THE UNIVERSITY OF HULL

An Examination of the Mental Health Service Provision in Saudi Arabia

with Particular reference to Counselling

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By

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ABSTRACT

This thesis aimed at elucidating the meaning of mental health services within the context of counselling practice in Saudi Arabia. The delineation of mental health practice within this context may help to overcome the incongruence among counselling theory, research, practice, and the experience of counselling patients' in that country.

Consequently, mental health treatment systems in Saudi Arabia have a history of incompatible philosophies and conflicts that have been associated with poor treatment outcomes for persons diagnosed, which was linked to a deterrent Poor Law to one which incorporated those suffering from a wide range of mental disturbances, which was largely based on treatment willingly undertaken and freely available, and which was associated with a preventive Ministry of Health. It examines the concepts and intentions which underlay policy, and the impact of policy upon the service and its clients. It describes the ways in which the service was moulded by the changing and sometimes conflicting demands of the needs of the mentally patients' and of society as a whole. There is almost full agreement among all those concerned with Psychiatric health care in Saudi Arabia that current treatment is not beneficial and may be harmful to the patients'. Most psychiatrists agree that the major benefit for the patient occur in the first week of his\her treatment. Mental health provision in the Kingdom of Saudi Arabia hospitals, historical background and the use of the current medical model, is examined in the first part of the study and qualitative and quantitative methodology were used in the second part.

From the analysis, the questionnaire, and exploratory interviews the major findings were, revealed statistically significant differences between practitioners in their aims and objectives, roles and responsibilities, awareness, effectiveness', referral system and procedures, and personal development. Although, practitioners experienced dissatisfaction with the whole service; patients' were raised the same issues criticising the poor standard of services in their hospitals. In addition, practitioners felt the referral system was inflexible and unclear, psychiatrists and counsellors failed to understand their patients' needs. It was concluded that there were considerable the lack of training amongst practitioners.

In the light of the findings, the researcher came up with several recommendations, the most important of which were the following.1) there is a need for a viable model for mental health treatment in Saudi Arabia.;2) Improve the current provision regulation;3) establish a mental health Act in Saudi Arabia.

ACKNOWLEDGMENTS

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Chapter One Introduction

OVERVIEW

In the past the problem of finding an appropriate and efficacious way to treat the mentally ill has been challenging. It is no less challenging today (Ingeby ,1981; Bean et al ,1991; Etzioni,1995; Rogers&Pilgrim,1996; Harris&Barraclough,1997; Goodwin,1997; Rogers& Pilgrim, 2001). Mental disorders are one of the largest causes of lost years and of quality of life in the world. The World Bank has estimated that five of the leading causes of disability worldwide are psychiatric in nature with depression ranking first the development mental health services. The development of mental health services has been one of the responses to the apparently growing problem of mental health illness and the overcrowding in mental hospitals. Rogers and Pilgrim (2001) reported that during 1980s and 1990s many countries throughout the world resorted to the development of some form of mental health service to deal with the problem. Saudi Arabia is one of the countries that developed a mental health service during the 1980s.

The examination of mental health and idea of development of services is not a straight forward task as mental health suffers from a lack of identity. Notwithstanding the number articles that have appeared in journals, and the plethora of books that have been published, there is little agreement as to what constitutes the mainstream of an effective mental health service. The literature and practitioners have approached the issue in a number of ways. One of the most prevalent has been negatively, that is, by criticism of mainstream medical psychiatry and clinical psychology. This is because of the difficulties inherent in the task of coming to a positive statement of mental health provision in light of the disagreement found

in the literature (Szasz, 1961; 1971;1979; 1990; 1994; Ingleby, 1981; Coppock & Hopton, 2000; Roth & Kroll, 1986; Littlewood & Lipsedge,1997). However, these debates have led to the development of new services and new specialties such as social work, psychotherapy, counselling and community mental health care (Burton, 1998).

