (Ralph, 2000:11).
- Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness.
- Recovery involves a shift of emphasis from pathology, illness and symptoms to health, strengths and wellness.
- Hope is of central significance. If recovery is about one thing it is about the Recovery of hope, without which it may not be possible to recover and that hope can arise from many sources.
- Recovery involves a process of empowerment to regaining active control over one's life.
- Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as sources of identity and belonging.
- Recovery is supported by resolving personal, social or relationship problems and both understanding and realistically coming to terms with ongoing illness or disability.
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles in society and gaining access to mainstream services that support ordinary living such as housing, adequate personal finances, education and leisure facilities.

- There is a pivotal need to discover (or rediscover) a positive sense of personal identity, separate from illness and disability.
- The language used and the stories and meanings that are constructed around personal experience, conveyed in letters, reports and conversations, have great significance as mediators of recovery processes.
- Services are an important aspect of recovery but the value and need for services will vary from one person to another.
- Treatment is important but its capacity to support recovery lies in the Opportunity to arrive at treatment decisions through negotiation and Collaboration.
- The development of recovery-based services emphasizes the personal qualities of staff as much as their formal qualifications, and seeks to cultivate their capacity for hope, creativity, care and compassion, imagination, acceptance, realism and resilience (Humphries et al , 2007:6).

3.27. The Recovery Model is built upon principles articulated by Anthony (1994):

- Recovery can occur without professional intervention. The task of professionals is to facilitate recovery; the task of consumers is to recover.
- Recovery can occur whether ones sees mental illness as biological or environmental.
- A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
- A recovery vision is not a function of one's theory about the causes of mental illness.
- Recovery can occur even though symptoms reoccur. The episodic nature of severe mental illness does not prevent recovery.
- Recovery changes the frequency and duration of symptoms. As one recovers, the symptom frequency and duration appear to have been changed for the better. That is, symptoms interfere with functioning less often, and for briefer periods of time … and return to previous function occur more quickly after exacerbation.
- Recovery does not feel like a linear process. Recovery involves growth and setbacks, periods of rapid change and little change … The recovery process feels anything but systematic and planned.
- Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult that impairment issues. An inability to perform valued tasks and roles, and the resultant loss of self esteem, are significant barriers to recovery.
- Recovery from mental illness does not mean that one was not really mentally ill. People who have recovered or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering (Johnson, 2000:6), (Voinovich and Hogan, 1995:8).

3.28. Fundamental Components of Recovery.

- **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. by definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities.
- **Non-Linear**: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles.
- **Peer Support**: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respec**t: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage.

- **Hope:** Recovery provides the essential and motivating message of a better future that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process (Martin, 2008:11), (US department of health and human services, 2004:1).

The researcher thinks that the key word in recovery process is hope, the hope that leads to recovery when the individual's belief that recovery is possible, focusing on strengths rather than on weaknesses, and looking forward rather than ruminating on the past.

3.29. Recovery terminology and associated concepts:

Some people use terminology with similar or slightly different meanings from recovery. It is unhelpful to see these associated concepts as in competition with one another as the recovery concept can encompass all of these meanings, but is not Restricted to any one of them:

- **Rehabilitation**: an organized statutory or voluntary sector programme designed to improve physical, mental, emotional and social skills to enable a transition back into society and the workplace.
- **Discovery**: taking a personal journey to new understandings of oneself and the world, rather than simply returning to the old self.
- **Restitution***:* regaining some of what has been lost or taken away due to ill-health, for example, social status, contacts, self-esteem.
- **Self-care**: looking after oneself well.
- **Self-management***:* making one's own health decisions and learning to manage long-term health problems, so as to live well with the minimum reliance on services.
- **Self-directed care***:* being informed and having the ability to exercise choice and responsibility for care provided to you by others.
- **Coping strategies and strategies for living***:* finding what helps one cope with problems and building one's own set of tools for dealing with mental or physical health problems.
- **Healing and wellness***:* rediscovering one's inner capacity for self-healing, with or without help from a practitioner and achieving a state of well-being, even if some of the symptoms remain.
- **Resilience**: having the ability to survive and to learn from life's challenges
- **Transformation:** a term used with respect to a process, outcome and vision for individuals and services that is not an end in itself but rather an intermediate state through which the goal of facilitating recovery in people's lives is realised (Humphries et al , 2007:7).

3.30. Important Factors to Recovery

- Clinical care
- Hope
- Support
- Work/meaningful activity
- Empowerment
- Community involvement
- Access to resources
- Education/knowledge
- Self-esteem
- Self-help
- Spirituality
- Physical health
- Self-responsibility
- Self-directed
- Individualized and person-centered
- Holistic
- Strengths based
- Growth oriented (Kopache, 2008: 5).

3.31. Recovery and Stigma:

Link (2006) mentioned that Stigma and social exclusion are important contributing factors in the occurrence and persistence of mental illness/ disorders and result in significant discrimination in multiple areas of living. Although there has been a decade of public education to reduce the stigma towards mental illness, there is evidence to show that it is increasing towards people living with serious mental illness and addictions. Professional training and public education has traditionally emphasized that mental illness is a biologically-based illness or brain disorders that is neither anyone's 'fault' nor a sign of personal weakness. An unexpected consequence may be that the public looks upon people with mental illness as incapable of recovering and therefore hopeless, leading to increasing social distance and discrimination (Martin, 2008:17).

From the researcher's view, there is a negative relationship between stigma and recovery and when the psychiatric patient has high level of stigma his recovery level will be low, Stigma is considered as one of the main factors inhibiting individuals from seeking mental health care, the main reason for why people do not seek counseling and other mental health services is the stigma associated with mental illness.

3.32. Recovery and the medical model:

There are several meanings of the recovery concept which developed from the consumer movement these definitions presumably fall along a continuum: the medical model definition, the rehabilitative model definition, and the empowerment model definition. According to the medical model, mental illness is viewed as a disease and recovery occurs when an individual is "cured"—when he or she returns to their former health state prior to the onset of their mental illness (Hupp, 2008:13).

Allot (2003) said: There is differences between the recovery and medical model as the following:

3.32.1. The recovery model focuses on the following:

- Distressing experience
- Interest centered on the person
- Pro-health.
- Strengths based.
- Experts by experience.
- Personal meaning.
- Understanding
- Humanistic.
- Growth and discovery.
- Choice.
- Transformation.
- Self management.
- Self control
- Personal responsibility.

3.32.2. The medical model focuses on the following:

- Psychopathology
- Interest centered on the disorders.
- Anti-disease.
- Treatment based.
- Doctors and patients.
- Diagnosis.
- Recognition.
- Scientific
- Treatment
- Compliance
- Return to normal
- Experts care coordinators
- Bringing under control.
- Professional accountability (Roberts and Wolfson, 2004:40).

3.33. Ralph (2000) identified the following four dimensions of recovery found in personal accounts:

Internal factors: factors that are within the consumer, such as awareness of the toll the illness has taken, recognition of the need to change, insight as to how this change can begin, and the determination it takes to recover.

Self-managed care: an extension of the internal factors in which consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face.

External factors: include interconnectedness with others, the supports provided by family, friends, and professionals, and having people who believe that they can cope with, and recover from, their mental illness.

Empowerment: a combination of internal and external factors—where internal strengths are combined with interconnectedness to provide self-help, advocacy, and caring about what happens to ourselves and to others (Onken et al, 2002:8).

3.34. The difference between rehabilitation and recovery:

Psychiatric and psychosocial rehabilitation involve targeted interventions which aid individuals to acquire and apply the skills, supports, and resources required to live a fulfilled life in their chosen community with minimal ongoing professional intervention. The aim of rehabilitation is the restoration of function and minimization of psychiatric disability through the development of strengths, restoration of hope, environmental modifications, and enhancement of vocational potential and maximization of social and recreational networks.

Deegan (1988) said: Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability. Recovery then forms the basis upon which rehabilitation services can be developed. It provides a framework that goes beyond offering people somewhere to go during the day. A framework of recovery ensures that hope, respect and pathways to community participation are incorporated into the day to day activities of rehabilitation programs, and rehabilitation services should not be considered the only vehicle for recovery. Instead rehabilitation services are one component of a comprehensive service system that collectively works towards the goal of recovery (Buckland, 2005:17).

According to Roberts et al (2006) Recovery is not the same thing as rehabilitation although they are often used interchangeably. Within psychiatry, rehabilitation medicine, through the use of the psychosocial rehabilitation model is beginning to refine its practices to incorporate more of the recovery principles with a greater emphasis on self-management, and a strengths-based approach, which emphasizes what people can rather than can't do (Martin, 2008:10).

3.35. Role of Work in Recovery

In this new vision of recovery, work plays an important role in recovery from mental illness boring, unfulfilling work can lead to stresses which contribute towards mental illness. Without work, or another equivalent social role (parent or student), a person loses membership in this society and the identity which accompanies membership. It then becomes necessary to assume a new identity as a consumer. The movement to find jobs for people labeled with mental illness as mental health providers helps many of us to regain an identity as worker and member of society and thereby recover from the mental illness (Fisher, 2011:3).

Previous studies:

The researcher shows previous studies in two main axis, the first axis is about stigma, where the second axis is about the recovery.

3.36. previous studies about the stigma of mental illness:

3.36.1. 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.

3.36.2. Descriptive epidemiology of stigma against depression in a general population.

Study conducted by Cook and Wang (2010) in Canada, aimed to estimate the percentages of various stigmatizing attitudes toward depression in a general population sample and to compare the percentages by demographics and socioeconomic characteristics.

The method of this study was a cross-sectional telephone survey in Alberta, Canada, between and June 2006. Random digit dialing was used to recruit participants who were aged 18-74 years old (n = 3047). Participants were presented a case Vignette describing a depressed individual, and responded to a 9-item Personal Stigma questionnaire. The percentages of stigmatizing attitudes were estimated and compared by demographic and socioeconomic variables.

The result showed that: 45.9% of participants reporting that they believed the person with depression in the case vignette to be unpredictable. This was followed by the refusal to vote for depressed individuals (39.5%), not wishing to employ individuals suffering from depression (22.1%), depressed individuals being dangerous (21.9%), that people with depression could “snap out of it” if they wanted (16.7%), and that they would not tell others of their depression (13.6%). Significant differences in stigmatizing attitudes were found by Gender, age, education, and immigration status. A greater proportion of men than women held stigmatizing views on each stigma item. No consistent trend Emerged by age in stigma against depression. Participants with higher levels Of education reported less stigmatizing attitudes than those with less Education. Participants who were not born in Canada were more likely to hold Stigmatizing attitudes than those who were born in Canada.

3.36.3. 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 of hospitalizations. 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.

3.36.4. 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.

3.36.5. Socio-Demographic Correlates of Stigma Attached to Mental Illness.

Study conducted by Ansari et al (2008) in Pakistan, .aimed to identify socio-demographic 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 in-patient 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.

3.36.6. Predictors of depression stigma.

Study conducted by Griffiths et al (2008) in Australia aimed to investigate and compare the predictors of personal and perceived stigma associated with depression.

Three samples were surveyed to investigate the predictors: a national sample of 1,001 Australian adults; a local community sample of 5,572 residents of the Australian Capital Territory and sample ages from 18 to 50 years; and a psychologically distressed subset (n = 487) of the latter sample. Personal and Perceived Stigma were measured using the two subscales of the Depression.

Stigma Scale. Potential predictors included demographic variables (age, gender, education, country of birth, remoteness of residence), psychological distress, depression literacy and level of exposure to depression. Not all predictors were used for all samples.

The result showed that Personal stigma was consistently higher among men, those with less education and those born overseas. It was also associated with greater current psychological distress, lower prior contact with depression, not having heard of a national awareness raising initiative, and lower depression literacy. These findings differed from those for perceived stigma except for psychological distress which was associated with both higher personal and higher perceived stigma. Remoteness of residence was not associated with either type of stigma.

3.36.7. Effect of stigma and working alliance on the quality of life of persons with severe mental disabilities receiving community-based case management services.

Study conducted by Kondrat (2008) in USA aimed to identify effects of stigma of mental illness on quality of life.

Information from the independent and dependent variables came from face-to-face interviews with research participants and by questionnaire. Use of a non-probability sampling.(convenience sample.). The researcher explored the differences between the sample of 175 consumers and the population of persons receiving ACT or ACT-like services from Southeast on gender, ethnicity, age, education, and primary psychiatric diagnosis. Research design is Non-experimental design. a cross-sectional design.

Results indicated perceptions of devaluation and discrimination and working alliance independently affected subjective quality of life., stigma withdrawal was unrelated to subjective quality of life. Perceptions of devaluation and discrimination seemed to be a barrier to positive appraisals of quality of life.

3.36. 8.The Economic Impact of Mental Health Stigma and Discrimination.

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.

3.36.9. The Stigma Scale: development of a standardized measure of the stigma of mental illness.

Study conducted by king et al (2007) in London, aimed to develop a standardized instrument to measure the stigma of mental illness.

The method of this study was used qualitative data from Interviews with mental health service users to develop a pilot scale with 42 items. The researcher's recruited193 service users in order to standardize the scale. Of these, 93 were asked to complete the questionnaire twice, 2weeks apart, of whom 60 (65%) did so. Items with a test-retest reliability kappa coefficient of 0.4 or greater were retained and subjected to common factor analysis. The results showed the final 28-item stigma scale has a three-factor structure: the first concerns discrimination, the second disclosure and the third potential positive aspects of mental illness. Stigma scale scores were negatively correlated with global self-esteem.

3.36.10. Stigma as a Barrier to Recovery: The role of stigma in the quality of life of older adults with severe mental illness.

Study by Depla et al (2005) aimed to investigate whether stigmatization of older adults with mental disorder is associated with the type of residential institution they live in or the type of disorder they suffer and, to assess the role of stigma experiences in their quality of life.

The method of this study was a cross-sectional study carried out of 131 older adults with severe mental illness, recruited in 18 elder care homes operating supported living programmes and in eight psychiatric hospitals throughout the Netherlands. Stigmatization was assessed with an 11-item questionnaire on stigma experiences associated with mental illness. quality of life was assessed with the Manchester Short Assessment of quality of life. To better ascertain the role of stigma, we also assessed in comparison the relationship of social participation to quality of life.

The result showed that 57% of the respondents had experienced stigmatization. No association emerged between residential type or disorder type and the extent of stigma experiences. Stigmatization did show a negative association with quality of life, a connection stronger than that between social participation and quality of life (WPA, 2005:31).

3.36.11. Barriers to the Diagnosis and Treatment of Depression in Jordan.

Study conducted by Nasir and Al-Qutob (2005) in Jordan, aimed to recognize the barriers to the diagnosis and treatment of depression in Jordan.

The method of this study was Five focus groups were conducted with the goal of exploring themes related to barriers to the diagnosis and treatment of depression, with a purposeful nationwide sample of 50 primary health care providers working in the public health clinics of the Jordanian Ministry of Health, Participant comments were transcribed and analyzed by the authors, who agreed on common themes.

The results showed, Lack of education about depression, lack of availability of appropriate therapies, competing clinical demands, social issues, and the lack of patient acceptance of the diagnosis and high level of mental illness stigma were felt to be among the most important barriers to the identification, diagnosis, and treatment of patients with depression in this population.

3.36.12. Attitudes towards help-seeking for mental health problems, in the United Arab Emirates

Study by Eapen and Ghubash (2004) in the United Arab Emirates, aimed to know attitudes help-seeking for mental health problems, Took a sample of 325 parents from the community were interviewed to ascertain their attitudes towards help-seeking for mental health problems.

The results showed that 62% of parents would not preferentially seek help from mental health specialists if their children developed psychiatric illness, stating the stigma attached to attending mental health services as one of the reasons for non-

consultation. In this study, there was a correlation between better parental education, socioeconomic status and occupation, and greater willingness to consult psychiatrists. The link between stigma and level of education is not as simple as one might expect. In this study, more education seems to lead to less perceived stigma associated with mental illness. (WPA, 2005:60).

3.36.13. Cross-national cultural attitudes towards stigma across the Arab world.

Study conducted by Al-Krenawi (2004) in the United Arab Emirates, Jordan and Palestine, cross-national attitudes to help-seeking among Arab women.

The sample of 262 female Arab Muslim undergraduate students was taken from Jordan, the United Arab Emirates, and Palestine. The women were questioned using a modified Orientation for Seeking Professional Help Questionnaire. As well as year of study.

The results revealed that marital status and age were found to be significant predictors of a positive attitude towards help-seeking. A high proportion of the participants said they would pray to God in times of psychological distress. One of the hypotheses of this study was that there would be statistically significant differences in predicting attitudes towards seeking professional mental health help between the countries studied. This was found not to be the case, supporting the idea that there may be common cross-national cultural attitudes towards stigma across the Arab world(WPA, 2005:60).

3.36.14. Stigma: the feelings and experiences of 46 people with mental illness.

Study conducted by Dinos et al (2004) in London, aimed to describe the relationship of Stigma with mental illness, psychiatric diagnosis, treatment and its consequences of stigma for the individual.

The method of study was narrative interviews were conducted by trained users of the local Mental health services; 46 patients were recruited from community and day mental health services in North London.

The result of study showed that Stigma was a pervasive concern to almost all participants .People with psychosis or drug dependence were most likely to report feelings and experiences of stigma and were most affected by them. Those with depression, anxiety and personality disorders were more affected by patronizing attitudes and feelings of stigma even if they had not experienced any overt discrimination.

3.36.15. Interpersonal contact and the stigma of mental illness.

Study conducted by Couture and penn (2003) in USA, The purpose of this study is to clarify the association between interpersonal contact and stigma of mental illness among SMI patients.

The method of this study reviewed the articles databases were conducted to identify all relevant studies. then studies grouped into retrospective and prospective reports of contact.

Participants in this study are 30 students who have volunteered to have 1 year of contact with individuals with SMI via the community program 'Compeer. The researchers used Non-experimental design. (Retrospective and prospective reports of contact).

The result of study showed that People who have had previous contact with a person of SMI may be less likely to stigmatize as a result of their life experiences.
Research shows that both retrospective and prospective contact tends to reduce stigmatizing views of persons with a mental illness.

3.36.16. Mental illness stigma and care seeking.

Study conducted by Cooper et al (2003) aimed to show whether stigma predicts care seeking across the various domains of care.

Method of this study was 79 participants whose drawn from the at-large student body of a local community college. This study assessed care seeking and mental illness stigma. Care seeking was measured through self-administration of the short scale for assessing the Attitudes toward Seeking Professional Psychological Help (ATSPPH). Stigma was assessed using the Attribution Questionnaire.

The result showed that it was found that respondents were less likely to seek services if they viewed people with mental illness as responsible for their disorder, did not pity them, reacted to them with anger, and were likely to withhold help.

