The Attitudes of Palestinian Primary Health Care Professionals in the Gaza Strip towards mental illness

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Objective: This survey sought to investigate the attitude of Palestinian primary health care professionals towards mental illness in the Gaza Strip. **Method:** A random ample of 166 General Practitioners and nurses were surveyed using Likert-type scale (29 items). **Results**: Factor analysis revealed three main attitude dimensions: western cognitive and community approach, emotional tolerance and reaction, and traditional attitude. Overall, older health professionals had significantly more traditional attitudes than the younger, whereas the younger showed a tendency toward more western attitudes. Older health professionals showed more emotional and tolerant attitudes towards mental illness than the younger. **Conclusion**: youngsters are usually the agents to introduce new concepts. Also, they are brought up with the frame of traditional values and conceptions, that can easily cause emotional as well as intellectual turmoil.

Introduction

Community attitudes and beliefs towards different social, political, religious and health related issues have been an interest of researchers at the beginning of this century (1,2). However, this interest did not focus on mentally disordered people until early 1950s (3), when the relation between mental health and other environmental factors became an important element in looking at the causes, methods of therapy, and prevention of mental disorders (4).

The attitude could be defined as a predisposition to respond positively or negatively towards a social object (5,6) or as a tendency to evaluate a particular "attitude object" with some degree of favor or disfavor (7*).* This illustrates the degree of acceptance or refusal for a certain subject as a result of previous experience, mainly belief and knowledge about that subject. Attitude makes the individual behave towards that subject in a positive or negative way. Social psychologists have divided the evaluative tendencies that reflect an attitude into three classes: cognitive reactions, affective reactions and behavior (5,7,8)

> Empirical studies have shown that beliefs about causes, tolerance and acceptance, and perception of metal illness differ in Western countries and Arab cultures.

By common consent people in the United Kingdom (UK), agreed that anyone could suffer from depression due to major external negative events such as death in the family or unemployment (9). Sims (10) showed that 90% of the respondents believed that mental illness could be caused by chemical inhalants in the brain, and by environmental conditions such as daily stress. One can see the difference in the Arab culture regarding the causes of mental illness, where mental disorders are often a source of fear (11,12). Its causes are commonly thought to be supernatural (13). Patients and their families tend to lack confidence in mental hospitals that are usually seen as custodial institutions in which troublesome and frightening people are segregated (14,15). Khalefa (16) indicated that 13% of the male's sample and 9% of the female sample agreed that mental disorders are because of possession by devils (Jinn). These findings correlate with Shuqueir in Saudi Arabia (17).

The previous studies confirmed that traditional and western cultures also differ in people's acceptance and tolerance of mental illness, their relatives and care takers. Wig et al (18) highlighted that the most common negative attitude among British and Danish patient's relatives are the expressed hostility towards their patients. To the contrary, Leff et al (19) report that high tolerance and acceptance of family members in rural traditional societies have contributed positively to their expressed emotions more than industrial urban ones. In the Arab culture the situation is different; people are still living in extended families where the family is the sources of psychological, economic and social support and the family feels responsible for the mentally ill client (20).

The Arab culture has its viewpoint on the treatment of mentally disturbed people (21). The common ways of treatment are the traditional ones. The traditional methods of treatment are varied and derived from the indigenous causation. Some healers use a combination of the biological methods and religious rituals to treat their clients. Khalefa (16) highlighted that 14% of males and 11% female students at the secondary level agreed that mental illness can be cured by visiting holy places or by religious

rituals. *Sims* (10) also reported that people welcomed facilities caring for chronic mental illness in institutions such as day care, hospital or nursing homes. Seventy four percent (74%) believed that anyone can become mentally ill and that mental illness can be cured. More than half-believed (58%) that those who have mental illnesses can be treated and return to their daily life. Forty-three (43%) believed that having a mental illness is not different than having a physical illness.

There appears to be no studies about the attitude of primary health professionals towards mental health in the Middle East. In the last few years community mental health services have progressed fast in Gaza, and there is a desire among health professionals to move towards the Western ideas of decentralizing mental health services (22). Therefore, one should expect that these Western ideas can be traced in the attitudes of health professionals.

The objective of the present paper is to describe: the primary health care professional's attitude towards mental illness and how these attitudes relate to sociodemographic factors such as age, gender, civil status and work related factors (type of profession).