Counselling research and practice in mental health care has been limited by the almost exclusive use of Western models to predict people's mental health and well being. This research explores how a counselling model may be applied in the context of mental health, in Saudi Arabian society. It can be seen at the outset that most Saudi psychiatric hospitals and institutions use the medical model to deal with patients, and most of mental health services are limited by an almost exclusive use of psychiatric models (Al-Subia, 1994).

However, there seems to be a gap between mental health practice, and research in Saudi Arabia, The mainstream of psychiatric and clinical psychology do not seem to be impressed with what that services such as Counselling has to offer. On the other hand, the relationship between mental health practitioners and the counselling paradigm has not been an easy one, practitioners seemed to get disenchanted with the divisive theoretical and approaches which are often in conflict.

1.1Statement of the Problem

Despite its wealth, Saudi Arabia has not been immune from problem of mental health. After the discovery of oil in Saudi Arabia in the 1930s, it entered into a new era of development in its history. Rapid change and modernization have brought prosperity to the country, but on the other hand brought problems, not least in the need for mental health services particularly with respect to counselling and psychotherapy (Al-Fahad, 1994). As a

result of Saudi Arabia is rapid development, many traditional values have been violated and many codes of culture have been changed. The people have been exposed to rapidly changing social, political, and economic environments. The circumstances surrounding these changes have created a new set of adjustment challenges for them. An exploration of how they respond to social changes and transitions may bring insight into their psychological well being and also provide insight into mental health problems. This inquiry is a response to the call for help from the people of Saudi Arabia. Furthermore, it has been noted by many scholars, writers, medical practitioners, and by members of the public that counselling can meet the psychological needs of some of those with mental health problems (Al-Yaha, 1988).

In the academic domain, studies and research have been conducted, focusing predominantly on theoretical and advisory considerations, with a relatively smaller number of empirical and analytical studies. Despite the great importance given to this subject, many researchers and practitioners claim a general weakness in the mental health services in the past twenty years and up to the present in Saudi Arabia. Al-Subaie (1989) states that *these political, social, and economic transformations of the past few decades have undoubtedly affected the mental health of Saudi Arabian population*" (p.245). This fact has been emphasised by many researchers from different backgrounds such as Al-Yaha (1988); Dubovsky (1983); Chaleby (1987); Racy (1980); El-Gaaly(1984); Al-Shanway (1992) and Al-Fahad(2001). Conspicuous weaknesses have been highlighted in all aspects of mental health service: counselling services; therapy outcome; the therapeutic relationship, and the model of counselling in the mental health context.

However, in this study, it would be appropriate to restrict literature discussion to the most recent research findings about mental health services, based on studies conducted in the Saudi society context within the last fifteen years.

It has been widely evidenced that mental health services are not matching client need, and observable that about one third of in-patients in Saudi psychiatric hospital stay longer than their case demands, although they have completed their course of medication. This fact is evidenced empirically by relatively new studies of mental health services such as Hussein (1989). Al-Subaie and Alhamad (2000) found that one in three psychiatric patients have sought help from traditional healers. Furthermore, in practising counselling it was remarked that, in mental health hospitals, there is a huge gap between the mental health counsellor and mainstream psychiatric model. Moreover, the standard of counsellor skills is astonishingly low in the mental health context (Chaleby, 1987).

1.2 Objectives of the study

The study has four primary objectives. The first is to assess and evaluate mental health service provision in the Kingdom of Saudi Arabia. The Second is, by focusing on the practise of mental health, to raise awareness of the aims and objectives, role and responsibilities, patient's referral system, treatments effectiveness and personal development of practitioners in the field of mental health.

The third objective is to ascertain the meaning of therapeutic change and therapeutic outcome within the context of patients-counsellor and patient- psychiatrists experience in the mental health setting in Saudi Arabia.

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The fourth objective is to contribute to knowledge about establishing new services within a mental health context.

Three guiding research questions are explored.

- The first question is set of when did the mental health services begin? What were the social, psychological, and mental health factors that contributed to the beginning of the services? What were the goals at the beginning of the services? Who were the key players and what did they achieve? Where did resources for the mental health come from? Moreover, what are the current and future goals of the service?