3.36.17. Stigma by association: psychological factors in relatives of people with mental illness.

Study conducted by Ostman and Kjellin (2002) in Sweden, aimed to investigate factors of psychological significance related to stigma of the relatives.

162 relatives of patients in acute psychiatric wards following both voluntary and compulsory admissions were interviewed concerning psychological factors related to stigma. The result showed that a majority of relatives experienced psychological factors of stigma by association. Eighteen percent of the relatives had at times thought that the patient would be better off dead, and 10% had experienced suicidal thoughts. Stigma by association was greater in relatives experiencing mental health problems of their own, and was unaffected by patient background characteristics.

3.36.18. Stigma of Mental Illness.

Study conducted by Min et al (2001) aimed to identify relationships between stigma and mental illness.

The method of this study was the views of 300 psychiatric out-patients and day-patients at the National University Hospital and 100 mental health workers concerning stigma were sought. The control group comprised 50 cardiac out-patients.

A questionnaire was designed to elicit the patients' opinions on different forms of social discrimination and rejection. Questions fell into one of several categories. First of all, there were several questions asking subjects about the possible effects of stigma on self-esteem, relationships, job opportunities and insurance coverage. Next, subjects were requested to give their opinions on whether the mass media portrayed mental illness negatively. Finally, subjects were asked to indicate if they felt that increased public awareness of mental illness would be helpful.

The result of study show that a fair proportion of patients with schizophrenia or depression perceived that stigma had a negative effect on their self-esteem, relationships and job opportunities. The majority felt a need for an increase in public awareness of mental illness. In contrast, the cardiac patients reported very little stigmatization.

3.36.19. Stigma as a Barrier to Recovery: the consequences of stigma for the self esteem of people with mental illness.

Study conducted by link et al (2001) in New York City aimed to determine whether stigma affects the self-esteem of persons who have serious mental illnesses or whether stigma has few, if any, effects on self-esteem.

The methods of this study was Self-esteem and two aspects of stigma, namely, perceptions of devaluation-discrimination and social withdrawal because of perceived rejection, were assessed among 70 members of a clubhouse program for people with mental illness at baseline and at follow-up six and 24 months later.

The result of study showed that two measures of perceptions of stigma strongly predicted self esteem at follow-up when baseline self-esteem, depressive symptoms, demographic characteristics, and diagnosis were controlled for. Participants whose scores on the measures of stigma were at the 90th percentile were seven to nine times as likely as those with scores at the 10th percentile to have low self-esteem at follow-up.

3.36.20. Adverse Effects of Perceived Stigma on Social Adaptation of Persons Diagnosed With Bipolar Affective Disorder.

Study conducted by Perlick et al (2001) in New York, The purpose of this study was to evaluate the effect of concerns about stigma on social adaptation among persons with a diagnosis of bipolar affective disorder. The sample comprised 264 persons who were consecutively admitted to a psychiatric inpatient or outpatient service at a university-affiliated hospital and who met research diagnostic criteria for bipolar I disorder, bipolar II disorder, or schizoaffective disorder, manic type. Patients were

evaluated with use of the Schedule for Affective Disorders and Schizophrenia, Lifetime Version (SADS-L), the Brief Psychiatric Rating Scale (BPRS), and a measure of perceived stigma. Social adjustment was measured at baseline and seven months later with the Social Adjustment Scale (SAS).

The results showed, patients who had concerns about stigma showed significantly more impairment at seven months on the social leisure subscale but not on the SAS extended family subscale, after baseline SAS score and symptom level had been controlled for. More refined models using SAS-derived factors as dependent variables indicated that concerns about stigma predicted higher avoidance of social interactions with persons outside the family and psychological isolation at seven-month follow-up, after baseline SAS and BPRS scores had been controlled for.

3.36.21. Attitudes of relatives of the mentally ill towards mental illness.

Study conducted by El Defrawi et al (2001) in Egypt aimed to know attitudes of relatives of the mentally ill towards mental illness.

The researchers interviewed 282 accompanied members of families of patients with psychoses attending psychiatric treatment facilities in Ismailia, Egypt. The assessment of knowledge and attitudes towards mental illness was made using a questionnaire sheet that had been developed and designed from an ongoing anti-stigma campaign in Ismailia. The data collected included assessment of level of education, knowledge of diagnoses, causes and the nature of mental illness, symptoms and perceived social distance.

The results revealed that 75% of relatives thought that mentally ill people cannot work and are likely to be dangerous. Most would not consider marrying a mentally ill person. These data indicate that even high levels of contact with mentally ill persons may not reduce negative stereotypes and stigmatizing attitudes among the relatives of sufferers (WPA, 2005:61).

3.36.22. Perceived Stigma as a Predictor of Treatment Discontinuation in Young and Older Outpatients With Depression.

Study conducted by Sirey et al (2001) in New Yourk, aimed to examine the extent to which perceived stigma affected treatment discontinuation in young and older adults with major depression.

Two-stage sampling design identified 92 new admissions of outpatients with major depression. Perceived stigma was measured by using a version of the Stigma Coping Scale and assessed at admission. Discontinuation of treatment was recorded at 3-month follow-up.

The result of study showed that although younger patients reported perceiving more stigma than older patients, stigma predicted treatment discontinuation only among the older patients.

3.37. previous studies about recovery:

3.37.1. Recovery and Recurrence Following Treatment for Adolescent Major Depression.

Study conducted by Curry et al (2011) in USA. aimed to determine whether adolescents who responded to short-term treatments or who received the most efficacious short-term treatment would have lower recurrence rates, and to identify predictors of recovery and recurrence.

Design of this study was naturalistic follow-up study. The study conducted in twelve academic sites in the United States.
Randomized to 1 of 4 short-term interventions (fluoxetine hydrochloride treatment, cognitive behavioral therapy, their combination, or placebo) in the Treatment for Adolescents with Depression Study were followed up for 5 years after study entry (44.6% of the original Treatment for Adolescents with Depression Study sample).

The result showed that almost all participants (96.4%) recovered from their index episode of major depressive disorder during the follow-up period. Recovery by 2 years was significantly more likely for short-term treatment responders (96.2%) than for partial responders or nonresponders (79.1%) (P_.001) but was not associated with having received the most efficacious short-term treatment (the combination of fluoxetine and cognitive behavioral therapy). Of the 189 participants who recovered, 88 (46.6%) had a recurrence. Recurrence was not predicted by full short-term treatment response or by original treatment. Full or partial responders were less likely to have a recurrence (42.9%) than were nonresponders (67.6%) (P=.03). Sex predicted recurrence (57.0% among females vs. 32.9% among males; P=.02).

3.37.2. The Role of the Wellness Management and Recovery (WMR) Program in Promoting Mental Health Recovery.

Study by Rourke (2009) in USA, the primary aim of this study was to understand how the recovery process works, as it pertains to the WMR program.
For quantitative purposes, a total of 291 consumers completed the WMR program. Consumers were receiving psychiatric, case management, or community support services from either traditional (n=225, 77.3%) or consumer-operated (n=66, 22.7%) sites across the state of Ohio by Narrative Evaluation of Intervention Interview.

The results showed, Individuals coming into the WMR program tended to present at varying levels of recovery. based on the data obtained there were a number of similarities that characterized their thoughts, feelings, behaviors, and states of mind as they entered the WMR program. Particularly relevant were feelings of fear, isolation, doubt, and inhibition.

3.37.3. The Role of the Wellness Management and Recovery (WMR) Program in Promoting Social Support.

Study by Hupp (2008) in USA, aimed to examine how this recovery program affects the quality and quantity of the social support of the participants

This study represents an integration of the current recovery and social support literature with an evaluation of the Wellness Management and Recovery (WMR) program.

Sample of 208 participants are mental health consumers who are recruited from their respective mental health agencies. Currently, there are 12 mental health and consumer-operated agencies involved in the WMR program, representing 15 sites across the state of Ohio. The primary referral sources are staff members, case managers, therapists, and psychiatrists working in the aforementioned agencies. Participants must be at least 18 years of age and, although experiencing severe and persistent mental illness, will be legally competent and able to sign consent for themselves.

This study was designed to evaluate whether a recovery-oriented program helped individuals with SMI to gain not only in number of social supports (quantitatively), but also whether these supports were perceived to be meeting their needs (qualitatively).

The results found that participants successfully completing the WMR program showed a significant increase in both quantity and quality of their social support networks**.**

3.37.4. Living with serious mental illness: the role of personal loss in recovery and quality of life.

Study conducted by Potokar (2008) in USA, aimed to investigate the relative contribution of demographic factors, self-reports of psychiatric symptoms, and individual factors of cognitive insight and personal loss in describing variation in reports of quality of life and recovery from mental illness.

This study hypothesized that cognitive insight and personal loss would each predict a significant portion of the variance in scores of quality of life and recovery from mental illness. A sample of 65 veterans with serious mental illness from the Minneapolis Veterans Affairs Medical Center completed structured interviews regarding psychiatric symptomotology and quality of life and completed questionnaires related to demographics, cognitive insight, personal loss due to mental illness, and recovery. Thirteen significant hierarchical regression models emerged.

Results indicated that personal loss is the strongest predictor of facets of quality of life and recovery from serious mental illness, explaining incremental variance in ten of the regression models. Cognitive insight, however, was found to only explain incremental variance in one aspect of quality of life. Additionally, psychiatric symptoms and demographic variables such as diagnosis and living arrangement were also found to be significant predictors of aspects of quality of life and recovery.

3.37.5. Risk Taking, Social Stigma and Recovery from Severe Mental Illness.

Study conducted by Young (2008) in Washington, aimed to explore patient perspectives on the role of personal growth-related risk taking in the recovery process, and to identify social stigma's role when consumers approach and evaluate new endeavors.

177 Kaiser Permanente Health Plan members participated in a mixed methods study of recovery among individuals with serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, affective psychosis). Participants completed 4 in-depth interviews over 24 months. Data were analyzed using a modified grounded theory approach. The author sub-coded and analyzed interview content, then extracted major themes to identify relevant text.

The result showed that The most helpful discussions about risk-taking occurred in the context of healthy, collaborative, mutually trusting clinician-patient relationships. Advice was accepted when clinicians listened well, knew patients' capabilities and interests, and pushed gently at a pace that was comfortable for patients. Concerns about social stigma were not observed commonly in this sample, however two participants independently discussed stigma despite not being directly asked about it.

3.37.6. Examining the Factor Structure of the Recovery Assessment Scale.

Study conducted by Corrigan & Ralph (2005) aimed to determine the factor structure of the Recovery Assessment Scale (RAS) and to examine the psychosocial and Symptom variables that are correlates of individual factors.

1824 persons with serious mental illness, participating in the baseline interview for a multi-state study on consumer operated services, completed RAS plus measures representing hope, meaningful life, quality of life, symptoms, and empowerment.

Results of exploratory and subsequent confirmatory factor analyses of the RAS for random halves of the sample yielded five factors: personal confidence and hope; willingness to ask for help; goal and success orientation; reliance on others; and Symptom coping. Subsequent regression analyses showed these five factors were uniquely related to the additional constructs assessed in the study.

3.37.7. Spontaneous Recovery from Depression in Women.

Study conducted by Naeem et al (2004) in Karachi, aimed to gain insight into the perceived vulnerability and restitution factors for anxiety/or depression.

The method of this study was Focus group discussion of seven married women recovered spontaneously from anxiety and/or depression, belonging to a lower middle class semi-urban community of Karachi**.**

The result showed that Poverty, unemployment, abuse and on going difficulties were perceived as risk factors for depression, A reliable social support system, positive thinking approach, faith, prayers, and experiencing a "turning point" event were reported as factors that promoted recovery from anxiety and/or depression.

3.37.8. Exploring recovery from the perspective of people with psychiatric disabilities.

Study conducted by Young and Ensing (2003) in USA, aimed to explore the meaning of the recovery process from the perspective of mental health consumers.

Eighteen people with psychiatric disabilities (African American = 5, European American = 13) participated in individual interviews or one of two focus group discussions consisting of five and six participants each. Only people who were diagnosed with a severe mental disorder, living independently in the community, and were their own legal guardians were recruited. A semi-structured qualitative interview guide consisting of eight primary questions designed to explore the recovery construct from the consumers' perspective was used in this study Follow-up questions were asked after each primary question to explore the unique aspects of each person's recovery experience. The researcher formulated the original protocol based on information obtained from a literature review and information obtained from consumers and professionals with expertise in this area.

The results of this study indicated that there are some general aspects of recovery that typify the process for many consumers. The higher order categories which emerged from the data are that recovery is a process of 1) overcoming "stuckness," 2) discovering and fostering self-empowerment, 3) learning and self-redefinition, 4) returning to basic functioning, and 5) improving quality of life.

3.37.9. Predictors of Early Recovery from Major Depression among Persons Admitted to Community-Based Clinics.

An observational study was conducted by Meyers et al (2002) in New Yourk, aimed to assess relationships between initial depression severity, personality dysfunction and other baseline characteristics, subsequent treatment, and 3-month outcomes among persons admitted to public and voluntary sector outpatient clinics, including 1 academic program.

2-stage sampling technique was used to recruit subjects (N=165) diagnosed by the Structured Clinical Interview for DSM-IV, Patient Version, as having a major depression episode. Sociodemographic and clinical characteristics were assessed at admission.

Data on treatment and outcome were obtained at 3 months using structured instruments from the Longitudinal Interview Follow-up Evaluation. Logistic regression was used to assess hypothesized predictors of early recovery. Analyses were carried out in the total sample and after dichotomizing subjects by baseline depression severity.

The results of this study found that only 30% of 165 subjects met recovery criteria. Less than half of the subjects (45%) met criteria for adequate pharmacotherapy. Less severe depression, having received adequate antidepressant treatment, female sex, and being married independently predicted early recovery. In the more depressed subgroup, early recovery was associated with female sex. Among less severely depressed subjects, high personality dysfunction scores and being married were significant predictors.

3.37.10. Symptomatic recovery and social functioning in major depression.

Study conducted by Furukawa et al (2001) in Japan, aimed to determine whether social functional recovery precedes, runs in parallel with, or lags behind symptomatic recovery from major depressive episodes.

The method of this study was Psychiatric out-patients or in-patients aged 18 years or over, diagnosed with unipolar major depressive disorder according to DSM-IV, and who had received no antidepressant medication in the preceding 3 months were identified at 23 collaborating centers from all over Japan (n=95). They were rated with the 17-item Hamilton Rating Scale for Depression (HRSD) and the Global Assessment Scale (GAS) monthly, and with the Social Adjustment Scale-Self Report (SAS-SR) 6-monthly. Remission was defined as 7 or less on the HRSD and recovery as 2 or more consecutive months of remission.

The results showed: The GAS ratings showed continuous amelioration from baseline to remission, remission to recovery, and after sustained recovery. The same trends were observed for SAS-SR scores.

3.38. Summary of previous studies:

Lack of local studies that discussed the relationship between stigma and recovery, what made the present study mainly depends on international studies.

There are many researches agree with my study and others disagree, The researcher found most of previous studies which related to stigma aimed to identify relationships between stigma and mental illness as Studies conducted by Min et al (2001), Dinos et al (2004), Couture and penn (2003).While some studies aimed to identify socio-demographic correlates of stigma attached to psychiatric illnesses as Studies conducted by Ansari et al (2008), Corrigan et al (2004), Cook and Wang (2010) Cechnicki and Bielanska (2009).

Some studies that related to recovery aimed to examine the Role of the Wellness Management and Recovery (WMR) Program in Promoting Mental Health Recovery, as studies conducted by Hupp (2008), Rourke (2009). And some studies aimed to determine the factors that promoted recovery from depression and explore the meaning of the recovery process from the perspective of mental health consumers As studies conducted by Furukawa et al (2001),Naeem et al (2004), Young and Ensing (2003).

Most of studies which related to stigma used tools as stigma scale, closed ended questions. as studies conducted by West et al (2011), Griffiths et al (2008), Kondrat (2008), king et al (2007), Depla et al (2005) , Al-Krenawi (2004), Cooper et al (2003), El Defrawi et al (2001) Min et al (2001), Perlick et al (2001).While some studies which related to recovery use tools as Recovery Assessment Scale (RAS) and questionnaires as studies conducted by Corrigan & Ralph (2005) Potokar (2008), Furukawa et al (2001).

Most of studies used the interview or the group discussions as studies conducted by Potokar (2008), Kondrat (2008) king et al (2007), Naeem et al (2004) Dinos et al (2004) Young and Ensing (2003) Ostman and Kjellin (2002) Meyers et al (2002) El Defrawi et al (2001). The researcher found the design of most previous studies which related to current study is non-experimental design.

The researcher took advantage of these previous studies and used it to develop questionnaire, selecting study design, and writing the conceptual framework, definition of terminologies and explanation of issues and recommendations. Previous studies were applied in many countries, used different tests and questionnaires about stigma and recovery in separated studies. In other hand, the researcher developed most aspects of stigma and recovery for depressed patients in one study.

According to the researcher knowledge, the number of instruments that attempt to measure recovery is few, compared to instruments that measure other areas in mental health and the attempts to measure recovery or aspects related to recovery are very recent. it is considered as the first study in mental health field in Gaza Strip about the relationship between stigma and recovery. That provides important information for decision makers about the present situation of these properties and this will aim to enhance the right of justice and equal opportunity for psychiatric patients and improve mental health services.

Finally: Most previous studies and articles are related to this study, the researcher found the results of previous studies as the following:

- There is a relationship between stigma and mental illness, as Studies conducted by El Defrawi et al (2001), Min et al (2001) Ostman and Kjellin (2002) Dinos et al (2004), West et al (2011).
- There is a relationship between socio-demographic data (age, gender, education level, income and social status) and developing stigma of mental illness, as Studies conducted by Ansari et al (2008), Cechnicki and Bielańska (2009), Cook and Wang (2010).
- There is a negative relationship between stigma and recovery. And stigma considers as a barrier to recovery, as Studies conducted by link et al (2001), Perlick et al (2001), Cooper et al (2003), Depla et al (2005) Kondrat (2008).

Chapter four
Methodology of the study

Chapter 4
Methodology of the study

4.1. Introduction:

This chapter describes the Materials and Methods that were used in this research. The Methodology to accomplish this study uses the following techniques: the Information about the research design, research population, research sample size, Research location, questionnaire design, statistical data analysis, content validity and Pilot study.

4.2. Research Phases:

The first phase of the research included identifying and defining the problems and establishment objective of the study and development research plan.

The second phase of the research included a summary of the comprehensive literature review. Literatures on claim management was reviewed.

The third phase of the research included a field survey which was conducted with The relationship between stigma and recovery among depressed patients in Gaza Strip.