Hypotheses of the study

A) We expect that health professionals would have both traditional and western ideas towards mental illness, b) that western attitudes towards mental illness are more prevalent in people with university degrees such as BA and more prevalent in younger people than older. The majority of health professionals get their education in western and commonest countries, which adopt different culture. Through out their years of study, young health professionals were attracted by the new approaches to mental health which is different from their own culture and belief. It could be argued that young health professionals are trying to introduce their new gained knowledge and experience into their own communities considering their own culture and beliefs.

Population and Methods

Study area

Primary health care (PHC) services are offered through two main bodies in the Gaza Strip; namely the governmental or public sector and the United Nations Relief and Work Agency (UNRWA). The public sector service is available in the Gaza Strip to both refugees and original residents who are covered by health insurance. This insurance is not necessary for children under 3 years. Around 40% of the population are not insured (23). Those people usually seek help through UNRWA or private clinics. There are around 33 PHC clinics run by public sector in the Strip. The health professionals working in these clinics are refugees and original residents. UNRWA offers free primary health care only to registered refugees. It runs 16 primary health care clinics spread throughout the Strip. All the health staff working in these clinics are registered refugees.

Sample and procedure

Health professionals (nurses, and GPs) working at 10 PHC clinics (5 belong to UNRWA and another 5 belong to public sector) were randomly selected from the five geographical regions of the Strip. These are the southern region, Gaza City, the Middle region, the Khan-Younis region and the Rafah region. Each clinic is run by 15-20 health professionals. All health professionals were asked to complete

questionnaires designed to assess attitudes towards mental illness. Participation was entirely voluntary for all health professionals without any discrimination of age, race, gender, occupation and job position, and was requested through direct contact in which the purpose of the study was explained. The questionnaires were distributed and collected everyday for one week. Any questions were clarified. One hundred and sixty one professionals (83 male and 78 female) returned the questionnaires. Thirty-nine (18%) health professionals refused to be involved in the survey. Sixty six percent of respondents were nurses (59% practical nurses, with 1.5 year nursing education, and 10% staff nurses and 2.5% have BA in nursing); 27% medical professionals (20% general practitioners and 8 %specialists); 5% midwives and 2% others.

The mean age of the sample was 37 years. Female professionals represent 48%, eighty five percent were married, 2% divorced, 4% widowed, and 9% single. Eighty four percent of the respondents are refugees, and 16% are residents. They lived in the towns (39%), in refugee camps (35%), in the villages 15%, and the rest in new residence areas (10%). The study took place in the clinics between June to October 1998. A written permit to conduct the research was obtained from the UNRWA headquarters and the Palestinian Ministry of health.

The Instrument

Information was gathered using a Likert-type scale questionnaire. An instrument was designed to assess primary health care professionals' attitudes towards mental illness (24,9,1). It is based on our experience of working with mentally ill clients, and it was developed with consultation with experts. It was composed of 29-items measuring attitude towards mental illness questionnaire, which cover the understanding the causes of mental illness, emotions, reaction and tolerance to mental illness. Statements were given which could be scored from 'strongly agree' to 'strongly disagree' on a 5 point scale. The items were scored in such away that higher numbers represent favorable attitudes towards mental illness and lower numbers unfavorable attitudes. This attitude scale was developed by Afana and Punamaki (25) and satisfies criteria for validity and reliability. Alpha Cronbach was .66.

Statistical methods

Factor analysis was carried out on the 29-attitudinal items because of contextual coherence and integrity. Initial factors were extracted using the method of principal component with varimax rotation. Factor scores were calculated by the regression method, using Statistical Program for Social Science version 8.0 (SPSS). To examine the associations between demographic variables and attitudes towards mental illness, analysis of variance (ANOVA) and T-test were applied. The independent variables were age, gender, profession, and place of residence and civic status and the dependant variables were the factor scores. The factor scores were estimated in two ways: 1) as the sum of scores on each item multiplied with the factor score coefficient for each variable – i.e. the "factor score" and 2) as the sum of scores on each item in the factor,

Factor analysis of the 29 items relating to attitude towards mental illness yielded of three factors, which accounted for 35.5% of the variance, all with Eigenvalues higher than 1.38. These were labeled according to the content of items loading on each factor. The earlier literature suggests that the attitude dimensions towards mental illness would be emotional (responses towards mentally ill), cognitive (knowledge

about and causes for mental illness), and behavioral (indicating tolerance and institutional issues), and belief systems (curing of mental illness). Therefore, solutions with three and four factors were explored.