- The second set is, knowing that psychiatric services are medication oriented, with less emphasis on using supportive counselling, and knowing that patients need such help from counsellors; can counselling models and skills help Saudi patients to confront their mental illness and provide emotional support?

- The Third question is what are some of the socio – cultural aspects that may influence in the development of counselling for Saudi mental health patients?

It is important to emphasise that this study is an exploratory study designed to define the issues rather than to provide specific answers to the questions listed above. It is hoped that these issues and questions will stimulate further empirical studies and investigations about the use of counselling within a mental health context in Saudi Arabia. As Brause (200) has commented, doctoral work is expected to break new ground and to contribute to the evolving knowledge base of a discipline. Indeed, contributing to the evolving knowledge base of a discipline dose not seems a breakthrough. As, more doctorate degrees are conferred, we could not expect an equal number of brilliant breakthroughs. Philips and Pugh 2000, p.63-64) pointed out that it is not so difficult to be original, they summarised fifteen different definitions of originality of Ph.D thesis as:

1. Setting down a major piece of new information in writing for the first time.
2. Continuing a previously original piece of work.
3. Carrying out original work designed by the supervisor.
4. Providing a single technique, or result in an otherwise unoriginal but competent piece of research.
5. Having many original ideas methods and interpretations all performed by others under the direction of postgraduate.
6. Showing originality in testing somebody else's idea.
7. Carrying out empirical work that has been not done before.
8. Making a synthesis that has not been made before.
9. Using already known material but with a new interpretation.
10. Trying out something that has previously only been done in other countries.
11. Taking a particular technique and applying it in a new area.
12. Bringing new evidence to bear on an old issue.
13. Being cross-disciplinary and using different methodologies.
14. Looking at areas that people in the discipline have not looked at before.
15. Adding to knowledge in a way that has not been done before.

Thus, they assured researcher that this is a better way to conceive of originality rather than simplistically. This thesis can target al least three or more of the above points.

1.3 The Central Aims of the Study

In the light of the problem expounded earlier, two aims were set to contribute in identifying the solution. *The first aim is to investigate, via documentary evidence, how the services was delivered in its various historical periods, what is the current situation of the mental health provision, and how the services could be developed The second aim is to examine, evaluate and prioritise, empirically, the current mental health services in Saudi Arabia as perceived by practitioners and specialists involved with the four mental health hospitals.*

1.4 Organisation of the Study

According to the study problem, and to achieve the aims set earlier, after this chapter the study will be in two parts, which will be followed by a conclusion. The first part will seek to achieve the first aim and will incorporate a theoretical/documentary investigation of the aspects of the related literature. These aspects will be presented in chapters two, three, four, and five.

In Chapter Two the main characteristics of the Saudi society will be presented, followed by a developmental of mental health provision in Saudi Arabia in various historical periods. This study will trace some roots of the current mental health services in the Western societies and also will examine the possibility of benefiting from some of the appropriate methods used in certain countries. Chapter five is concerned mainly with the current counselling practice in the Western within the context of the Saudi mental health counselling services.

The first part of the study, i.e. the theoretical review, will help in identifying the background of the study, setting the appropriate framework for developing the current provision of mental health in Saudi Arabia and offering a number of the suggestions which will be examined and prioritised through the second, empirical, part of the study.

The second part is intended to achieve the second aim of the study, *to identify and prioritise, empirically, the mental health provision in Saudi Arabia as perceived by practitioners (psychiatrists, counsellors, and specialists involved with the services.* This part consists of three chapters; the sixth; the seventh, the eighth, and the ninth chapters.

The research methodology will be explained in Chapter Six, giving details of the plans followed in the two chapters of the empirical study: the quantitative chapter using a questionnaire and the qualitative chapter using interviews. The ninth chapter will present and discuss the results, and then will conclude the study, providing a summary of the result of the study and an overall discussion. The limitations of the study will be considered, recommendations put forward, and suggestions made for further research

Chapter Two Saudi Arabia

Geography and location

Family system

Religion and belief system

 Economy power

Health Services in Saudi Arabia

Summary

Chapter Two Saudi Arabia

Introduction

Saudi Arabia is a developed country, which through sudden oil wealth and changes the whole country from an impecunious and mainly desert area into wealthy and modern country. This complex and challenge of new development presented the possibilities of modern services such as Education, Economic, Politics, and Health (Lipsky, 1959; Al-Zahrany, 1997; Ali, 2001).