The fourth phase of the research focused on the modification of the questionnaire design, through distributing the questionnaire to pilot study. The purpose of the pilot study was to test and prove that the questionnaire questions are clear to be answered in a way that help to achieve the target of the study. In addition, it was important to ensure that all information received from physically disabled would be useful in achieving the research objective. The questionnaire was modified based on the results of the pilot study.

The fifth phase of the research focused on distributing the questionnaire. This questionnaire was used to collect the required data in order to achieve the research objectives.

The sixth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis.
The final phase includes the conclusions and recommendations.

Figure (4.1) shows the methodology flowchart, which leads to achieve the research objective.

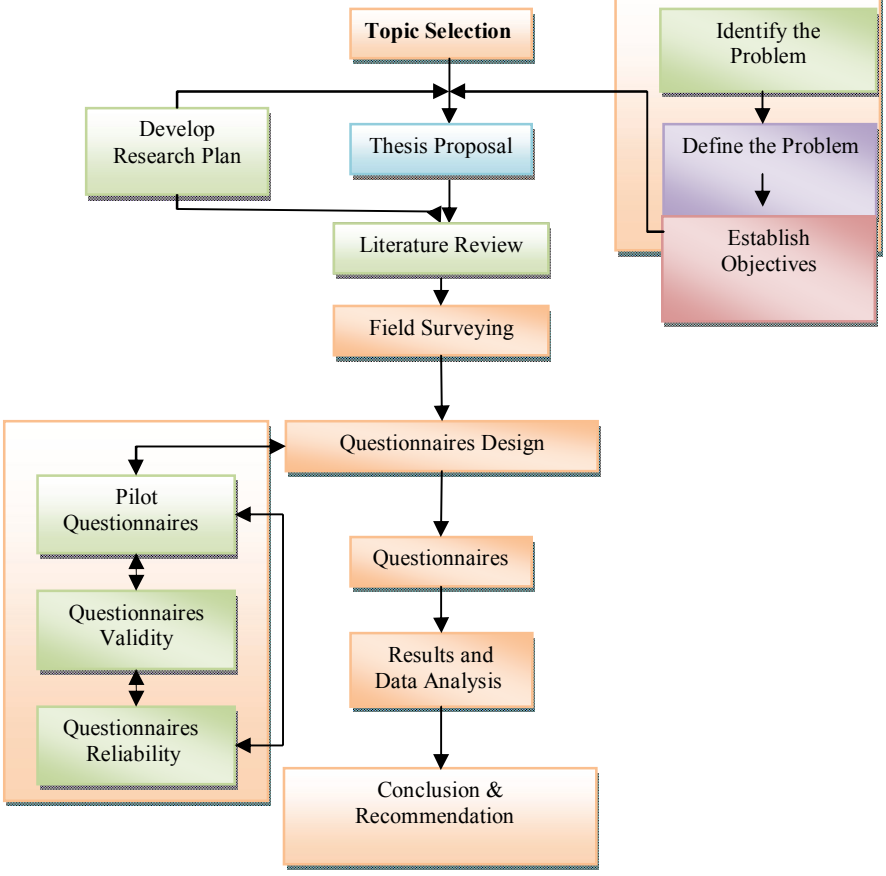


Figure (4.1) illustrates the methodology flow chart.

4.3. Study design:

The design of this study is descriptive, analytical and cross-sectional one which involves the collection of data at one point. The justification of selected non-experimental (descriptive, analytical, and cross-sectional):-

The researcher preferred to use non-experimental design because we deal with human being and mental health behavior, in addition to the ethically reason .

- Play important role in the mental health because, many problems are not amenable to experimentation.
- To determine, describe and explore the relationship between variables.
- **Cross-sectional** is practical, easy to do, fast, safe, and economical (Ismail, 2011:41).

4.4. The Study Population:

Unfortunately, there is no formal statistics about the accurate number of depressed patients in governmental mental health clinics in Gaza Strip at 2009-2010, So, the researcher calculated the numbers of depressed patients in both record (2009-2010).The study population includes all depressed patients are treated in the governmental mental health clinics in Gaza Strip at 2009-2010. The total number is 383. Male (245) female (138).Figure (4.2) show distribution of total population.

4.4.1. Sample size:

The sample size was calculated by statistical equation [n = N/[(0.05)²(N)] +1]. Therefore, the sample size is 195 patient (Afana, 1997). The sample size is equal 180 on the six studied community mental health clinics.15 depressed person refused to participate in this study. Figure (4.3) show distribution of sample study

$$N = \frac{NP}{(0.05)^2 * NP + 1} = \frac{383}{(0.05)^2 * 383 + 1} = 195$$

Where
N: Sample size.
NP: population size.
E: the errors term = 0.05.

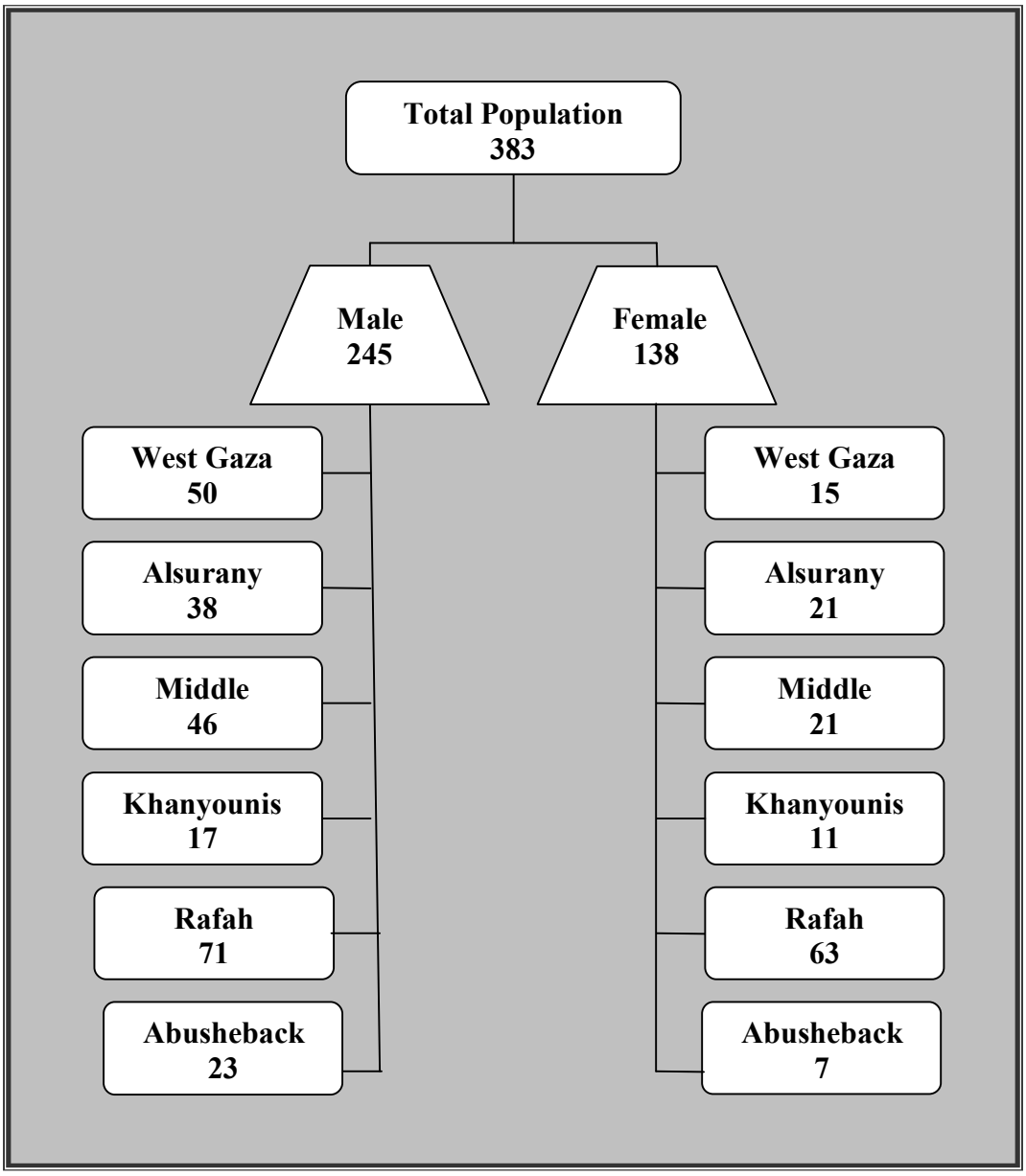
4.4.2. Sample and sampling:

The total participants who responded to the study were 180 participants meet the Inclusion and exclusion criteria (Purposeful sampling).
Each individual was interviewed at community mental health clinic personally by the researcher.

4.5. Research period:

The study started on June2011 when the initial proposal was approved. The Literature review was completed on 1st September 2011. The validity testing, piloting and questionnaire distribution and collection took two month and half and completed on the beginning of December 2011. The analysis, discussion, conclusion and recommendation was completed on the mid of may 2012.

Figure 4.2: Distribution of the study population according to place of resident and gender

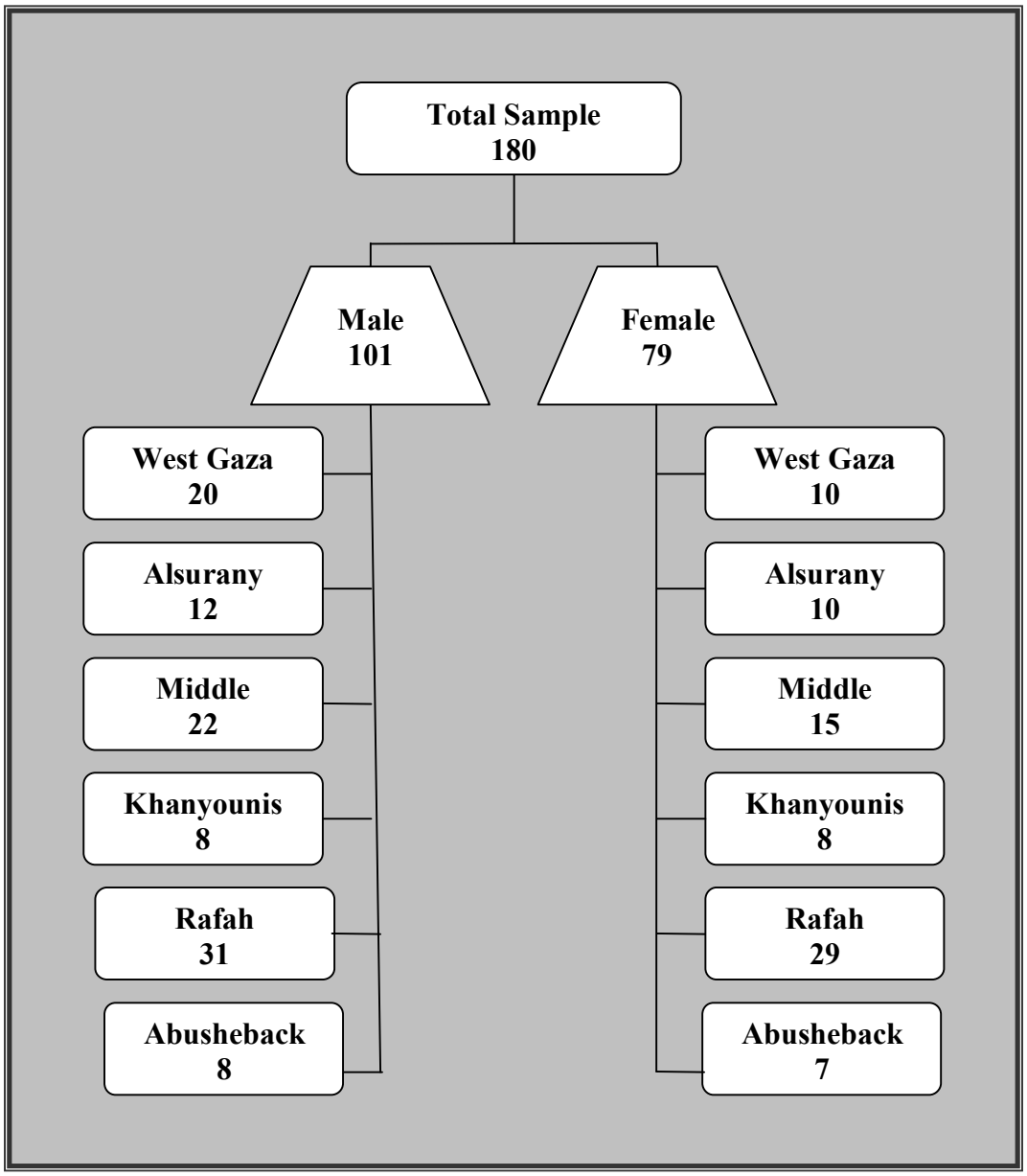


4.6. Study Setting:

The research was carried to the depressed patients visiting community mental health clinics.

- West Gaza clinic.
- Alsurany clinic.
- Mid-area governorate clinic.
- Khanyounis clinic.
- Abusheback clinic.
- Rafah clinic.

Figure 4.3: Distribution of the sample according to place of resident and gender



4.7. Data collection

Interviewed questionnaire was used in this study. Each selected and eligible patient received full information about the study and its purposes and encouraged to participate in the study. Scanning by questionnaire can be the fastest and the easiest method of collecting data. Questionnaires are much less costly and require less time and energy to administer. And is more accurate when starting processing and analyzing these data. Interviewed questionnaire method was used to ensure highest possible response rate, and to encompass difficulties that may arise in completing or understanding the questionnaire.

4.8. Questionnaire Design and Content

After reviewing the literature and after interviewing experts who were dealing with similar subject at different levels, all the information that could help in achieving the study objectives were collected, reviewed and formalized to be suitable for this study. After many stages of brain storming, consulting, amending, and reviewing executed by the researcher with both supervisors, a questionnaire was developed and designed into closed ended questions.

The questionnaire was sent to a specialist in English translation and after that the Arabic version sent to a specialist in Arabic for accreditation then finally back translation to English was done. An English version is attached in (Annex 4).
Unnecessary personal data, complex and duplicated questions were avoided.

A questionnaire was provided with a covering letter explaining the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage a high response. The questionnaire included multiple choice questions: which used widely in the questionnaire, the variety in these questions aims first to meet the research objectives, and to collect all the necessary data that can support the discussion, results and recommendations in the research.
The questionnaire, which is used, aimed to study the relationship between stigma and recovery among depressed patients in Gaza Strip. This questionnaire has been prepared in suitable papers, pointed, cleared statements and proper arranged of ideas to make fullness of the questionnaire easy and simple.

The researcher designed two questionnaires (stigma scale and recovery scale).
1-The stigma questionnaire design composed of four sections to accomplish the aim of the research, as follows:

- **First:** demographic questions.
- **Second:** perceived stigma.
- **Third:** Role of media in developing the stigma.
- **Fourth:** Effect of stigma on daily life of depressed patients**.**

2-The recovery questionnaire design composed of fifth sections to accomplish the aim of the research, as follow:

- **First** demographic questions.
- **Second:** Hope.
- **Third:** self determination.
- **Fourth :**self esteem and self confidence.
- **Fifth**: asking help and support.

And all questions follow likert scale as the following:

Level	**Totally disagree**	**disagree**	**Don't Know**	**Agree**	**Totally agree**
Scale	1	2	3	4	5

4.9. Pilot Study

A pilot study for the questionnaire was conducted before starting to collect data. It provides a trial run for the questionnaire, which involves testing the wordings of question, identifying ambiguous questions, testing the techniques that used to collect data, and measuring the effectiveness of standard invitation to respondent's .It is a customary practice that the survey instrument should be piloted to measure its validity and reliability and test the collected data. The pilot study was conducted by distributing the prepared questionnaire to panels of experts having experience in the same field of the research to have their remarks on the questionnaire, some minor changes, modifications and additions were introduced to the questions and the final questionnaire was constructed in the pilot study and distributed after modifications from panel of experts. Number of the participants in the pilot study is 25 depressed person from six community mental health clinics in Gaza Strip, and they excluded from total sample .

Two panels were contacted to assess the questionnaire validity. The first panel, which consisted of 7 experts, in addition to both supervisors was asked to verify the validity of the questionnaire topics and its relevance to the research objectives. The second panel, which consisted one experts in statistics, was asked to identify that the instrument used was valid statistically, and that the questionnaire was well designed enough to provide relations and tests among variables, in addition to two experts in English and Arabic languages.

4.10. Eligibility criteria for sample:

Patients who will participate in this study should have the following criteria:

4.10.1. Inclusion criteria:

- Depression diagnosis confirmed by psychiatrist.
- All depressed patients more than one year.
- Both sexes are included.
- All depressed pts treated in the governmental mental health clinics in Gaza strip at 2009-2010.
- Depression not co morbid by medical problem.

4.10.2. Exclusion criteria:

All depressed patients who refuse to participate in the study.

- Depressed pts treated in the nongovernmental organizations (NGOs).
- Depressed pts treated in the psychiatric hospital.
- All depressed patient less than one year.

4.11. Ethical Consideration and Permission:

Consent form and agreement of patients to participate in this study was obtained. The permission was obtained from general mental health directorate before starting this study (Annex 6).

4.12. Validity of the Research:

4.12.1. Content Validity of the Questionnaire:

Content validity test was conducted by consulting two groups of experts. The first 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 other was requested to evaluate that the instrument used is valid statistically and that the questionnaire was designed well enough to provide relations and tests between variables. The two groups of experts did agree that the questionnaire was valid and suitable enough to measure the concept of interest with some amendments.