Percentage agreement /disagreement response with selected items were calculated by combining the two agreement categories (strongly agree and agree) or the two disagreement categories (disagree and strongly disagree).

The Results

The attitudes towards mental illness

The results of attitudes towards mental illness revealed a three-factor structure involving the following dimensions (items loading on each factor are highlighted in table (1):

Factor (1), *WESTERN CONGITIVE AND COMMUNITY APPROACH* that encompasses the health professionals perception of de-institutionalization of mental illness. It also highlights the health professional's potential to be sympathetic towards mentally ill people. For example, mental illness can be managed in community mental health centres (loading, .62); we are responsible to provide the best care for mentally ill (loading, .60); more money should be spent on treatment and rehabilitation of mentally ill in the community (loading, .63). Factor (2), *EMOTIONAL REACTION AND TOLERANCE* concerned the health professional's acceptance and tolerance of mentally ill clients either through direct contact (living in the same house) or by indirect contact (allowing mentally ill to live in the same region). It includes items such as "Mental health facilities should be kept out of residential areas" (loading, .59); and "people have good reasons to resist the localization of mental health service in their neighborhood (loading, .61). Factor 3, *TRADITIONAL COGNITIVE*, involved traditional beliefs of the causes and cure of mental illness in one hand and the spiritual possession and traditional healing in the other. It includes items such as; "taking mentally ill clients to holy places to cure them" (loading, .62) and "mentally ill people can be cured by traditional healers" (loading .69).

Association between Demographic factors and attitude

In order to carry out the analysis, two strategies were applied: first, the factor scores and the second is sum of the item scores for each factor. The first analysis shows significant difference with age. Older (vs. younger) health professionals have high traditional attitude (T=2.158, P= 0.03) and younger (vs. older) show marginally Western cognitive and community way of thinking (T = 1.819, P=0.07). Older (vs. younger) showed more emotional and tolerance attitude (T = 2, P=0.04).

The second analysis (sum of item scores of each factor, table 2) showed that older (vs. younger) health professionals hold more traditional attitude towards mental illness (T= 2.46, P= 0.01). It also showed that health professionals having a university degree such as (BAs) holds less traditional attitude than others who have diplomas, or certificate in nursing (F) T= 2.256 P=0.05)

Of the respondents 17% of the younger and 38% of the older professionals supported the idea of taking mental ill client to holy places in order to cure, while 4% of the younger and 17% of the older health professionals believed that mentally ill clients can be cured by traditional healers. Of the respondents, 3% of the younger and 8% of the

older health professionals believed that mental illness is caused by possession of evils (table 3).

Both younger and older health professionals felt responsible to offer the best care to mentally ill. Ninety seven percent (97%)of the younger health professionals support the idea that any one can become mentally ill, while 90% of the older supported that.

Discussion

The majority of health professionals working in both governmental and UNRWA clinics are refugees and the majority of the respondents are nurses with different educational backgrounds. This survey is the first study in Gaza that tackles one of the stigmatizing fields that never studied before. Therefore, there was no complete cooperation from health professionals, mainly GPs, although they show their interest at the beginning. This was apparent when 18% of the total population did not complete the questionnaire. It was unclear whether health professionals who did not return the questionnaire initially did this because they hold different attitudes towards mentally ill clients or because of time limitations as they indicated.

Previous studies looked at attitude towards mental illness through two main dimensions either negative attitude or positive attitude towards mentally ill people. The earlier literature highlighted that the attitude dimensions towards mental illness would involve emotional (responses towards mentally ill), cognitive (knowledge about and causes for mental illness), and behavioral (indicating tolerance and institutional issues), and belief systems (curing of mental illness). The factor analysis of the attitudinal items in this survey produced three factors: Western cognitive and community approach, emotional tolerance and traditional cognitive approach towards mental illness.

The results of the study showed that younger primary health care professionals had less traditional and slightly more western attitudes than the older. This indicates that younger health professionals, as might be expected, are somewhat less attached to the traditional ideas and more open to the western ideas in community psychiatry. The fact that even the younger to a certain extent keep up traditional ideas, however, may indicate that their attitudes oscillate between the western methods of intervention and the traditional approaches. It could be argued that young health professionals are trying to find a complementary model that embraces their medical educational concepts, i.e. what they learned throughout their professional training on the one hand and their traditional values and beliefs in the other. For young health professionals it is important not to come in conflict with the traditional values and beliefs. Especially when we talk about the traditional dimension, religious concepts appear as the first principle in shaping that dimension. Therefore, seeing mental illness as environmentally related reflects the greater understanding of the relationship between stress and mental illness.