Hence the government of Saudi Arabia pays sedulous attention to this development and provides unique opportunity and subsidies from the government to focus on the different aspects of development. Each service has been give special contemplation to improving modern life. The most improved services since 1960 are in Health and Education (Al-Shammri et al ,1995). The new system of health and education facing to meet many of the difficulties of Saudi's society. This chapter is an overview of that development, with a focus on some common barriers to helping services and address these within the context of culture and society.

Indeed, it maybe that the society and culture in Saudi Arabia need more consideration. This chapter looks first at the Kingdom of Saudi Arabia, and then considers the development of Mental Health services.

2.1 Geography

Saudi Arabia is located in the south western angle of Asia and divided into five main geographical divisions;

2:1:1 The Middle (Najd or "highland") the largest regions and heart of the Kingdom, the region has the capital city of Saudi Arabia "Riyadh" which allow has rich population as many modern services. Some villages in the region are rules by a family using the tribal basis of authority which sometimes depended on the noble tribes governor. People from this region were engaged in farming and herding. The environment with its harsh climate, did not allow people to be innovative in cultivating the region and that give such a power for people to be creative in politics and helped form a vast variety of political families. Hence the net result of this furious intellectual culture is characterising by Islamic ideology, self preservation, and tribal identification which are the important human characteristics of the old Najdis.

2:1:2 The Western (Hejaz "barrier") second important region has a special significance to all Muslims due to the existence there of two holy cities of Makkah and Al-Madinah, these give this region a mixed society of people from all around the Muslims world. There are also Jeddah and Taif, which Jeddah the most modern city in the country which located in the Red sea and the most important city used by pilgrims. Taif still has the biggest mental health hospital in the country (Sihar). People from this region are a mix of original Arabian tribes and a smaller number of pilgrim families. This variety of culture and background has been given this region a distinct social character with very strong personal skills (Al-Zahrany, 1997).

2:1:3 The Eastern region lie beside the Arabian Gulf. Most in the region are farmers, fisherman and mariners. At also has industry as oil production. The eastern region is mostly enclosed with small gravel and sand. The shores of the Arabian Gulf provided the population with fishing and marketing and that has given the people of this region

an opportunity to travel and establish relations with Persian countries such as Iran, the area is occupied mostly by the Shiat, whose intellects and attitude toward Islam differ from the rest of the country . However, the presence of American companies in this region has played a major part in the modernisation of life and created many educational and economic institutions.

2:1:4 The Southern (Asir "difficult") it's a semi-mountainous region in the south western corner of the peninsula. The climate is extremely cold throughout the year. Most of population are mixed tribes and describe as hardworking. In the past people lived in villages constructed of stone while in recent years they have moved to new towns. Some still have social customs and like other regions traditionally regard illness as a God well or as the work of evil spirits. The most powerful city in the south is Najran that because of its ancient origins reflects the various religious backgrounds, which are stronger Shait in the world. People behave and worship in different ways to the other regions, and there is still irresolvable conflict between their aims and methods, their history and the nature of the Muslims religion. The second city in the south is Jizan; the people there are of mixed African and Arabian origins, and this is effected in the way of they dress, and the houses they live in (these house normally are copies of African huts). Jizanis are characterised as very strong believers in magic and evil sprit (AlSubih, 1998).

2:1:5 Northern regions. This region was isolated from the other part of Kingdom, it has a difficult environment and lack natural resources. Recently the government established new education institutions and several Hospitals around the region (Al-Shammari,et al.1995). People living in this region value their religion and protect their

tribal values and traditions. Furthermore, as they are neighbours to Jordan and Iraq, they share the same values and traditions as many Jordanian and Iraqi people. However, many Northern people travel to Jordan and Syria to seek health treatment and education.