4.12.2. Statistical Validity of the Questionnaire:

To insure the validity of the questionnaire, two statistical tests should be applied. The first test is Criterion-related validity test (Pearson test) which measures the correlation coefficient between each item in the field and the whole field. The second test is structure validity test (Pearson test) that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

4.12.3. Criterion Related Validity:

Internal consistency:

Internal consistency of the questionnaire is measured by a scouting sample, which consisted of twenty five questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. Tables No. (4.1-4.2) below shows the correlation coefficient and p-value for each field items. As show in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table (4.1)
The correlation coefficient between each paragraph in the field and the whole field Stigma scale

No.	statement	Pearson coefficient	p-value
Perceived stigma			
1	I feel shy about telling people that I am psychiatric patient.	0.852	0.000
2	Increasing illness years increase my shyness from psychiatric illness.	0.640	0.001
3	I feel that I am less than people because of my psychiatric illness.	0.797	0.000
4	I believe that the fear from psychiatric illness deprives me from appropriate treatment in the appropriate time.	0.836	0.000
5	Social and family support decreases the shyness from psychiatric illness.	0.540	0.005
6	Denial of psychiatric illness opens the door to the witches and sorcerers.	0.745	0.000
7	I think that the admission in the psychiatric hospital is a weak point for the person.	0.805	0.000
8	When you meet a person at the first time, you make effort to hide the fact that you are a psychiatric patient.	0.688	0.000
9	I think that people don't know that the psychiatric illness is as organic illness and it can be cured.	0.647	0.000
10	I prefer going secretly to the mental health clinic to avoid any embarrassment.	0.736	0.000
Media and stigma developing			
11	Link the media between violence and mental illness led people to fear from psychiatric patient.	0.545	0.005
12	I think that the reason of the shyness from the psychiatric illness is to link media between psychiatric illness and insanity.	0.611	0.001
13	Newspapers/television take a balanced view about mental health problems	0.580	0.002
14	Media use words that offend the psychiatric patient.	0.456	0.022
15	Media link between the criminals and psychiatric patients.	0.474	0.017

Effect of stigma on daily life			
16	My request was rejected for several jobs because my psychiatric illness.	0.807	0.000
17	I prefer staying at home alone and not mixing with others because my psychiatric illness.	0.572	0.003
18	People avoid me because of my psychiatric illness.	0.808	0.000
19	People accuse me of insanity due to my psychiatric illness.	0.886	0.000
20	People look at me into sadness and pity, because I am psychiatric patient .	0.471	0.018
21	People don't invite me to share their occasions .	0.682	0.000
22	People humiliate me, because of my psychiatric illness .	0.841	0.000
23	People do not accept the psychiatric patient as close friend.	0.714	0.000
24	I blame myself because I am responsible for psychiatric illness.	0.506	0.010
25	I feel ashy because of my psychiatric illness, and this prevents me from to express my point of view easily.	0.915	0.000
26	People drive me to feel shy from my psychiatric illness.	0.727	0.000
27	I avoid the establishment of social relationships with people so I do not feel the discrimination between them.	0.653	0.000
28	I prefer giving pen name and change my look and clothes when I go to the psychiatrist to avoid an embarrassment.	0.846	0.000
29	I resorted to practice some popular rituals People (witches, charlatans .... etc.) due to my shyness from psychiatric illness.	0.729	0.000
30	For the married / the psychiatric illness led me fail in my marriage. For non-married / I believe that psychiatric illness was the main reason for the prevention of my marriage.	0.512	0.009

Table(4.2)

The correlation coefficient between each paragraph in the field and the whole field

(Recovery scale)

No.	statement	Pearson coefficient	p-value
Hope			
1	I feel my life is normal. despite of the psychiatric illness.	0.409	0.042
2	I feel that my life is meaningless.	0.425	0.034
3	I give up to recover from psychiatric illness.	0.784	0.000
4	I have a hope of recovery, and I think that my life will be better in the future.	0.510	0.009
5	I have the ability to be an effective and productive member in my society.	0.655	0.000
Self determination			
6	I have a desire to work hard to be the best.	0.467	0.018
7	I work, learn and exercise my daily life despite of my psychiatric illness.	0.624	0.001
8	I establish my social relationships, and share people in their occasions despite of my psychiatric illness.	0.549	0.004
9	I am ready to take risks in order to recover from psychiatric illness.	0.716	0.000
10	Most of the time, I stay at home and watch TV.	0.758	0.000
Self esteem and self confidence			
11	I feel that I am like people .. I am not different from them or lower them.	0.716	0.000
12	I deserve to be loved and respected from others.	0.799	0.000
13	I feel that I am lower than people due to my psychiatric illness.	0.449	0.024
14	I feel that psychiatric illness out of my control	0.866	0.000
15	I feel at peace with myself.	0.761	0.000
16	I have the ability to follow up on initial signs that alarm of relapse and I can deal with it	0.524	0.007
17	I do not accept myself as it, and is not happy for myself.	0.569	0.003
18	I feel guilty when I do or say what I want.	0.617	0.001
Asking help and support			
19	Asking for help is a part of my recovery.	0.627	0.001
20	I often begin to ask for help when I need for it	0.560	0.004
21	I hasten to seek support from someone close to me when I need it.	0.582	0.002
22	My compliance to prayer and reading Koran is important factor for recovery.	0.684	0.000
23	My compliance to take medications regularly contributes to recovery from psychiatric illness.	0.559	0.004
24	I find it difficult to know when to increase my mental worse and when I ask for help.	0.548	0.005
25	My shyness from psychiatric illness prevents me from seeking help and support.	0.716	0.000

4.13. Reliability of the Research

4.13.1. Half Split Method

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation : Consistency coefficient = 2r/(r+1), where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient 2r/(r+1) is between 0.0 and + 1.0 As shown in Table No.(4.3) the general reliability for all items equal 0.8611, and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes group are reliable.

Table (4.3)
Split-Half Coefficient method

	section	person-correlation	Spearman-Brown Coefficient	Sig. (2-(Tailed
Stigma scale	**Perceived stigma**	0 .7845	0 .8792	0.000
	Media and stigma developing	0.7283	0.8428	0.000
	Effect of stigma on daily life	0 .74760	0 .89290	0.000
	Total (**Stigma scale**)	0 .8390	0 .9125	0.000
(Recovery scale)	**Hope**	0.7594	0.8633	0.000
	Self determination	0.6782	0.8083	0.000
	Self esteem and self confidence	0.7412	0.8514	0.000
	Asking help and support	0.7265	0.8416	0.000
	Total(Recovery scale)	0.7494	0.8567	0.000
	Stigma& Recovery scale	0.7561	0.8611	0.000

4.13.2. Cronbach's Coefficient Alpha

Is another internal consistency approach, used to overcome disadvantages seen with the split-half reliability approach, which is, in essence, the average of all possible split-half correlations within a measure.

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. (Monette and Dejong, 2005: 10). The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table No. (4.4) Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. the general reliability for all items equal 0.8788 . This range is considered high; the result ensures the reliability of the questionnaire.

Table (4.4)

Cronbach's Alpha for Reliability

	section	Cronbach's Alpha
Stigma scale	**Perceived stigma**	0 .8282
	Media and stigma developing	0.8629
	Effect of stigma on daily life	0.8892
	Total (**Stigma scale**)	0.8793
(Recovery scale)	**Hope**	0.8847
	Self determination	0.8396
	Self esteem and self confidence	0.8895
	Asking help and support	0.8795
	Total(Recovery scale)	0.8892
	Stigma& Recovery scale	0.8788

4.14. Statistical Manipulation:

To achieve the research goal, researcher used the SPSS for Manipulating and analyzing the data.

4.14.1. Statistical methods are as follows:

- Frequencies and Percentile.
- Alpha- Cronbach Test for measuring reliability of the items of the questionnaires.
- Person correlation coefficients for measuring validity of the items of the questionnaires.
- Spearman –Brown Coefficient.
- One sample t test.
- Independent sample t test.
- One way ANOVA.

Chapter five
Data Analysis and Results

Chapter 5
Data analysis and Results

Introduction:

This chapter illustrates the results of statistical analysis of the data including Descriptive analysis that presents the demographic characteristics and the answers of the research questions about the relationship between stigma and recovery among depressed patients in six community mental health clinics (West Gaza clinic. - Alsurany clinic - Mid-area governorate clinic -Khanyounis clinic, Abusheback clinic -Rafah clinic).Where west Gaza clinic and alsurany clinic are representing Gaza governorate, while Abusheback clinic is represent Northern governorate.

5.1. Descriptive analysis of the study:

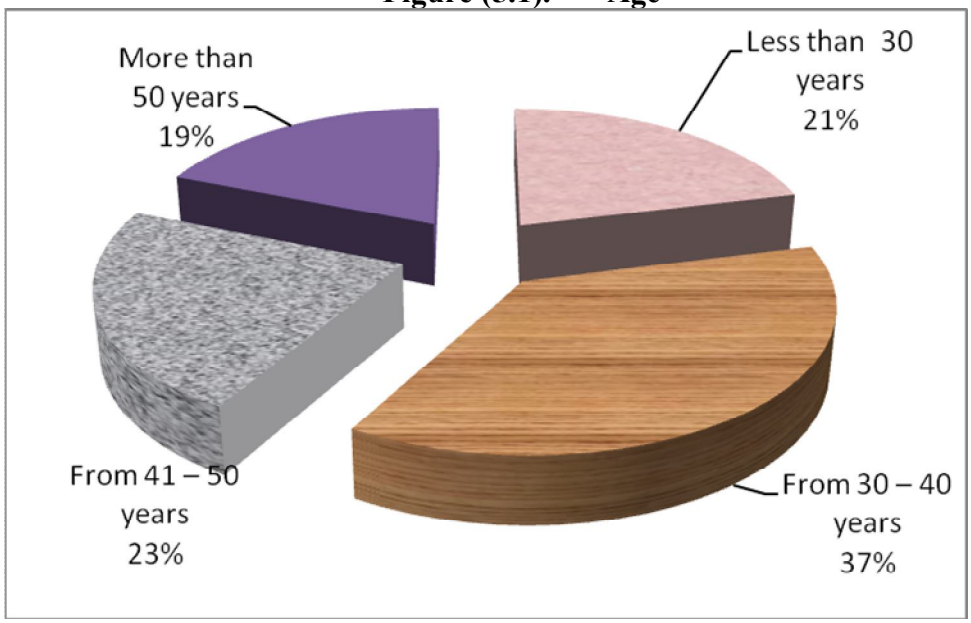
The total number of this study sample was 180 participants were (8.3 %)from Northern governorate and 28.9% from the sample are from " Gaza governorate " , and 20.6 % from the sample are from " Mid-area governorate " , and 8.9% from the sample are from " Khanyounis governorate " , and 33.3 % from the sample are from " Rafah governorate " . The next followed tables will illustrate the demographic and the properties of the samples.

5.2. Demographic data:

5.2.1. Age:

Figure No.(5.1) illustrated that 21.1% from the sample ages " Less than 30 years ", and 37.2% from the sample ages from " From 30 – 40 years ", and 22.8 % from the sample ages " From 41 – 50 years " and 18.9 % from the sample ages " More than 50 years " .

Figure (5.1). Age



5.2.2-Gender

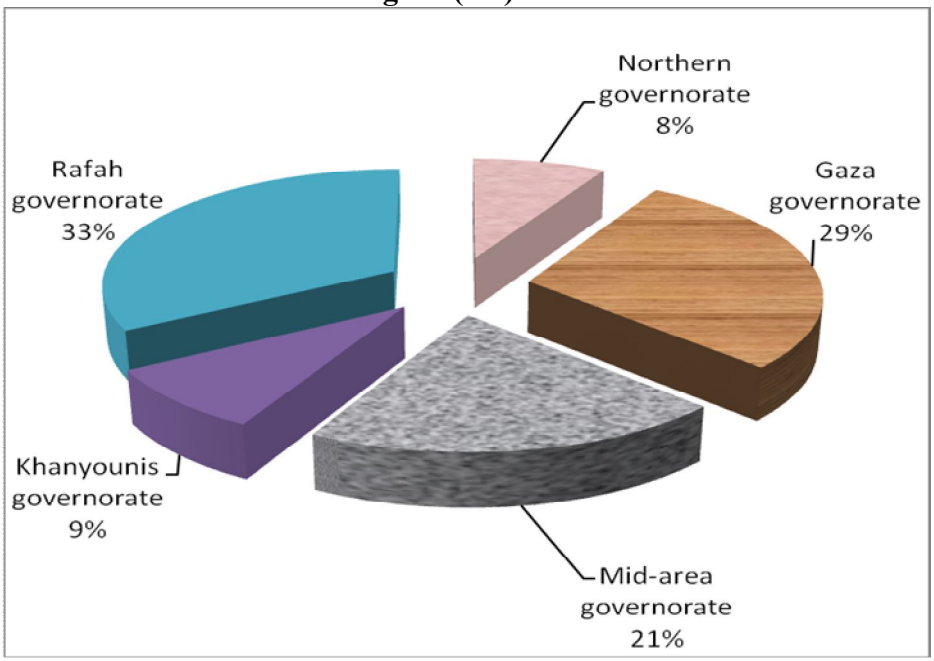
Figure No. (5.2) illustrated that 56.1 % from the sample are "Male", and 43.9 % from the sample are "Female ".

Figure (5.2) Gender

5.2.3. Address

Figure No.(5.3) illustrated that 8.3 % from the sample are from " Northern governorate " , and 28.9% from the sample are from " Gaza governorate " , and 20.6 % from the sample are from " Mid-area governorate " , and 8.9% from the sample are from " Khanyounis governorate" and 33.3 % from the sample are from " Rafah governorate".

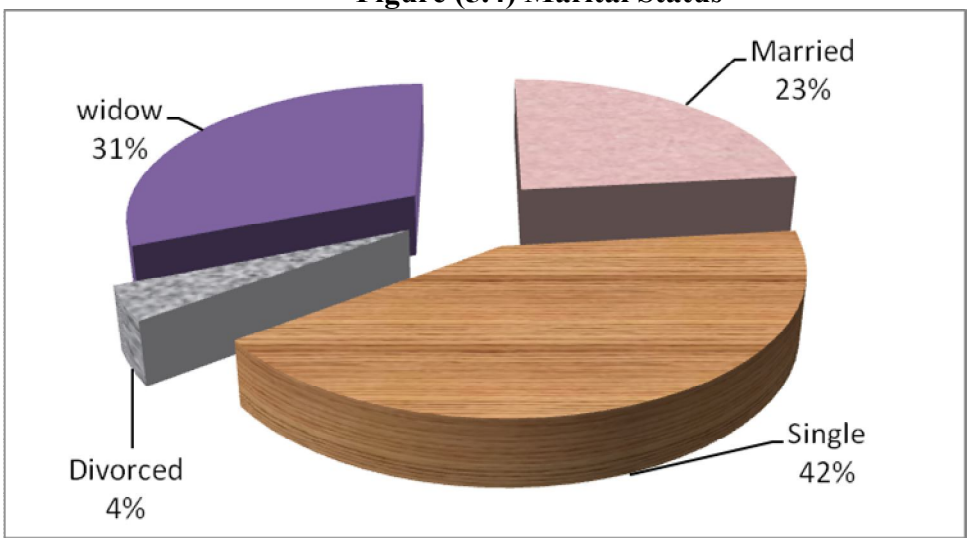
Figure (5.3) Address



5.2.4. Marital Status

Figure No.(5.4) illustrated that 42% from the sample are " Single " , and 23% from the sample are " Married " , and 31 % from the sample are " widow " , and 4% from the sample are " Divorced " .

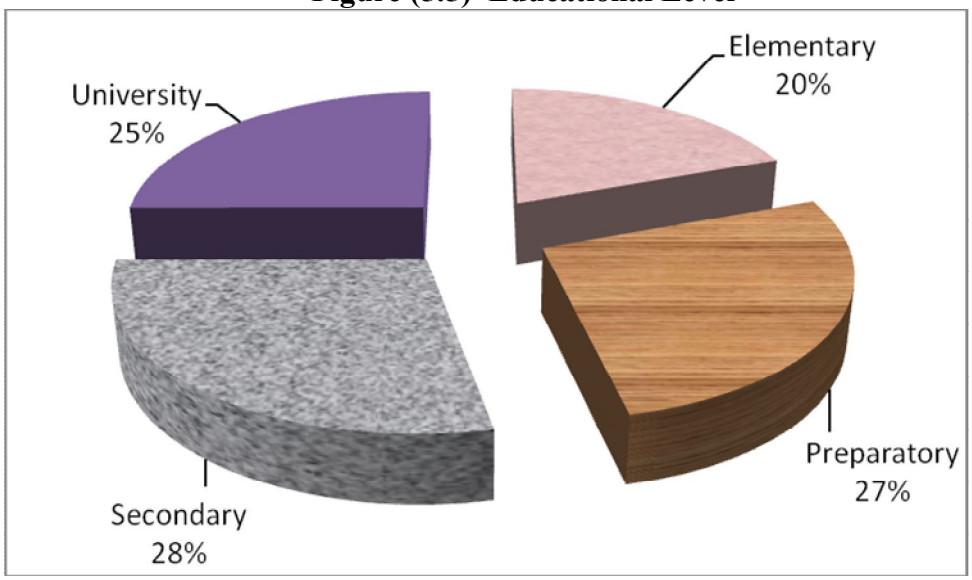
Figure (5.4) Marital Status



5.2.5. Education level

Figure No.(5.5) illustrated that 19.4% from the sample the educational level are " Elementary " , and 27.2% from the sample the educational level are " Preparatory " , and 28.3 % from the sample the educational level are " Secondary " , and 25.0 % from the sample the educational level are " University " .

Figure (5.5) Educational Level



5.2.6. Income level

A-Family income Sources

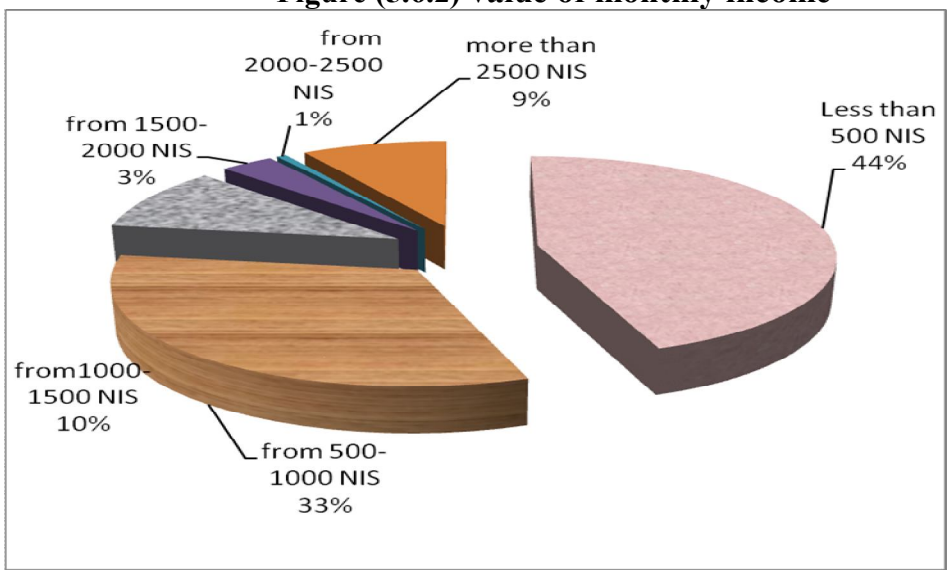
Figure No.(5.6.1) illustrated that 35.0 % from the family income sources are " Social affairs " ,and 15.6% from the family income sources are " person' s work " ,and 6.1% from the family income sources are " wife's work " and 3.9% from the family income sources are " son' s work " , and 23.3% from the family income sources are " Ranching " and 16.1% from the family income sources are " another work ".