Huxley (26) believed that understanding mental illness in its social context tends to reduce the importance which people give to medical and clinical issues.

In this study we do not know whether the two approaches contradict or successfully embrace the western concepts and the traditional approaches to mental illness. We do not know also the effect of such model on the health service delivery. Many questions could be raised that need further investigations and study.

The study also shows a beginning of awareness, sympathy and feelings of responsibility to provide good care for mentally ill people among health professionals compared with fifteen years ago (27). Health professionals then totally rejected the idea of opening psychiatric units in general hospitals. They wished to house psychiatric services in a remote area in the middle of the Gaza Strip in an old hospital used to treat tuberculosis patients. Such promising change in attitude of health professionals might be attributed to three main reasons.

First, in the Gaza Strip, the social influence of people's attitude and behavior towards mental health were significantly influenced by Egyptian TV movies. These movies had a negative impact on public opinion towards mentally ill people. It showed psychiatrists and psychiatric nurses as crazy, unpleasant in appearance, wicked, jumping over tables, eating the clients food and ignoring treatment success and outcomes. These movies misled the public, creating a climate of unjustifiable bias against psychiatric care (28). However, in the last few years the TV movies tried to correct the negative image about mental disorders and that may have positively affected the Palestinians in Gaza. Although some researchers indicated that mass media have a limited impact on attitude change (29,30), others found it effective and that it has a great impact on changing public opinions (31). Others claim that media effect in general ranges from broad insignificant to particularly unimportant in changing the people's attitude (32). The second reason might be that when the Intifada erupted in 1987, psycho-social and stress related problems surfaced. The question of mental health was raised and increasingly became highlighted. Thirdly, the comprehensive mental health training activities and public awareness campaigns through public meetings carried out by the Gaza Community Mental Health Programme in the last eight years may have had some effect. However, it is argued that these campaigns only made a modest achievement (32,33).

The current study also highlights that older health professionals show more tolerant attitudes than younger ones. Such results might be explained through the traditional Palestinian family, which is characterized by its extended nature. Families are traditional and patriarchical, with the oldest male making decisions. Social support and tangible aid are sought first from the extended family and peers of similar background. Families share their grief and celebrations, and their conflicts with other families, as one unit. Youngsters are influenced by westernized life style moving towards a nuclear family structure as a form of independence. However, some aspects of the traditional life style are still prominent, especially those related to family bonds; and certain values have been cherished for generations such as the respect of elderly, and the sense of duty for care of the ill family members.

The study also showed that university level (BAs) health professional such as BA nursing or chemistry hold less traditional attitude than others, but no difference in attitude between males and females. This result is congruent to other findings in Egypt and Saudi Arabia. The higher educated students showed less traditional beliefs than those who are less educated.

The modern concepts of community mental health are of rather recent origin, tracing back to 1960s. Youngsters are usually the agents to introduce new concepts. Also they are brought up with the frame of traditional values and conceptions, that can easily cause emotional as well as intellectual turmoil. A way out of these conditions would be

to build bridges between the old and the new approaches. In addition, this complementary approach probably fits into the needs of the population. The bridge is a pragmatic approach. The young health professional's acceptance of traditional attitude could also reflect national political tradition in the Middle East.

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Table 1. Three analysis of the attitudes scale