2.2 Family System

The family in Saudi Arabia can be seen as the special unit in Saudi Society (Motalk, 1999). Members of the family in Saudi society are controlled by the head of the family and he/she responsible for all decisions, guiding individual members. All members should follow the heads decision even if they disagree. It is rare for any member to reject the heads judgment.

The Saudi household has many members resident in the house, especially parents and siblings. The wife is generally to direct the children and servants within the home responsibility, while the husband practices his authority in outside decisions. In recent year polygamy is thought of as undesirable way of family life.

The basic element of the Saudi's social structure is the kinship system. The family is the centre of all social organisations and constitutes the dominant social institution through which individuals and groups inherit their religion, class, and cultural affiliations (Al-subih, 2003). However, the very concept of Arabic (aila or usra) reflects such mutual commitments and relationships in interdependence and reciprocity. The root of the word (aila/usra) means to support through the father's role is defined as provider and the mother's as role as homemaker, Children change from being dependants to supporters once their parents reach old age.

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Kinship mark Saudi's strongest loyalty and alliance (Racy, 1998). Through such relationships, the individuals in each nuclear family, and within the concept of the extended kin system or (ashirah) receives his\her sense of identity and belonging, as well as security and support in times of individual and social distress. However, with these privileges comes a set of duties and obligations that are expected from all single family units and their individual members. There is an essential requirement for the individual to subordinate him\herself to the family and the tribe with which they are identified(Alturki,2003) this subordination involves putting the needs and priorities of the family as a whole ahead of personal needs and desires. This hierarchical structure is based on gender and age and, as such, requires the young to obey the old and adhere to their expectations. Within these lines of relationships, the success or failure of an individual member becomes that of the family as a whole (Barakat, 1993). Thus, failure are not confined to the individual or the unclear family, instead, a failed member mean a failed family.

Saudi's tend to include the extended family in activities and consult for advice, which normally offered even when not requested out of love, care, and a sense of loyalty for friends or relatives. As Saudi's become older, their children, sons in particular, and their extended family are obligated to care for them. Similarity, caring for again parents is a religious duty for Muslims.

A significant value is related to the status of insider and outsider, the internal world of family and close friends and the external world of acquaintances and everyone else. Communication in personal relationship varies according to inside and outsider, privacy and resistance to disclosure of personal information are important in family affaires,

family matters remain within the family and are not for sharing with outsiders (Al-Subaie&Alhamad, 2000). With the context of personal relationships, verbal agreements are considered binding. Meleis and Jonsen (1983) described an Arab family's negative reactions to personal questions, requests for written informed consent, and frank discussions of diagnosis and prognosis.

Thus, Saudi's communication patterns are influenced by hierarchy of relationship and depend on the social status of the other person in relation to one self. For instance, communication may be supportive of lower status person or competitive with those of equal status, or may be characterised by currying the favour of those of higher class. The interpersonal relationships operate by indirectness aimed at maintaining a pleasant relationship and attempts to please others through modesty and politeness. Lipsky (1959) noted that politeness within Arab culture results in a preference for more indirect modes of communication; Saudi's people have qualms about giving offence to others and will sacrifice clear communication in order to avoid stressful interpersonal conflicts and confrontations.

However, Saudis like most Arabs are very concerned with respectability and good reputation, respect is expected when speaking with those who are older and those who are in higher social positions. For instance, older people should never be called by their first names without an adjective or title attached to the name. An adjective such as grandfather or uncle may be used with the name. Respect is also shown in deferential behaviour; a young person who disagrees with an older person should not answer back. Anger directed at people of higher status, such parents or superiors, is condemned. In addition most Saudi's refrain from showing anger or other strong emotions to outside.

In Saudi-Arab society, where self-control is valued, showing anger can produce embarrassment, that in the family, or damage to some one's reputation. Racy (1977) described Arab society as traditional, authoritarian, group oriented, in harmony with nature and oriented to shame rather than guilt.