Figure (5.6.1) Family income Sources

B-value of monthly income

Figure No.(5.6.2) illustrated that 44.4% from the sample the value of monthly income Less than 500 NIS " , and 32.8% from the sample the value of monthly income from 500-1000 NIS " , and 10.0 % from the sample the value of monthly income from1000-1500 NIS " , and3.3 % from the sample the value of monthly income from 1500-2000 NIS " , and 0.6% from the sample the value of monthly income from 2000-2500 NIS " , and 8.9% from the sample the value of monthly income more than 2500 NIS " .

Figure (5.6.2) value of monthly income



5.3. One Sample K-S Test (Kolmogrov-Simirnove).

One Sample K-S test will be used to identify if the data follow normal distribution or not, this test is considered necessary in case testing hypotheses as most parametric Test stipulate data to be normality distributed and this test used when the size of the sample are greater than 50. Results test as shown in table (5.1), clarifies that the calculated p-value is greater than the significant level which is equal 0.05 (p-value. > 0.05), this in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (5.1)
One Sample K-S

	section	Statistic	P-value
Stigma scale	**Perceived stigma**	0.856	0.456
	Effect of stigma on daily life	1.338	0.056
	Total (**Stigma scale**)	0.905	0.386
(Recovery scale)	**Hope**	0.666	0.767
	Self determination	1.306	0.066
	Self esteem and self confidence	0.803	0.539
	Asking help and support	1.340	0.055
	Total(Recovery scale)	0.736	0.651
	Stigma& Recovery scale	0.747	0.632

5.4. Analysis and interpretation of each section's items.

In the following tables We use a one sample t test to test if the opinion of the respondent in the content of the sentences are positive (weight mean greater than "60%" and the p-value less than 0.05) or the opinion of the respondent in the content of the sentences are neutral (p- value is greater than 0.05) or the opinion of the respondent in the content of the sentences are negative (weight mean less than "60%" and the p-value less than 0.05) .

5.4.1. Stigma scale

A. Perceived stigma:

We use a one sample t test to test if the opinion of the respondent about the Perceived stigma and the results shown in Table No. (5.2) which shows that the average mean for all items equal 3.23 and the weight mean equal 64.54 % which is greater than " 60%" and the value of t test equal 7.300 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the members of the sample have high perceived stigma.

Table (5.2)
Perceived stigma

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	I feel shy about telling people that I am psychiatric patient.	3.99	1.153	79.78	11.506	0.000
2	Increasing illness years, increase my shyness from psychiatric illness.	3.80	1.165	76.00	9.216	0.000
3	I feel that I am less than people because of my psychiatric illness.	3.98	0.974	79.56	13.465	0.000
4	I believe that the fear from psychiatric illness deprives me from appropriate treatment in the appropriate time.	3.73	0.996	74.56	9.801	0.000
5	Social and family support decrease the shyness from psychiatric illness.	3.84	0.968	76.89	11.707	0.000
6	Denial of psychiatric illness opens the door to the witches and sorcerers.	3.93	0.894	78.67	14.000	0.000
7	I think that the admission in the psychiatric hospital is a weak point for the person.	3.99	1.129	79.78	11.756	0.000
8	When you meet a person at the first time, you make effort to hide the fact that you are a psychiatric patient.	3.81	1.232	76.22	8.835	0.000
9	I think that people don't know that the psychiatric illness is as organic illness and it can be cured.	3.74	1.058	74.89	9.443	0.000
10	I prefer going secretly to the mental health clinic to avoid any embarrassment.	3.96	1.204	79.11	10.645	0.000
	All statement	3.23	0.418	64.54	7.300	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

B. Media and developing of stigma:

We use a one sample t test to test if the opinion of the respondent about the Media and stigma developing and the results showed in table no. (5.3) which shows that the average mean for all items equal 3.92 and the weight mean equal 78.49% which is greater than " 60%" and the value of t test equal 17.056 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the media play role in the stigma developing.

Table (5.3)
Media and developing of stigma

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	Link the media between violence and mental illness led people to fear from psychiatric patient.	4.07	1.028	81.33	13.920	0.000
2	I think that the reason of the shyness from the psychiatric illness is to link media between psychiatric illness and insanity.	3.94	0.981	78.78	12.838	0.000
3	Newspapers/television take a balanced view about mental health problems	2.44	1.197	48.89	-6.227	0.000
4	Media use words that offend the psychiatric patient.	3.88	0.913	77.56	12.894	0.000
5	Media link between the criminals and psychiatric patients.	4.18	0.983	83.67	16.151	0.000
	All statement	3.92	0.727	78.49	17.056	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

C. Effect of stigma on daily life:

We use a one sample t test to test if the opinion of the respondent about the Effect of stigma on daily life of depressed pts, and the results shown in Table No. (5.4) which shows that the average mean for all items equal 3.93 and the weight mean equal 78.67% which is greater than " 60%" and the value of t test equal 23.335 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means stigma affected negatively on daily life of the members of the sample.

Table (5.4)
Effect of stigma on daily life

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	My request was rejected for several jobs because my psychiatric illness.	3.69	1.064	73.78	8.688	0.000
2	I prefer staying at home alone and not mixing with others because my psychiatric illness.	4.25	0.890	85.00	18.846	0.000
3	People avoid me because of my psychiatric illness.	3.96	0.948	79.22	13.608	0.000
4	People accuse me of insanity due to my psychiatric illness.	3.62	1.053	72.44	7.931	0.000
5	People look at me into sadness and pity, because I am psychiatric patient .	3.91	0.882	78.11	13.768	0.000
6	People don't invite me to share their occasions .	3.92	1.013	78.33	12.138	0.000
7	People humiliate me, because of my psychiatric illness .	3.97	0.936	79.44	13.934	0.000
8	People do not accept the psychiatric patient as close friend.	4.36	0.837	87.22	21.807	0.000
9	I blame myself because I am responsible for psychiatric illness.	3.61	1.318	72.11	6.164	0.000
10	I feel ashy because of my psychiatric illness, and this prevents me from to express my point of view easily.	3.80	1.160	76.00	9.254	0.000
11	People drive me to feel shy from my psychiatric illness.	3.76	1.198	75.22	8.527	0.000
12	I avoid the establishment of social relationships with people so I do not feel the discrimination between them.	4.24	0.727	84.78	22.848	0.000
13	I prefer giving pen name and change my look and clothes when I go to the psychiatrist to avoid an embarrassment.	3.72	1.188	74.33	8.095	0.000
14	I resorted to practice some popular rituals People (witches, charlatans .... etc.) due to my shyness from psychiatric illness.	3.86	1.112	77.22	10.385	0.000
15	For the married / the psychiatric illness led me fail in my marriage. For non-married / I believe that psychiatric illness was the main reason for the prevention of my marriage.	4.34	0.861	86.89	20.954	0.000
	All statement	3.93	0.537	78.67	23.335	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

5.4.2.: Recovery scale

A. Hope:

We use a one sample t test to test if the opinion of the respondent about the Hope and the results shown in Table No. (5.5) which shows that the average mean for all items equal 2.60 and the weight mean equal 51.91 % which is less than " 60%" and the absolute value of t test equal 7.280 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the hope level for recovery is low among the participants in this study.

Table (5.5)
Hope

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	I feel my life is normal. despite of the psychiatric illness.	2.24	1.335	44.89	-7.590	0.000
2	I feel that my life is meaningless.	3.78	0.925	75.56	11.283	0.000
3	I give up to recover from psychiatric illness.	3.55	1.188	71.00	6.212	0.000
4	I have a hope of recovery, and I think that my life will be better in the future.	2.88	1.199	57.56	-1.368	0.173
5	I have the ability to be an effective and productive member in my society.	3.18	0.983	63.67	2.502	0.013
	All statement	2.60	0.745	51.91	-7.280	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

B. Self determination:

We use a one sample t test to test if the opinion of the respondent about the Self determination and the results shown in Table No. (5.6) which shows that the average mean for all items equal 2.48 and the weight mean equal 49.69% which is less than " 60%" and the absolute value of t test equal 9.799 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the samples members not ready to take risks in order to recover from psychiatric illness.

Table (5.6)
Self determination

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	I have a desire to work hard to be the best.	3.18	1.075	63.67	2.288	0.023
2	I work, learn and exercise my daily life despite of my psychiatric illness.	2.07	1.175	41.33	-10.656	0.000
3	I establish my social relationships, and share people in their occasions despite of my psychiatric illness.	2.06	1.187	41.22	-10.609	0.000
4	I am ready to take risks in order to recover from psychiatric illness.	3.22	0.995	64.44	2.997	0.003
5	Most of the time, I stay at home and watch TV.	4.11	1.051	82.22	14.182	0.000
	All statement	2.48	0.706	49.69	-9.799	0.000

Critical value of **t** at DF "179" and significance level 0.05 equal 1.97

C- Self esteem and self confidence:

We use a one sample t test to test if the opinion of the respondent about the Self esteem and self confidence and the results shown in Table No. (5.7) which shows that the average mean for all items equal 2.31 and the weight mean equal 46.25% which is less than " 60%" and the value of t test equal 16.461 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the samples feel lower than people due to psychiatric illness.

Table (5.7)
Self esteem and self confidence

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	I feel that I am like people.. I am not different from them or lower them.	2.26	1.278	45.11	-7.817	0.000
2	I deserve to be loved and respected from others.	3.47	1.005	69.33	6.230	0.000
3	I feel that I am lower than people due to my psychiatric illness.	3.68	0.906	73.67	10.118	0.000
4	I feel that psychiatric illness out of my control	3.99	1.151	79.89	11.595	0.000
5	I feel at peace with myself.	2.38	1.037	47.56	-8.054	0.000
6	I have the ability to follow up on initial signs that alarm of relapse and I can deal with it	2.13	0.988	42.67	-11.766	0.000
7	I do not accept myself as it, and is not happy for myself.	3.94	0.813	78.78	15.493	0.000
8	I feel guilty when I do or say what I want.	4.12	0.827	82.33	18.106	0.000
	All statement	2.31	0.560	46.25	-16.461	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

D- Asking help and support:

We use a one sample t test to test if the opinion of the respondent about the Asking help and support and the results shown in Table No. (5.8) which shows that the average mean for all items equal 2.99 and the weight mean equal 59.89% which is less than " 60%" and the value of t test equal 0.121 which is less than the critical value which is equal 1.97 and the p- value equal 0.904 which is greater than 0.05. that's means the stigma prevents the participants from asking help and support.

Table (5.8)
Asking help and support

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	Asking for help is a part of my recovery.	3.49	0.989	69.78	6.634	0.000
2	I often begin to ask for help when I need for it	2.93	1.246	58.56	-0.777	0.438
3	I hasten to seek support from someone close to me when I need it.	2.96	1.298	59.11	-0.459	0.647
4	My compliance to prayer and reading Holley Quran is important factor for recovery.	4.11	0.894	82.11	16.595	0.000
5	My compliance to take medications regularly contributes to recovery from psychiatric illness.	3.81	1.040	76.22	10.464	0.000
6	I find it difficult to know when to increase my mental worse and when I ask for help.	4.23	0.891	84.67	18.565	0.000
7	My shyness from psychiatric illness prevents me from seeking help and support.	4.09	1.082	81.89	13.576	0.000
	All statement	2.99	0.617	59.89	-0.121	0.904

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

Table 5.9

General results to the questionnaire item's.

The Summary of the Results:

First part: stigma scale.

Perceived stigma.	**64.54 %**
Media and stigma developing.	**78.49%**
Effect of stigma on daily life.	**78.67%**
Total level of stigma.	**73.93%**

Second part: Recovery scale.

Hope.	**51.91 %**
Self determination	**49.69%**
Self esteem and self confidence	**46.25%**
Asking help and support	**59.89%**
Total Level of recovery.	**49.69%**

- There was a significant relationship at significant level $\alpha = 0.05$ between Stigma and Recovery. (see table 5.12).

- There were no significant differences at significant level $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to age .(see table 5.13)

- There were a significant differences at significant level $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to gender and differences in favor of female. (see table 5.14).

- There were no significant differences at significant level $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to education level. (see table 5.15).

- There were no significant differences at significant level $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to income level. (see table 5.16).

- There were a significant differences at $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to Marital statue, and the difference between " Married " and " Divorced " and differences in favor of " Married (see tables 5.17-5.18).

- There was a significant relationship at significant level $\alpha = 0.05$ between the role of media and developing of stigma among depressed patients in Gaza Strip. (see table 5.19).

- The study found there was a significant relationship at significant level ($\alpha \leq 0.05$) between stigma and daily life of depressed patients. (see table 5.20).

5.5. Statistical analysis for research questions

5.5.1-What is the prevalence rate of stigma among depressed patients in Gaza Strip?

We use a one sample t test to test if the opinion of the respondent about the all Stigma scale and the results shown in Table No. (5.10) which shows that the average mean for all items equal 3.70 and the weight mean equal 73.93% which is greater than " 60%" and the value of t test equal 22.691 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the prevalence rate of stigma among the participants in this study is high.

Table (5.10)
All Stigma scale fields

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	Perceived stigma	3.23	0.418	64.54	7.300	0.000
2	Media and stigma developing.	3.92	0.727	78.49	17.056	0.000
3	Effect of stigma on the daily life of patient	3.93	0.537	78.67	23.335	0.000
	All statement	3.70	0.412	73.93	22.691	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

5.5.2- What is the level of recovery among depressed patients in Gaza Strip?

We use a one sample t test to test if the opinion of the respondent about the All Recovery scale statements and the results shown in Table No. (5.11) which shows that the average mean for all items equal 2.48 and the weight mean equal 49.69% which is less than " 60%" and the value of t test equal 9.799 which is greater than the critical value which is equal 1.97 and the p- value equal 0.000 which is less than 0.05, that's means the level of recovery among the participants in this study is low.

Table (5.11)
All Recovery scale statements

No.	statement	Mean	standard deviation	Weight mean	t-value	P-value
1	Hope.	2.48	0.706	49.69	-9.799	0.000
2	Self determination.	2.31	0.560	46.25	-16.461	0.000
3	Self esteem and self confidence.	2.99	0.617	59.89	-0.121	0.904
4	Asking the help and **support**	2.59	0.503	51.89	-10.810	0.000
	All statement	2.48	0.706	49.69	-9.799	0.000

Critical value of **t** at df "179" and significance level 0.05 equal 1.97

5.5.3-Is there a relationship between stigma and recovery among depressed patients in Gaza Strip at significant level α =0.05?

To test the question we use the Pearson correlation between Stigma scale and Recovery scale, and the results shown in table No. (5.12) which illustrate that the p-value equal 0.030 which is less than 0.05, and the value of Pearson correlation is equal -0.162 which is less than the critical value which is equal 0.141, that's means there was significant relationship at significant level α =0.05 between Stigma and Recovery .

Table No. (5.12)
Correlation between Stigma and Recovery

section	statistic	Recovery scale
Stigma scale	Pearson coloration	-0.162
	p-value	0.030
	N	180

Critical value of r at significance level 0.05 and df equal 179 equal 0.141

5.5.4-Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to socio-demographic data (age, gender, education level, income and marital status)?

And these questions divided into sub questions as follows:

a. **Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to age?**

To test the question we use the one way ANOVA and the result illustrated in table no. (5.13) which shows that the p-value equal 0.120 which is greater than 0.05 and the value of F test equal 1.973 which is less than the value of critical value which is equal 2.66 , that's means there were no significant differences at α ≤ 0.05 in developing of stigma among the participants in this study due to age .

Table No. (5.13)
One way ANOVA test for difference in developing of stigma among depressed patients in Gaza Strip due to age.

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
stigma developing of mental illness among depressed patients in Gaza Strip due to age	Between Groups	0.988	3	0.329	1.973	0.120
	Within Groups	29.383	176	0.167		
	Total	30.371	179			

Critical value of F at df "3,176" and significance level 0.05 equal **2.66.**

b. Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to gender?

To test the question we use the Independent Samples Test and the result illustrated in table no. (5.14) which shows that the p-value equal 0.000 which is less than 0.05 and the absolute value of T test equal 3.629 which is greater than the value of critical value which is equal 1.97, that's means there were a significant differences at α ≤ 0.05 in developing of stigma among the participants in this study due to gender. and differences in favor of female.

Table No.(5.14)
Independent Samples Test for difference in developing of stigma among depressed patients in Gaza Strip due to gender.

Field	Gender	N	Mean	Std. Deviation	T	P-value
stigma developing of mental illness among depressed patients in Gaza Strip due to gender	male	101	3.601	0.406	-3.629	0.000
	female	79	3.819	0.389		

Critical value of **t** at df "178" and significance level 0.05 equal 1.97.

c. Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to education level?

To test the question we use the one way ANOVA and the result illustrated in table no. (5.15) which shows that the p-value equal 0.295 which is greater than 0.05 and the value of F test equal 1.245 which is less than the value of critical value which is equal 2.66, that's means there were no significant differences at α ≤ 0.05 in developing of stigma among the participants in this study due to education level.

Table No.(5.15)
One way ANOVA test for difference in developing of stigma mental illness among depressed patients in Gaza Strip due to education level.

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
stigma developing of mental illness among depressed patients in Gaza Strip due to education level	Between Groups	0.631	3	0.210	1.245	0.295
	Within Groups	29.740	176	0.169		
	Total	30.371	179			

Critical value of F at df "3,176" and significance level 0.05 equal **2.66.**

d. Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to income level?

To test the question we use the one way ANOVA and the result illustrated in table no. (5.16) which shows that the p-value equal 0.221 which is greater than 0.05 and the value of F test equal 1.415 which is less than the value of critical value which is equal 2.27, that's means there were no significant differences at α ≤ 0.05 in developing of stigma among the participants in this study due to income level.

Table No.(5.16)
One way ANOVA test for difference in developing of stigma among depressed patients in Gaza Strip due to income level.

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
stigma developing of mental illness among depressed patients in Gaza Strip due to income level.	Between Groups	1.187	5	0.237	1.415	0.221
	Within Groups	29.185	174	0.168		
	Total	30.371	179			

Critical value of F at df "5,174" and significance level 0.05 equal 2.27

e. Is there a significant difference at α ≤ 0.05 in developing of stigma among depressed patients in Gaza Strip due to marital status?

To test the question we use the one way ANOVA and the result illustrated in table no.(5.17) which shows that the p-value equal 0.006 which is less than 0.05 and the value of F test equal 4.327 which is greater than the value of critical value which is equal 2.66 , that's means there were a significant differences at α ≤ 0.05 in developing of stigma among the participants in this study due to marital statue and table no.(5.18) illustrated that the difference between " Married " , and " Divorced " and differences in favor of " Married " .

Table No.(5.17)
One way ANOVA test for difference in developing of stigma among depressed patients in Gaza Strip due to marital status.