The attitude-related factors towards mental illness among Palestinian Primary Health Care Professionals, *Items loading on each factor*				
	I	***II***		***III***
I. Western cognitive and community approach				
Virtually, any one can become mentally ill	.68			
More money should be spent on treatment and rehabilitation of mentally ill in the community	.63			
We are responsible to provide the best care for mentally ill	.*60*			
Mental illness can be managed in community mental health centres	.62			
Mentally ill patients are always dangerous. We should keep ourselves away from them	.50			
Any one with history of mental problems should be isolated from general public	.47			
As soon as a person complains from mental ill-health problem must be admitted to psychiatric hospital	.37			
Mental illness can be cured	.39			
Defense mechanisms help individuals to adapt the difficult situations	.38			
by living with mentally ill people, the person becomes mentally ill	.33			
II. Emotional reaction and tolerance				
People have good reasons to resist building mental health facilities in their neighborhood		.61		
Mental health facilities should be kept out of residential areas		.59		
Localizing community mental health centres in residential areas doesn't endanger local residents		.59		
How would you feel talking with mentally ill clients		.56		
Residents should accept building mental health centres in their neighborhood areas to serve the local needs.		.52		
It is frightening to think of people with mentally ill people living in residential areas		.49		
How would you feel about having a mentally ill person in the same house		.48		
III. Traditional cognitive				
Mentally ill people can be cured by traditional healers				.69
Taking mentally ill people to holy places can cure them				.62
I feel that the main cause for mental illness is due possession				.45
Mentally ill people deliberately talk and behave in an abnormal way				.39
Marriage cures mentally ill people				.36
Eigenvalue	**3.6**	**2.7**		**1.8**
Percentage of variance explained	**12.5**	**9.5**		**6.3**

Table (2) The means and standard deviations of the attitude variables according to the demographic variables

	No.	**Western cognitive and community approach**		**Emotional reaction and tolerance**		**Traditional cognitive**	
Independent variable		***M***	**±*sd***	***M***	**±*sd***	***M***	**±*sd***
Age						**	
Young (≤ .40)	94	41.48	3.9	21.63	4.22	22.88	2.51
Old ((>.40))	63	40.68	3.6	22.41	4.92	21.82	2.81
Profession							
Doctor	43	41.37	4.00	22.23	5.18	25.58	2.80
Nurse	114	41.16	3.82	21.68	4.23	25.64	2.73
Civil Status							
Refugee	26	41.20	3.55	22.02	4.94	21.92	2.91
Original residence	134	41.54	4.68	21.42	4.8	22.61	2.64
Gender							
Male	83	41.13	3.70	22.01	4.54	22.60	2.71
Female	78	41.28	3.89	21.83	4.46	22.41	2.67
Education						**	
BA Medicine	31	40.81	4.29	21.9	5.14	22.97	2.44
BA Nursing	4	41.75	4.92	23.75	4.35	26.5	1.73
BA pharmacy	3	41.0	4.36	23.69	2.52	23.0	1.73
Diploma (3 years), nursing	15	41.8	4.39	22.27	4.79	22.26	1.79
Certificate in nursing (1.5 years)	92	41.03	3.76	21.43	4.18	22.32	2.82

The mean and standard deviation are drawn from the sum of each item in each factor

0.01< p< 0.05 *
0.001< p< 0.01 **
p< 0.01 ***

Table (3) some selected items and level of agreement of disagreement

Item / Age	We are responsible to provide the best care for mentally ill				Virtually, any one can become mentally ill			
	Disagree	No-opinion	Agree	Total	Disagree	No-opinion	Agree	Total
≤ 40 years	3 3.2	4 4.3	87 92.6	94 100.0	2 2.1	1 1.1	91 96.8	94 100.0
> 40 years	4 6.3	1 1.6	58 92.1	63 100.0	6 9.5	0 0.0	57 90.5	63 100.0
total	7 4.5	5 3.2	145 92.4	157 100.0	8 5.1	1 0.6	148 94.3	157 100.0
Item / Age	Taking mentally disordered people to holy places can cure them				Mental illness can be managed in community mental health centres			
	Disagree	No-opinion	Agree	Total	Disagree	No-opinion	Agree	Total
≤ 40 years	62 66.0	16 17.0	16 17.0	94 100.0	8 8.5	1 1.1	84 90.4	94 100.0
> 40 years	32 50.8	7 11.1	24 38.1	63 100.0	1 1.6	3 4.8	59 93.7	63 100.0
total	94 59.9	23 14.6	46 25.5	157 100.0	9 5.7	4 2.5	144 91.7	157 100.0
Item / Age	I feel that the main cause for mental illness is due possession				mentally ill people can be cured by traditional healers			
	Disagree	No-opinion	Agree	Total	Disagree	No-opinion	Agree	Total
≤ 40 years	88 93.6	3 3.2	3 3.2	94 100.0	87 92.6	3 3.2	4 4.3	94 100.0
> 40 years	54 85.7	4 6.3	5 7.9	63 100.0	46 73.0	6 9.5	11 17.5	63 100.0
total	142 90.4	7 4.5	8 5.1	157 100.0	133 84.7	9 5.7	15 9.6	157 100.0