Field	Source	Sum of Squares	df	Mean Square	F value	Sig.(P-Value)
stigma developing of mental illness among depressed patients in Gaza Strip due to marital status	Between Groups	2.086	3	0.695	4.327	0.006
	Within Groups	28.285	176	0.161		
	Total	30.371	179			

Critical value of F at df "3,176" and significance level 0.05 equal **2.66**

Table No.(5.18)
Tukey honestly significant difference (HSD)

Mean Difference	Married	Single	Divorced	widow
Married		0.2114	0.4063*	0.0492
Single	-0.2114		0.1949	-0.1622
Divorced	-0.4063*	-0.1949		-0.3571
widow	-0.0492	0.1622	0.3571	

* The mean difference is significant at the .05 level.

5.5.5-Is there a relationship at significant level α =0.05 between the role of media and developing of stigma among depressed patients in Gaza Strip?

To test the question we use the Pearson correlation between the role of media and stigma of mental illness among depressed patients in Gaza Strip, and the results shown in table No.(5.19) which illustrate that the p-value equal 0.000 which is less than 0.05,

and the value of Pearson correlation is equal 0.603 which is greater than the critical value which is equal 0.141, that's means there was a significant relationship at significant level α =0.05 between the role of media and stigma developing among the participants in this study.

Table No. (5.19)

Correlation between the role of media and developing of stigma among depressed patients in Gaza strip.

section	statistic	stigma of mental illness among depressed patients in Gaza Strip
the role of media	Pearson coloration	0.603
	p-value	0.000
	N	180

Critical value of r at significance level 0.05 and df equal 179 equal 0.141

5.5.6-What is the effect of stigma on the daily life of depressed patients in Gaza Strip?

To test the question we use the Pearson correlation between effect of stigma on the daily life of depressed patients in Gaza Strip, and the results shown in table No.(5.20) which illustrate that the p-value equal 0.000 which is less than 0.05, and the value of Pearson correlation is equal 0.371 which is greater than the critical value which is equal 0.141, that's means there was a significant relationship at significant level α =0.05 between stigma and daily life of depressed patients in Gaza Strip**.**

Table No. (5.20)

Correlation between Stigma scale and the daily life of depressed patients in Gaza Strip.

section	statistic	the daily life of depressed patients in Gaza Strip
Effect of Stigma	Pearson coloration	0.371
	p-value	0.000
	N	180

Critical value of r at significance level 0.05 and df equal 179 equal 0.141.

Chapter six
Discussion, Conclusion and Recommendations

Chapter 6

Discussion, conclusion and recommendations

Discussion:

6.1 introduction

As outlined in Chapter two, the stigma of depression is different from that of other mental illnesses due to the negative nature of the illness that makes depressives seem unattractive and unreliable. Self stigmatization makes patients shameful and can prevent the recovery process. Stigma and depression share many symptoms, including: low self –esteem, lack of self confidence, loss of hope, isolation, loss of interest, and lack of social relationships.

As discussed in Chapter Three, the literature confirms that the stigma problem is spread widely among psychiatric patients. Also it considers the main barrier to achieve recovery from depression.

In this study, the researcher uses two scales to measure the level of stigma and recovery and to find the relationship between stigma and recovery among depressed patients in Gaza Strip.

In this chapter the researcher discusses the main findings of the study. This study is the first one on the field of mental health in Palestine according to the researcher's knowledge.

The study investigated the opinions of 180 depressed patients about the relationship between stigma and recovery on Gaza Strip in all community mental health clinics.

6.2. Discussion of the demographic characteristics of Participants:

The participants in this study represent depressed patients who treated in all community mental health clinics in 2009-2010 year.
Males (56.1 %), and largely young (21.1% under 30 years 37.2 % from 30 – 40 years). as PCBS (2010) reported that the population of the Palestinian Territory is young.
Female (44%), the researcher believes that the reason of why females numbers are less than males numbers is that the stigma level is high among females, which prevents females from seeking treatment and coming to the mental health clinics.

About Forty two percent of the participants are single at the time of collecting data. The result shows increase in numbers of single persons This is due to effect of stigma on the social status, self esteem, and lead to marriage failure. and most people with depression have never been married at time of depression episode and reduced likelihood of getting married after depression. Furthermore the psychiatric illness history has a negative effect on the marital status, and most persons refuse to married from any person who has history of psychiatric illness.

The educational background of the participants in this study tends to be lower than those of the general population, And address of the participants is distributed according to the numbers of depressed patients in each governorate. It was also found that (33.3 %) of the sample lived in Rafah Governorate.

According to the study result, the economic level for the participants is low due to the closure and siege, which increases unemployment and poverty in Gaza strip. Approximately 44.5% of the participants benefit from social affairs and were fully dependent on government funded support programs. And the value of their monthly income Less than 500 NIS(125$).

This low income level was due to a high rate of unemployment and poverty in Gaza strip as PCBS (2010) reported that the unemployment rate in Gaza strip is 43.8% (PCBS, 2010:16).

6.3. stigma scale

6.3. 1. Perceived stigma:

As predicted, the result shows high degree of perceived stigma among the participants in this study with general rate 64.54 %. The result shows that the majority of the participants are all likely to have experience of stigma. Often based on fear and misunderstanding of mental illness.

The researcher believes that the main evidence for presence of perceived stigma among depressed patients they prefers going secretly to the mental health clinic to avoid any embarrassment.

The current study found stigma connected to mental illness is pervasive and high among depressed patients. Perceived stigma result in a loss of self-esteem and self-efficacy and in limited prospects for recovery.

These findings were supported by Ansari et al (2008). They designed a study To identify socio-demographic correlates of stigma attached to psychiatric illnesses have found feelings of stigma was present in (47%) of the studied population. Another study by Depla et al (2005) found (57%) of the respondents had experienced stigmatization.

While the total weight mean of perceived stigma in current study (64.54 %.) the increase in a mean in current result may related to lack of understanding and awareness of mental illness.

The researcher considers that the stigma problem is spread across the world among psychiatric patients but the stigma level differs from a society to another According to culture, education, social, economic factors and status of mental health system in every society.

6.3. 2. Media and developing of stigma:

The result shows that (78.49%) from the participant reported that the media play a role in the stigma developing. The researcher thinks that there is a relationship between the media coverage and the stigma developing. And this result means link the media between violence and mental illness leads people to fear from psychiatric patient and Newspapers/television take unbalanced view about mental health problems.

The study result indicates that there is influence of the media on attitudes to mental health. Many people's knowledge about mental health and illness comes from the media coverage. Many studies have found that newspapers use derogatory language. Studies of UK television programmes and newspapers (Philo and colleagues, 2010) and (Shift, 2008) found that most of these were unsympathetic towards mental health issues.

The Social Exclusion Unit's (2004) reported on mental health found that (40%) of daily tabloid articles and nearly half of Sunday tabloid articles about mental health contained derogatory terms such as 'nutter' and 'loony'(Young minds, 2010:11).

Study conducted by Corrigan et (2005) found 39% of all stories in the media focused on dangerousness and violence and linked it with mental illness (WPA, 2005:14). The total weight mean of media and stigma developing in current study (78.49%) the increase in a mean in current result may related to media coverage linked mental illness with violence and crime, and that the mostly of these items were presented negatively.

The researcher's thinks that the Palestinian media don't give the enough attention toward mental health problems.

6.3. 3. Effect of stigma on daily life:

About (78.67%) of the total number of 180 participants mentioned that there was an effect of stigma on their daily life, that's means stigma affected negatively on daily life of the depressed patients.

The researcher thinks that the People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the stigma of mental illness. Stigma stops patients from getting the best treatment, This result was approved with study by Min et al (2001) showed that a fair proportion of patients with schizophrenia or depression perceived that stigma had a negative impact on their self-esteem, relationships and job opportunities.

This study found that there were significant effect for (stigma) on daily life of depressed patients as reduced self-esteem, increased social isolation, and failure to seek treatment. The participants in this study reported that the effect of stigma is more difficult to bear than the actual illness.

6.3. 4. Prevalence rate of stigma:

The study found the prevalence rate of stigma among the participants (73.93%). While study by Ritsher and Phelan (2004) found 33 percent of participants have very high scores of internalized stigma (Peterson et al, 2008:16). The increase in a mean in current result may related to lack of information systems about mental health to educate both professionals and the general public.

This high prevalence rate of stigma was similar of many studies all over the world for example: West et al (2011) found that 36% of the sample had elevated internalized stigma, Brohan et al(2010) found that 42% of survey respondents with schizophrenia across 14 European countries reported moderate or high levels of self-Stigma (Wahl, 2012:10). Study by Ansari et al (2008) found Feelings of stigma was present in (47%) of the studied population, another study by Depla et al (2005) found (57%) of the respondents had experienced stigmatization, study by Dinos et al (2004) Stigma was a pervasive concern to almost all participant.

6.4. Recovery scale:

The result shows that (51.91 %) from the participants have hope to recover from depression, that's means the hope level for recovery is low, Stigma leads to low self-esteem, isolation, and hopelessness. While the total weight mean for self determination (49.69%), that's means the participants are not ready to take risks in order to recover from psychiatric illness. And lack of desire and initiatives among participants to work hard to be the best.

The weight mean for self esteem and self confidence (46.25%), that's means the participants feel lower than the ordinary people due to psychiatric illness, feel with worthlessness and low self esteem and lack of self confidence and this is agreed with the study by Link et al (2001) found the stigma associated with mental illness harms the self-esteem of many people who have SMI and An important consequence of reducing stigma would be to improve the self-esteem of people who have mental illnesses, While the weight mean for asking help and support (59.89%), that's means stigma prevents depressed patients from asking help and support. As The APA reported that "20% of Americans don't seek help from a mental health professional because they feel there is a stigma associated with therapy (Hobson, 2008:7). All the above results indicate that recovery aspect which presented in the questionnaire is low among the participants.

The researcher thinks that the stigma of mental illness put people at risk of having low self-esteem and low self confidence.

6.4. 1. Total level of recovery:

The study found that the recovery level (49.69%) among depressed patients, while NAMHC (National Advisory Mental Health Council) states that recovery rates include: schizophrenia, 60%, bipolar disorder, 80%, major depression, 65-80%, and addiction treatment, 70 % (Humphries et al, 2007:8). The researcher thinks that the decrease in a mean in current results that related to stigma which associated with people who have serious mental illness continues to be one of the major barriers to the recovery process.

In 27 major long-term follow-up studies published between 1960 and 1991, the percentage of patients assessed as clinically recovered ranged from a low of 6 percent to a high of 66 percent, the percentage of patients who showed a social recovery ranges from a low of 17 percent to a high of 75 percent (Ralph, 2000: 17).

According to the current result, the recovery level is low, and the stigma is an important factor in decreasing the recovery level.

6.5. The relationship between stigma and recovery

The study found that the prevalence rate of stigma (73.93%) whiles the recovery level (49.69%) and there is a relationship between independent variable (stigma) and dependent variable (recovery). Which indicates that the stigma is the main barrier to achieve recovery.

This result was approved with study by Depla et al (2005) found the stigma is a barrier to achieve Recovery, Stigmatization did show a negative association with quality of life and recovery from serious mental illness.

In the current study, 73.93% of the patients have feeling of stigma because of their mental illness. The result showed that more than two third from participants in this study would have low recovery level due to the effects of stigma.

6.6. Socio-demographic data (age, gender, education level, income and marital status) and developing of stigma.

6.6. 1. Age and developing of stigma:-

The study shows that there is no significant difference at $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to age (table 5.20), that's means that age is not play a role in developing of stigma

According to the current study stigma of depression is pervasive and prevalent in majority of participants of all ages, the researcher believes that stigma is common and prevalent in individuals of all ages.

Different Study by Rose et al (2007) found Children and young people have experience higher levels of stigma than adults.

Study conducted by Sirey et al (2001) found younger adults reported higher levels of overall perceived stigma than the older adults with major depression. Chandra (2007) indicate to the Studies which look at attitudes to mental health reveal that younger people have very negative views and use pejorative terms in their everyday language. This is associated with a low level of knowledge about mental health; it seems that young people with mental health problems are more likely to experience higher levels of stigma than adults (Young Minds, 2010:3).

As a researcher I see that, stigmatizing attitudes towards depression differ by Socio-demographic characteristics from a society to another. In this current study the result shows that there is no age difference in the stigma developing and no clear relationship between depression stigma and participant age.

6.6. 2. Gender and developing of stigma:-

The study found that there is a significant difference at $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to gender and differences in favor of female. (table 5.21), that's means that females have high stigma more than males and females are more likely to be exposed to stigma than males. And gender plays a role as a factor in the developing mental-illness stigma.

This incongruent result with study conducted by Cechnicki and Bielanska (2009) found gender proved to be of no significance for the explanation of the indicators of stigma. Another Study conducted by Ansari et al (2008) found Males had slightly more feelings of stigma than female. show that feeling of stigma was more in males then in female as 49% of male as compare to 45.41% of female.

From the researcher's view, the current result indicates female plays a role in the stigma developing. Therefore, gender differences in the stigmatizing attitudes observed in this study was expected in favor of female, this may be due females are more likely to be exposed to depression and females emotionally weak more than males.

6.6. 3. Education level and developing of stigma:-

The study found that there is no significant difference at $\alpha \leq 0.05$ in stigma developing of stigma among depressed patients in Gaza Strip due to education level. (table 5.22), that's means that education level is not play role in the stigma developing.

The findings in this study are completely different with the Study conducted by Ansari et al (2008) found a part from people with no formal education who had maximum stigma feelings, another study conducted by Griffiths et al (2008) showed that Personal stigma was consistently higher among men, those with less education. Which was consistent with study in Canada found higher educational level were less likely to report stigmatizing attitudes than others (Cook and Wang, 2010:18).

6.6. 4. Income level and developing of stigma:-

The study found that there is no significant difference at $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to income level. (table 5.23), that's means that income level is not play a role in the stigma developing.

The current study result disagree with study conducted by Cook and Wang (2010) found that participants with an annual income of $80,000 or more (46.5%) were more likely to have stigma than those with an annual income below $30,000 (33.5%).

Another Study conducted by Sharac et al (2008) found Mental illness stigma/discrimination was found to impact negatively on employment, income, public views about resource allocation and healthcare costs. The researcher's thinks that the stigma negatively affects on the economic level for psychiatric patients, so this study found the majority of participants have low economic level.

6.6. 5. Marital status and developing of stigma:-

The study found that there is a significant difference at $\alpha \leq 0.05$ in developing of stigma among depressed patients in Gaza Strip due to Marital status, and the difference between " Married " and " Divorced " and differences in favor of " Married " . (tables 5.24-5.25), that's means that Married persons have stigma more than others (single, divorced, widowed).This result is partially consistent with study conducted by Cook and Wang (2010) found Participants who were married or in a common-law relationship (41.3%) and those who were divorced, separated or widowed (43.8%) indicated that they have stigma of depression. This findings disagree with study by al-Krenawi (2004) found marital status were found to be significant predictors of a positive attitude towards help-seeking. According to current study, the reason of why stigma is high among married persons more than others is that married people live under many special circumstances, in other hand more responsibility, more sociality and also more payment for live requirements so; all the previous reasons increase the stigma level among the married people.

6.7. Conclusions

Generally, this result clearly shows high prevalence rate of stigma and low level of recovery among depressed patients on the six studied clinics. In which strongly supports the idea of urgent need to reduce stigma and increase people awareness about mental illness.
The results are similar to the other studies results which are on the literature review section. Most of the studies on the review section showed high level of stigma among psychiatric patients.

Stigma was perceived as a common phenomenon among depressed patients who are treated in the community mental health clinics in Gaza Strip. Recovery level is low among depressed patients who are treated in the community mental health clinics in Gaza Strip. In current study, some demographic variables seems to be markedly negative affected by the feelings of stigma due to psychiatric illness as education and income level and some demographic variables play a role in the stigma developing as gender and marital status. About (78.67%) from participants reported there is a negative effect of stigma on their daily life. And there was significant effect for (stigma) on daily life of depressed patients as reduced self-esteem, increased social isolation, and failure to seek treatment. The stigma associated with depression represents a challenge for effective mental health care. The solution for minimizing this stigma through anti-stigma programs is essential and necessary. There is a relationship between the media coverage and stigma developing. Approximately seventy eight from participants have reported that the media plays role in the stigma developing. And there is a negative relationship between stigma and recovery. Which indicates the stigma is the main barriers toward recovery achievement. Stigma has been found to contribute to lowered self-esteem, treatment avoidance. The findings highlight the importance of treating the concepts of personal and perceived stigma and

improve recovery level among depressed patients. Reduce the prevalence rate of is a core component of the ongoing process of recovery from depression.

The stigma of depression presents a serious barrier not only to diagnosis and treatment but also to acceptance in the community and stigma is still a tangible obstacle to providing proper mental health care for the mentally ill in Gaza Strip. The findings of the study would suggest that changing attitudes regarding personal responsibility for mental illness may increase the public's openness to seeking mental health services when in need. Compliance to prayer and reading Holley Quran is important factor for recovery.

6.8 Recommendations

The researcher set some recommendations which might help the concerned parties from the authorities to reduce stigma and improve recovery process this would lead to better lives to the psychiatric patients.

6.8.1.Practical recommendations:

- Encourage 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 this group.
- Challenge any myths or misconceptions about mental illness, such as links to violence or misunderstanding about the behavior of those who are unwell.
- Provide public education to fight the stigma. Involve people with mental illness and their families. Public meetings should be held to raise awareness of mental health and its prevention and promotion .
- Creating strong systems of mental health services and supports with staff who can offer acceptance and hope.
- Provide Information on the rights of people who have mental illnesses. MOH should bear the responsibility for protection of the psychiatric patient's rights.
- Using recovering people effectively as examples of success in recovery.
- Helping psychiatric patients to understand the importance of their personal strengths and presence of hope to improve their recovery level.
- Training and technical assistance to help create effective anti–stigma campaigns. The campaign involved educational leaflets, booklets and videos aimed to reduce stigma and improve recovery level.
- The researcher recommends that MOH and decision makers should put enough budgets for rehabilitation of psychiatric patients.
- Increase the spiritual support because the Islamic religion play important role in definitions of health and illness as well as stigma reduction and management.

6.8.2.Research recommendations:

According to study results and limitations, the researcher recommends the following further researches.

- Future studies should use probability sample and increase the sample size at both community mental health clinics and psychiatric hospital to be more representative of the psychiatric patients in Gaza Strip.
- Further research is necessary to measure the level of stigma and recovery from all different mental disorders.
- Provide information about depressive disorders, symptoms, neurology, treatment, recovery, etc. This information might come in the form of written Materials, presentations, and contact with real people who are successfully managing depressive disorders**.**

6.9. Limitations of the Study:

- The population in this study is composed of depressed patient who treated in governmental mental health clinics, so this sample is not representative depressed patient who treated in the psychiatric hospital or NGOs.
- Incomplete archive system in some community mental health clinics since 2009-2011 year.
- No Statistics resources of mentally ill persons in Palestinian territories especially about depressed persons.
- Some depressed persons aren't cooperative and refuse to participate in this study; this takes long time to persuade them for participation in this study.
- Lack of related local researches.
- Lack of related text's and references.
- Lack of logistic support (regular electricity cut).
- Purposive sample is the weakest form of sample, it affect on the external validity and unable to generalize the results of the study.

Reference:-

American Psychiatric Association (2005): **Use of the Concept of Recovery**, Revised by Committee on Public and Community Psychiatry, Approved by the Assembly and he Board of Trustees, 1-1.

Ansari, M., Rahman, R., Siddiqui, A., Jabeen, R., Qureshi, N., Sheikh, A. (2008): **Socio-Demographic Correlates of Stigma Attached to Mental Illness**, Orginal article, Department of Psychiatry, Liaquat National Hospital, Karachi, Sindh-Pakistan, 199-203.

Alhajar, B. (2005): **psychiatric mental health nursing**, Islamic university of Gaza, faculty of nursing, 1-200.

Afana, A. (1997): **Educational Statistics**. Part one, Descriptive Statistics. Almugdad, Gaza, Palestine.

Brohan, E., Slade, M., Clement, S.and Thornicroft, G. (2010): **Experiences of mental illness stigma**, Health Services Research ,Institute of Psychiatry, King's College London, 10:80, 1-11.

Baun, K.(2009): **The Media's Impact on Public Perceptions of Mental Illness**, Ontario, Canadian Mental Health Association, National Office, 1-3.

Barkway, P. (2005): **Theories in mental health and illness**, psychiatric and mental health, by Christine wade, SANE Australia, 1-447.

Byrne, P. (2000): **Stigma of mental illness,** Advances in Psychiatric Treatment, vol. 6, by Royal College of Psychiatrists, London, 65–72.

Buckland, S. (2005): **Sharing Responsibility for Recovery**, Queensland health government, Australia, ISBN 1 921021 160, 1-32.

Bromley, J., Cunningham, S. (2004): Stigma and psychiatric in-patients, Psychiatric Bulletin, V 28, original articles, PP(371-374).

Coyle, B. (2011): **Depression, Causes and Risk Factors**, Article Release, by National Institute of Health Publication, 1-2.

Curry, J., Silva, S., Rohde, P., Ginsburg, G., Kratochvil, CH., Simons, A., Kirchner, J., May, D., Kennard, B., Mayes, T., Feeny, N., Albano, A., Lavanier, S., Reinecke, M., Jacobs, R., Weidman, E., Weller, E., Emslie, G., Walkup, J., Kastelic, E., Burns, B., Wells, K., March, J.(2011): **Recovery and Recurrence Following Treatment for Adolescent Major Depression**, orginal article, Arch Gen Psychiatry, VOL 68, NO 3, 263-270.

Corrigan, P.(2004): **How Stigma Interferes With Mental Health Care**, American Psychologist, University of Chicago, by the American Psychological Association Vol. 59, No. 7, 614–625.

Cook, T., Wang, J. (2010): **Descriptive epidemiology of stigma against depression in a general population,** by Department of Community Health Sciences and Department of Psychiatry, Faculty of Medicine, University of Calgary, Canada, Research article, BMC Psychiatry journal, 1-34.

Couture, SH., Penn, D. (2003):**Interpersonal contact and the stigma of mental illness**, Journal of Mental Health, vol 12, 3, University of North Carolina at Chapel Hill, USA, 291 – 305.

Cechnicki, A., Bielańska, A. (2009): **Demographic, social and clinical variables of Anticipated and experienced stigma of mental illness**, by journal of the European association for psychotherapy, Vol 2, 49–63.

Cooper, E., Corrigan, W., Watson, C. (2003): **Mental illness stigma and care seeking**, Original article, The Journal of Nervous and Mental Disease, Volume 191, issue 5, 41-339.

Corrigan, P., Ralph, R. (2005): **Examining the Factor Structure of the Recovery Assessment Scale**, University of Chicago Center for Psychiatric Rehabilitation, 1-24.

Davidson, K., Rieckmann, N., Lesperance, and F. (2004): **Psychological Theories of Depression**: Potential Application for the Prevention of Acute Coronary Syndrome Recurrence, Psychosomatic Medicine 66, by the American Psychosomatic Society, 165-173.

Dinos, S., Stevenes, S., Serfaty, M., Weich, S., King, M. (2004): **The feelings and experiences of 46 people with mental illness**, British journal of psychiatry, Vol 184, 176-181.

Dowd, T.(2004) : **Depression, Theory, assessment, and new directions in practice**, Kent State University, USA, International Journal of Clinical and Health Psychology, Vol. 4, No 2, 413-423

Everet, B. (2006): **stigma the hidden killer**, Background Paper and Literature Review, By Mood Disorders Society of Canada, 1-51.

Elder, R., Evans, K., Nizette, D. (2005): **Psychiatric and mental health nursing**, mood disorders, printed in Australia by Southwood Press, by National Library of Australia Cataloguing-in-Publication Data, Elsevier Australia, 1-436.

Fisher, D. (2011): **New Vision of Recovery**, original article, by National Empowerment Center, from outside the US: 978-685-1494, 1-3.

Furukawa, T., Takeuchi, H., Hiroe, T., Mashiko, H., Kamei, K., Kitamura, T., Takahashi, K.(2001): **Symptomatic recovery and social functioning in major depression, by Department of Psychiatry**, Nagoya City University Medical School, Japan, 257-261.

Giacaman, R., Rabaia, Y, Gillham, V., Batniji, R., Punamäki, R., Summerfield, D.(2010): **Mental health, social distress and political oppression**, The case of the occupied Palestinian territory Global Public Health, First published on: 23 November 2010, 1-13.

Griffiths, K., Christensen, H., Jorm, A.(2008): **Predictors of depression stigma, by** Centre for Mental Health Research, The Australian National University, BMC Psychiatry, 8:25, 1-12.

Humphries, R., Hollins, S. and Kilgallon, B. (2007): **A common purpose Recovery in future mental health services**, by the Social Care Institute for Excellence, Care Services Improvement Partnership and Royal College of Psychiatrists, 1-37.

Hobson, H. (2008): **The effect of mental health education on reducing stigma and increasing positive attitudes toward seeking therapy**. The faculty of Humboldt State University, 1-59.

Hupp, D. (2008): **The Role of the Wellness Management and Recovery Program in Promoting Social Support,** the University of Toledo, 1-93.

Ismail, A. (2011): **Nursing research**, Islamic university of Gaza, faculty of nursing, 1-78.

Jesoor for Trauma Recovery (2009): **Stop radicalization of our children**, Jesoor Annual report, azroub building, Gaza City, 1-12.

Johnson, E. (2000): **Recovery Principles**, an Alternative in Maricopa County For Individuals Who Experience Psychiatric Symptoms, META Services, 1-15.

Kondrate, D. (2008): **Effects of stigma and working alliance on the quality of life of persons with severe mental disabilities receiving community based case management services,** the Ohio state university, approved by social work graduate program, 1-214.

Kopache, R. (2008): **Beyond Maintenance: Facilitating Recovery from Mental Illness**, Northern Kentucky University, 1-41.

Kirby, M., Howlett, M., Chodos, H. (2009): **Toward recovery and wellbeing, a framework for a mental health strategy for Canada**, draft for public discussion, by mental health commission of Canada, 1-57.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., Weich S., Serfaty, M. (2007): **The Stigma Scale, development of a standardized Measure of the stigma of mental illness**, British journal of psychiatry, 198, 248-254.

Kaptien, K. (2008): **recovery from depression**, by university of Groningen, 1-179.

Link, B., Struening, E., Todd, Sh., Asmussen, S., Phelan, J.(2001):**The consequences of stigma for the self esteem of people with mental illness**, Psychiatric Services, vol 52, No 12, 1621-1626.

Ministry of health (MOH), (2010): **Annual report about the activities of General mental health directorate**, 1-4.

Mental Health Atlas, world health organization (2005): **information on mental health resources in the world**, department of mental health and substance abuse, 517-540.

Morgan, G.(2003) :**The views of members of the Highland Users Group on the stigma of mental illness**, report about the stigma of mental illness, by Highland Users Group, Highland Community Care Forum and Highland House, Scotland, 1-18.

Martin, N. (2008): **Promoting a shared understanding of recovery**, consumer focused recovery, by the mental health commission of Canada, 1-23.

Min, L., Hong, C., Chee, C. (2001) :**Stigma of Mental Illness**, original article, Singapore Med Journal, vol 42, No 3, 111-114.

Meyers, B., Sirey, J., Bruce, M., Hamilton, M., Raue, P., Friedman, S., Rickey, C., Kakuma, T., Carroll, M., Kiosses, D., Alexopoulos, G.(2002): **Predictors of Early Recovery From Major Depression Among Persons Admitted to Community-Based Clinics**, Weill Medical College of Cornell University and New York, Arch Gen Psychiatry, VOL 59, 729-735.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. (2005): **Applied Social Research, A Tool for the Human Services**, Sixth Edition, Thomson Learning, Inc: Toronto, Canada, 1-11.

M Lai, Y., Hong, C., Chee, C. (2001): **stigma of Mental Illness**, Singapore Med, original articles, Vol 42(3), Singapore, 111-114.

National Collaborating Centre for Mental Health (2010): **Depression, the treatment and management of depression in adults**, by The British Psychological Society and The Royal College of Psychiatrists, London, updated edition, 1-195.

Naeem, S., Ali, B., Iqbal, A., Mubeen, S., Gul, A.(2004): **Spontaneous Recovery from Depression in Women**, by Department of Psychiatry The aga Khan University, Karachi, 1-4.

Nasir, L., Qutob, R. (2005): **Barriers to the Diagnosis and Treatment of Depression in Jordan**, by Department of Family and Community Medicine, University of Jordan Faculty of Medicine, Amman, Jordan, Vol. 18 No. 2 , 125-131.

Novak, L., Svab, V.,(2009): **Anipsychotic side effect, influence on stigma of mental illness**, Psychiatria Danubina, Vol. 21, No. 1, 99–102.

Newell, R., Gournay, and K. (2008): **mood disorders, mental health nursing**, second edition, Elsevier health science right department, London New York oxford Philadelphia. Etiologic Factors Related to mood disorders, 1-419.

National Institute of Health (2008): **depression**, U.S, department of health and human services, NIH publication No. 08 3561, 1-23.

National Alliance on Mental Illness (NAMI), (2008): **Understanding bipolar disorder and recovery**, Wilson Boulevard, Arlington, 1-29.

Nasir, L., Qutob, N. (2005): **Diagnosis and Treatment of Depression in Jordan**, family medicine, world perspective, Vol. 18 No. 2, 125-131.

Ostman, M., kjellin, L. (2002): **Stigma by association**, British journal of psychiatry, 181, 4 9 4 -4 9 8.

Onken, S., Dumount, J., Ridgway, P., Doman, D., and Ralph, R. (2002): **Mental health recovery**, by National Technical Assistance Center for State Mental Health Planning, new yourk, USA, 1-108.

Potokar, D. (2008): **The role of personal loss in recovery and quality of life**, College of Bowling Green, 1-195.

Palestinian Central Bureau of Statistics (2010): **Palestine in Figures 2009**, Palestine national authority, Ramallah, Palestine, 1-64.

Palestinian Central Bureau of Statistics (2011): **Information about Palestinians population at the end of 2011**, Palestine national authority, Ramallah, Palestine, 1-3.

Perlick, D., Rosenheck, R., B.(2001): **Adverse Effects of Perceived Stigma on Social Adaptation of Persons Diagnosed With Bipolar Affective Disorder**, Psychiatric Services Vol 52, No. 12, 1627–1632.

Potokar, D.(2008): **living with serious mental illness, the role of personal loss in recovery and quality of life,** all rights reserved by Daniel Nicole potokar, 1-209.

Peveler, R., Carson, A., Rodin, G.(2003): **Depression in medical patients**, ABC of psychological medicine, by BMJ Books, BMA House, Tavistock Square, London, British Library Cataloguing in Publication Data, Printed and bound in Spain by GraphyCems, Navarra, 1-57.

Peterson, D., Alex, B., Duncan, CH.(2008): **fighting shadows, self stigma and mental illness**, mental health foundation of New Zealand, PP(1-87).

Ralph, R. (2000): **A Synthesis of a Sample of Recovery Literature**, by the National Association of State Mental Health Program Directors, 1-35.

Roberts, G., Wolfson, P. (2004): **The rediscovery of recovery**, advances psychiatric treatment journal, published by the royal college of psychiatrist, vol, 10 , 37-49.

Rourke, M. (2009): **The Role of the Wellness Management and Recovery (WMR) Program in Promoting Mental Health Recovery**, The University of Toledo, and 1-109.

Roca, C. (2010):**Depression**, U.S. Department of Health and Human Services, Office on Women's Health, by National Institute of Mental Health, Content last updated March 17, 2010, 1-6.

Stuart, G. (2007): **principle and practice of psychiatric nursing**, the Stuart stress adaptation model of psychiatric nursing care, by evolve, 9edition, 1-487.

Sherman, p. (2007): **Stigma, mental illness**, **and culture**, 1-11.

Scheffer, R. (2003): **Addressing Stigma, by public education and information services**, Center for addiction and mental health, 1-12.

Sadock, Benjamin J.; Sadock, Virginia A. (2007): **Synopsis of Psychiatry**: Behavioral Sciences/Clinical Psychiatry, mood disorders, 10th Edition, Lippincott Williams & Wilkins, 1-1391.

Sharac, J., McCrone, P., Clement, S., Thornicroft, G. (2008): **The Economic Impact of Mental Health Stigma and Discrimination**: A Systematic Review, Institute of Psychiatry, King's College London, 1-27.

Sirey, Jo., Bruce, M., Alexopoulos, G., Perlick , D., Raue, P., Friedman, S., Meyers, B.(2001): **Perceived Stigma as a Predictor of Treatment Discontinuation in Young and Older Outpatients With Depression**, Am J Psychiatry 158:3,479-481.

US department of health and human services (2004): **National consensus conference statement on mental health recovery**, by US department of health and human services substance abuse and mental health administration, 1-2.

Vickers, D., Masri, S. (2005): **Final report mental health needs assessment in Palestinian refugee camps**, Lebanon, by Karim Rida Said Foundation In Collaboration with UNRWA, 1-30.

Videbeck, S.(2003): **Psychiatric Mental Health Nursing**, mood disorders, Community College of Denver Denver, Colorado, , second edition, Lippincott Williams & Wilkins, 1-542.

Voinovich, G., Hogan, M. (1995): **The Recovery Concept**, Ohio Department of Mental Health, Columbus, Ohio 43266-0414, 1-25.

World psychiatric association (2005): **The wpa global programme to reduce stigma and discrimination because of schizophrenia**, Bibliography, second edition, 1-68.

West, M., Yanos, ph., smith, S., Roe, D., Lysaker, P.(2011): **Prevalence of Internalized Stigma among Persons with Severe Mental Illness**, by Department of Psychology, John Jay College of Criminal Justice, USA, Vol 1, No 1, 54-59.

Woll, P. (2007): **Healing the stigma of depression**, by Midwest AIDS training and education center, university of Illinois at Chicago, 1-176.

Wolpert, L. (2001): **Stigma of depression**, University College London, London, UK British Medical Bulletin; 57, 221–224.

WHO and WPA (2002): **Reducing stigma and discrimination against older people with mental disorders**, Geneva, by WHO 1-26.

Young Minds (2010): **The stigma review of the evidence**, London, Registered charity No 1016968, 1-15.

Young, A.(2008): **Risk Taking, Social Stigma and Recovery from Severe Mental Illness**, Oregon State University, University Honors College, 1-21.

Young, SH., Ensing, D. (2003): **Exploring recovery from the perspective of people with psychiatric disabilities**, by Psychiatric Rehabilitation Journal, Vol. 22 Issue 3, 1-22.

Zeev, D.(2010): **DSM-V and the stigma of mental illness**, Journal of Mental Health, 19(4), Institute of Psychology, Illinois Institute of Technology, Chicago, Illinois, USA., 318-327.

Annexes

Annex (1)

نموذج موافقة للمشاركة في الدراسة

عزيزي المشترك:

تهدف هده الاستبانة إلي جمع البيانات اللازمة لدراسة **العلاقة بين الوصمة والتعافي بين مرضى الاكتئاب في محافظات غزة.**

أرجو التكرم بالتعاون في تعبئة هده الاستبانة، حيث إنها جزء من دراستي للحصول علي درجة الماجستير في الصحة النفسية المجتمعية–علوم التمريض.

كما سيكون لآرائكم بالغُ الأثر في نجاح هده الدراسة وما يترتب عليها من تحسين في خدمات الصحة النفسية المجتمعية.

الاستبانة تحتوي علي خمسة خيارات للإجابة وهي(موافق بشدة، موافق، لا أعرف، غير موافق، غير موافق بشدة) فحاول اختيار مدى الرضي الذي يصف شعورك بدقة، إذا وافقت علي المشاركة في البحث فيبقي لك الحق في الانسحاب من البحث متى شئت، علماً بأن إجابتك ستحترم وستعامل بسرية تامة، وستستخدم لأغراض البحث العلمي فقط، ولا داعي لذكر اسمك.

شكرا لتعاونكم

الباحث: أسامة جبر عماد.

Annex (2)

الرقم ----------

(خاص بالباحث)

إستبـــــانـة

المعلومات الأولية الشخصية:

١-العمر.....سنة.

من فضلك ضع علامة (×) في المربع المناسب لك.

٢-الجنس:

☐ ذكر ☐ أنثى.

٣-العنوان

☐ محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى ☐محافظة خان يونس ☐محافظة رفح.

٤-الحالة الاجتماعية:

☐أعزب/ آنسة ☐ متزوج/ ة ☐ أرمل/ ة ☐ مطلق/ ة.

٥- المستوى التعليمي:

☐ابتدائي ☐ إعدادي ☐ ثانوي ☐ جامعي.

٦: المستوى الاقتصادي

أ. مصادر دخل الأسرة:

☐ شئون اجتماعية ☐ عمل الشخص نفسه ☐عمل الزوج/ ة ☐ عمل الأولاد ☐أراضي زراعية

☐ تربية المواشي والأغنام ☐ أعمال أخرى.

ب. قيمة الدخل الشهري:

☐ اقل من ٥٠٠ شيقل ☐ من ٥٠٠-١٠٠٠شيقل ☐ من ١٠٠٠-١٥٠٠شيقل ☐ من ١٥٠٠-٢٠٠٠ شيقل ☐من ٢٠٠٠- ٢٥٠٠ شيقل ☐ أكثر من ٢٥٠٠ شيقل.

أولا: استبانة الوصمة.

الرقم	العبارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
الشعور بالوصمة						
١	أشعر بالخجل عند إخبار الناس بأني مريض نفسياً .					
٢	زيادة عدد سنوات المرض يؤدي إلي زيادة خجلي من المرض النفسي.					
٣	أشعر بأني أقل قيمة من الناس بسبب مرضي النفسي.					
٤	أعتقد بأن الخوف من المرض النفسي يحرمني من العلاج المناسب في الوقت الناسب.					
٥	الدعم الاجتماعي والعائلي يخفف الخجل من المرض النفسي.					
٦	إنكار المرض النفسي يفتح الباب أمام السحرة والمشعوذين.					
٧	اعتقد بأن الدخول في مستشفي الطب النفسي هو علامة ضعف للشخص.					
٨	عند مقابلتك شخصا لأول مرة فإنك تبذُل جهداً لإخفاء حقيقة أنك مريض نفسي.					
٩	أعتقد بأن الناس يجهلون أن المرض النفسي مثل المرض العضوي وهو قابل للعلاج.					
١٠	أُفضل الذهاب سرا إلي عيادة الصحة النفسية منعاً لأي إحراج.					
وسائل الإعلام و تطور الوصمة						
١١	ربط وسائل الإعلام بين المرض النفسي والعنف أدى إلي خوف الناس من المريض نفسياً .					
١٢	أعتقد بأن سبب الخجل من المرض النفسي هو ربط وسائل الإعلام بين المرض النفسي والجنون.					
١٣	تتناول وسائل الإعلام المشاكل النفسية بشكل متزن ومحايد.					
١٤	وسائل الإعلام تستخدم كلمات تسيء للمريض النفسي.					
١٥	تربط وسائل الإعلام بين مرتكبي الجرائم والمرضي النفسيين.					

تأثير الوصمة على حياة المريض اليومية						
الرقم	العبارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
١٦	تم رفض طلبي لعدة وظائف بسبب مرضي النفسي.					
١٧	أُفضل البقاء بالمنزل لوحدي وعدم الاختلاط بالآخرين بسبب مرضي النفسي.					
١٨	الناس يتجنبونني بسبب مرضي النفسي.					
١٩	الناس يتهمونني بالجنون بسبب مرضي النفسي.					
٢٠	الناس ينظرون إلي بعين الحزن والشفقة، لأني مريض نفسياً .					
٢١	الناس لا يُوجهون إلي الدعوة لكي أشاركهم مناسباتهم.					
٢٢	أتعرض للإهانة ممن حولي بسبب مرضي النفسي.					
٢٣	الناس لا يتقبلون المريض النفسي كصديق مقرب.					
٢٤	ألوم نفسي لأني المسئول عن حدوث المرض النفسي.					
٢٥	أشعر بالخجل بسبب مرضي النفسي، وهذا يمنعني من التعبير عن وجهة نظري بسهولة.					
٢٦	الناس يُشعرونني بالخجل من مرضي النفسي.					
٢٧	أتجنب إقامة علاقات اجتماعية مع الناس حتى لا اشعر بالتمييز بينهم.					
٢٨	أُفضل إعطاء اسم مستعار وتغيير هيئتي ولباسي عند الذهاب للطبيب النفسي منعا لأي إحراج .					
٢٩	لجأت إلى ممارسة بعض الطقوس الشعبية (الفتاحين، المشعوذين ....الخ) بسبب خجلي من مرضي النفسي.					
٣٠	للمتزوج/ة المرض النفسي أدي إلي فشل حياتي الزوجية. لغير المتزوج/ة أعتقد بأن مرضي النفسي كان السبب الرئيسي وراء عدم زواجي.					

ثانيا/ استبانه التعافي.

الرقم	العبارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
الأمل						
١	أشعر بأن حياتي طبيعية رغم وجود المرض النفسي					
٢	أشعر بأن حياتي بدون معني أو قيمة.					
٣	أشعر باليأس من التعافي من مرضي النفسي.					
٤	لدي الأمل في التعافي، وأعتقد أن حياتي ستكون أفضل في المستقبل.					
٥	لدي القدرة علي أن أكون عضواً فعالاً ومنتجاً في المجتمع.					
التصميم والعزيمة						
٦	لدي الرغبة للعمل بجدّ لكي أكون أفضل.					
٧	أعمل، أتعلم وأمارس حياتي اليومية علي الرغم من وجود المرض النفسي.					
٨	أقيمُ علاقاتي الاجتماعية وأشارك الناس مناسباتهم علي الرغم من وجود المرض النفسي.					
٩	أنا علي استعداد لتحمل المخاطر من اجل التعافي من مرضي النفسي.					
١٠	أبقي في المنزل وأشاهد التلفاز معظم الأحيان.					
تقدير الذات والثقة بالنفس						
١١	أشعر أنى مثل الناس ..لست مختلفا عنهم أو أقل منهم.					
١٢	أنا أستحق أن أكون محبوباً وموضع احترام الآخرين.					
١٣	أشعر بأني أقل قيمة من الناس بسبب مرضي النفسي.					

الرقم	العبـــــارة	موافق بشدة	موافق	لا أعرف	غير موافق	غير موافق بشدة
١٤	أشعر بأن مرضي النفسي خارجُ تماماً عن سيطرتي وتحكمي.					
١٥	أشعر بالارتياح والرضى بشأن نفسي.					
١٦	لدي القدرة علي متابعة العلامات الأولية التي تنذر بالنكسة وأستطيع التعامل معها.					
١٧	لا أتقبل نفسي كما هي، وغير سعيد بنفسي.					
١٨	أشعر بالذنب عندما أفعل أو أقول ما أريد.					
	طلب المساعدة والدعم					
١٩	طلبي للمساعدة جزء من التعافي من مرضي النفسي.					
٢٠	ألجأ أن اطلب المساعدة عندما احتاج إلي ذلك.					
٢١	أسارع إلي طلب الدعم من شخص مقرب متى أحتاج إلي ّ ذلك.					
٢٢	التزامي بالصلاة وقراءة القرآن عامل مهم للتعافي.					
٢٣	التزامي بتناول الأدوية بشكل منتظم يساهم في التعافي من المرض النفسي.					
٢٤	أجد صعوبة في معرفة متى تزداد حالتي النفسية سوءا ومتى أطلب المساعدة.					
٢٥	خجلي من المرض النفسي يمنعني من طلب المساعدة والدعم.					

تمت بحمد الله.

Annex (3)
Participant letter

Dear participant
This Questionnaire aims to collect necessary data for a research about:

"The relationship between stigma and recovery among depressed patients in Gaza governorates "

Seeking your generous cooperation in filling up this Questionnaire which is a part of my research study of master degree in community mental health, nursing science.

Your opinion would be very effective towards this successful study which will enhance community mental health services.

The Questionnaire contains five choices of answers (totally agree, agree, Don't Know, disagree, totally disagree) . So please try to choose the accurate one. If you accept to join this study, you have the right to withdraw from the study at any time.

However: your answers will be respected and confidentially taking as it will be used for the study purposes only. You don't have to write your name.

May Thanks
Yours sincerely
Researcher, Osama J. Emad

Annex (4)
Questionnaire

Date: / / 2011. Number----------
(For the researcher only)

Personal information:

1-Age: ----------years.

Please put (x) in the appropriate square:

2-gender:

☐ male ☐ female

3-Address:

☐ Northern governorate ☐ Gaza governorate ☐ Mid-area governorate
☐ Khanyounis governorate ☐ Rafah governorate

4-Marital status:

☐ Married ☐ Single ☐ Divorced ☐ Widow

5-Education level:

☐ Elementary ☐ preparatory ☐ secondary ☐ university

6-Economic level:

A- Family income sources:

☐ Social affairs ☐ person's work ☐ wife's work ☐ husband's work
☐ Son's work ☐ agricultural land ☐ Ranching ☐ another work.

B- Value of monthly income:

☐ Less than 500 NIS ☐ from 500-1000 NIS ☐ from1000-1500 NIS
☐ From 1500-2000 NIS ☐ from 2000-2500 NIS ☐ more than 2500 NIS

Stigma scale

No	statement	Totally agree	Agree	Don't Know	disagree	Totally disagree
Perceived stigma						
1	I feel shy about telling people that I am psychiatric patient.					
2	Increasing illness years, increase my shyness from psychiatric illness.					
3	I feel that I am less than people because of my psychiatric illness.					
4	I believe that the fear from psychiatric illness deprives me from appropriate treatment in the appropriate time.					
5	Social and family support decrease the shyness from psychiatric illness.					
6	Denial of psychiatric illness opens the door to the witches and sorcerers.					
7	I think that the admission in the psychiatric hospital is a weak point for the person.					
8	When you meet a person at the first time, you make effort to hide the fact that you are a psychiatric patient.					
9	I think that people don't know that the psychiatric illness is as organic illness and it can be cured.					
10	I prefer going secretly to the mental health clinic to avoid any embarrassment.					
Media and stigma developing						
No	**statement**	**Totally agree**	**Agree**	**Don't Know**	**disagree**	**Totally disagree**
11	Link the media between violence and mental illness led people to fear from psychiatric patient.					
12	I think that the reason of the shyness from the psychiatric illness is to link media between psychiatric illness and insanity.					
13	Newspapers/television take a balanced view about mental health problems					
14	Media use words that offend the psychiatric patient.					
15	Media link between the criminals and psychiatric patients.					

Effect of stigma on daily life						
No	**statement**	**Totally agree**	**Agree**	**Don't Know**	**disagree**	**Totally disagree**
16	My request was rejected for several jobs because my psychiatric illness.					
17	I prefer staying at home alone and not mixing with others because my psychiatric illness.					
18	People avoid me because of my psychiatric illness.					
19	People accuse me of insanity due to my psychiatric illness.					
20	People look at me into sadness and pity, because I am psychiatric patient .					
21	People don't invite me to share their occasions.					
22	People humiliate me, because of my psychiatric illness.					
23	People do not accept the psychiatric patient as close friend.					
24	I blame myself because I am responsible for psychiatric illness.					
25	I feel ashy because of my psychiatric illness, and this prevents me from to express my point of view easily.					
26	People drive me to feel shy from my psychiatric illness.					
27	I avoid the establishment of social relationships with people so I do not feel the discrimination between them.					
28	I prefer giving pen name and change my look and clothes when I go to the psychiatrist to avoid an embarrassment.					
29	I resorted to practice some popular rituals People (witches, charlatans .... etc.) due to my shyness from psychiatric illness.					
30	For the married / the psychiatric illness led me fail in my marriage. For non-married / I believe that psychiatric illness was the main reason for the prevention of my marriage.					

(Recovery scale)

No	statement	Totally agree	Agree	Don't Know	disagree	Totally disagree
	Hope					
1	I feel my life is normal. Despite of the psychiatric illness.					
2	I feel that my life is meaningless.					
3	I give up to recover from psychiatric illness.					
4	I have a hope of recovery, and I think that my life will be better in the future.					
5	I have the ability to be an effective and productive member in my society.					
	Self determination					
6	I have a desire to work hard to be the best.					
7	I work, learn and exercise my daily life despite of my psychiatric illness.					
8	I establish my social relationships, and share people in their occasions despite of my psychiatric illness.					
9	I am ready to take risks in order to recover from psychiatric illness.					
10	Most of the time, I stay at home and watch TV.					
	Self esteem and self confidence					
11	I feel that I am like people.. I am not different from them or lower them.					
12	I deserve to be loved and respected from others.					
13	I feel that I am lower than people due to my psychiatric illness.					
14	I feel that psychiatric illness out of my control					
15	I feel at peace with myself.					
16	I have the ability to follow up on initial signs that alarm of relapse and I can deal with it					
17	I do not accept myself as it, and is not happy for myself.					
18	I feel guilty when I do or say what I want.					
	Asking help and support					
19	Asking for help is a part of my recovery.					
20	I often begin to ask for help when I need for it					
21	I hasten to seek support from someone close to me when I need it.					
22	My compliance to prayer and reading Koran is important factor for recovery.					
23	My compliance to take medications regularly contributes to recovery from psychiatric illness.					
24	I find it difficult to know when to increase my mental worse and when I ask for help.					
25	My shyness from psychiatric illness prevents me from seeking help and support.					

Annex (5)

List of arbitrators:

1-Dr. Ayesh Sammour
Director of general mental health administration in Gaza strip, MOH.

2-Dr. Yousef Aljeash
Assistant Prof. in Public Health-Islamic University-Gaza..

3-Dr. Habib El Hawajri
Chief of psychologist, MOH.

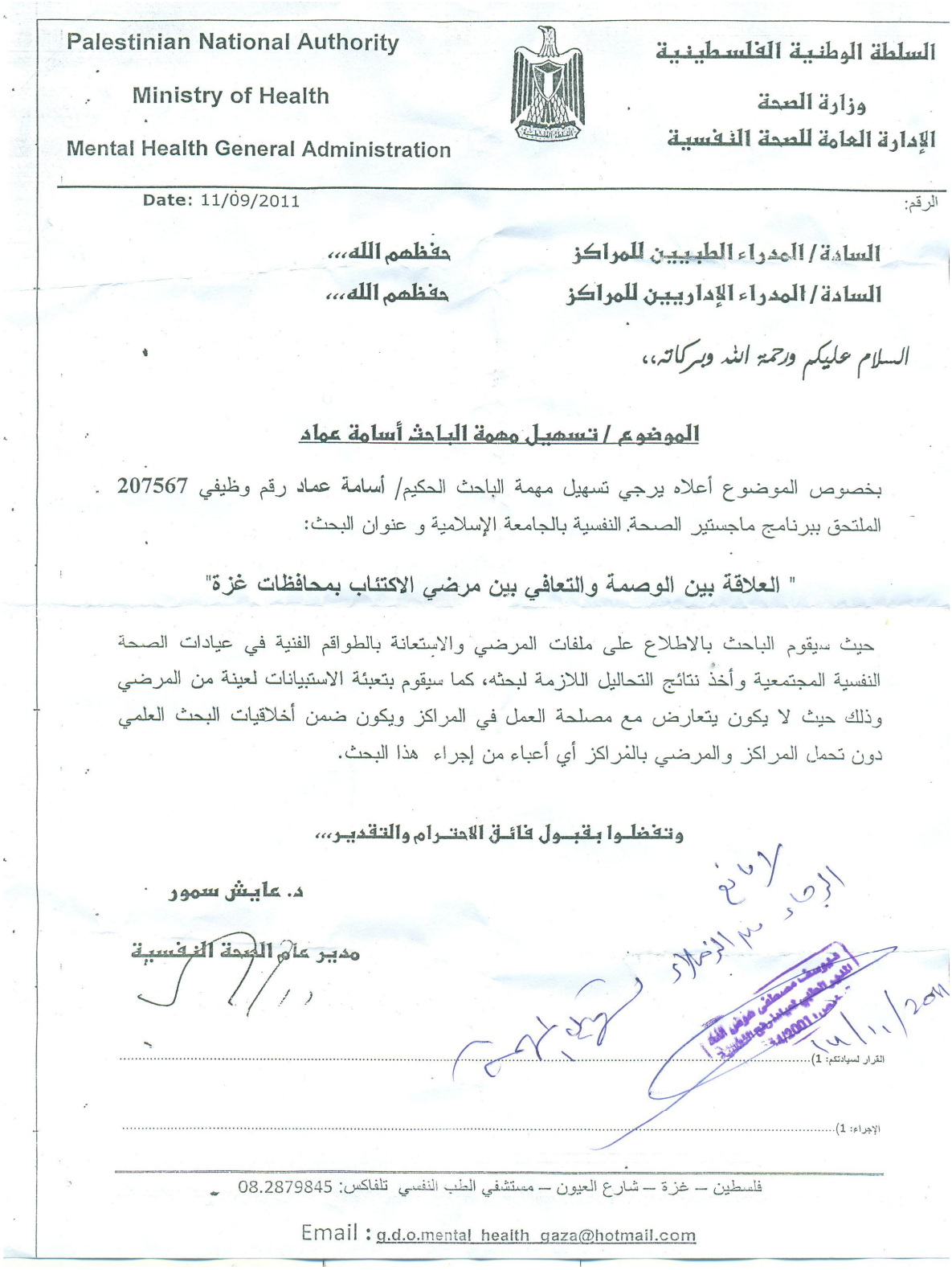
4-Dr. Omar EL-Buhaisi
Director of Mid-area mental health clinic.

5-Dr. Hukmi Al Rumi
psychiatrist. MOH.

6-Dr. Hassan Al Khwaga
psychiatrist. MOH.

7-Prof. Dr.Mohammed EL-Helou
Faculty of Education, Islamic university, Gaza.

Annex (6)
approval letter



Palestinian National Authority
Ministry of Health
Mental Health General Administration

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للصحة النفسية

Date: 11/09/2011

الرقم:

السادة / المدراء الطبيين للمراكز — حفظهم الله،،،
السادة / المدراء الإداريين للمراكز — حفظهم الله،،،

السلام عليكم ورحمة الله وبركاته،،

الموضوع / تسهيل مهمة الباحث أسامة عماد

بخصوص الموضوع أعلاه يرجي تسهيل مهمة الباحث الحكيم/ أسامة عماد رقم وظيفي 207567 الملتحق ببرنامج ماجستير الصحة النفسية بالجامعة الإسلامية و عنوان البحث:

" العلاقة بين الوصمة والتعافي بين مرضي الاكتئاب بمحافظات غزة"

حيث سيقوم الباحث بالاطلاع على ملفات المرضي والاستعانة بالطواقم الفنية في عيادات الصحة النفسية المجتمعية وأخذ نتائج التحاليل اللازمة لبحثه، كما سيقوم بتعبئة الاستبيانات لعينة من المرضي وذلك حيث لا يكون يتعارض مع مصلحة العمل في المراكز ويكون ضمن أخلاقيات البحث العلمي دون تحمل المراكز والمرضي بالمراكز أي أعباء من إجراء هذا البحث.

وتفضلوا بقبول فائق الاحترام والتقدير،،،

د. عايش سمور
مدير عام الصحة النفسية

القرار لسيادتكم: 1).....

الإجراء: 1).....

فلسطين – غزة – شارع العيون – مستشفي الطب النفسي تلفاكس: 08.2879845

Email : g.d.o.mental_health_gaza@hotmail.com

Annex (7)

Palestine map (Gaza Strip-left).