Saudis need to become familiar with personal interactions and get to know someone, developing feeling for the person before thoughts can be shared. Trust is gained, not expected, and develop trust in each other by having a meal together. Therefore, greetings, inquiries about well being, pleasantries and cup of tea precede business, conversant stand close together, maintain eye contact and touch (only between members of the same sex) the other's hand or shoulder.

In summary to understand the culture and the value of the Saudi's society, one must comprehend the kinship system along with its relationship structure and systems of obligation. Arab anthropologists have identified the concept of harmonious interpersonal relationship, the debt of obligation and shame, as the predominant values that are learned and fostered within the family. The socialisation of Saudis child is geared to the ideals of family, sensitivity to how others feel and learning to live with others, these values are in contrast to western values of autonomy, self-determination and self-disclosure of feeling and believe to those outside the family.

2.3 Religion and Belief role

Wherever one looks there are strong indications of the role of religion in public life of Saudi society. From the constitution of the country to the way people greet each other. Islam plays a prominent role. The influence of Islam cannot be exaggerated, but the

problem in the society will always be how to distinguish between pure religions influences and social customs that have developed in the culture (Al-Homiday, 1998). Indeed, the most apparent influence of religion can be found in the areas of religion practices and public morality. The loud call to prayers five times every is a constant reminder of the importance of this religions duty .Hence, government, offices, shops, businesses ,and even television broadcasting come to a halt for a few minutes when it is time to pray. Prayer in Saudi society takes precedence over other activities in a fashion not found in any other Islamic country (Al-Dowrehim, 1999). Obviously, all social occasions, business hours, and even football matches are normally scheduled around the times of prayer.

2.3.1 Beliefs and practices

The first and most important belief on which a Muslim bases his faith is belief in (Tawhid), a revolutionary concept which constitutes the essence of the teaching of Islam (al-Alwani, 1989). It that means there is only one supreme lord of the universe and only God who is omnipotent all-loving, all-judging ,all-powerful ,and all-creating.

The other five articles of belief are: belief in the angels of God; belief in the revealed scriptures from God to mankind through the messengers of God; belief in the Messengers of God that were sent before the Prophet Mohammed; belief in the Day of Judgment; and belief in the divine decree. which Henley and Schott (1999) concludes: " *Most practising Muslims follow five main duties or pillars of Islam: faith in one God; prayer at five set times every day; giving a required amount to charity each year; fasting during the holy month of Ramadan; and making a pilgrimage (hajj) once in their lives to the sacred city of Makka (Mecca) if they can " (p.504).*

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Any person who believes in these articles of faith becomes a Muslim and is required to practise Islam by carrying out the five pillars of Islam which are obligatory for the individual Muslim (Ammarh, 1997).

2.3.2 The Saudis code of behaviour

Many in Saudi society practice as Muslims behaviour as individuals and in the community based on teaching in the holy Qur'an.

The Qur'an is assigned a special place in Saudi Arabia. It is taught in schools as an integral part of the Educational system and plays a very important part in social life and behaviours. For instance, many Saudis classified the self as having up to seven stages. The Holy Qur'an describes at least three main types of "self"; in Saudi Muslim individuals see themselves as their personality as one of the three main types of self when acting in the social life:

A)   Nafs al-ammara Bissu; which means the soul which commands. This is the self that brings punishment itself. By its very nature it directs the owner towards every wrong action Allah says" *the human soul is certainly prone to evil*" (12:35) ;

B)   Nafs al-lawwama means the soul that blames; this self is conscious of its own imperfections ,Allah says about this self ," *And I do call to witness the nafs that blames*" (75:2);

C)   Nafs al-mutmainna means the soul at peace this self is tranquil as it rests on the certitude of God, Allah refers this self "O *self, in complete rest and satisfaction*" (89:27).

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This classification of self is accepted as normal in classical psychological literature in Saudi society (Shinawwy, 1992) and is accepted by all the Muslim community, who find references to the method of self-examination to detect mixtures of intention and an emphasis on self-discipline.

However, another method of spreading and strengthening the way of life in Saudi society is Dawah which means guidance. It is closely connected to the activities of social life, which is intended to show the community the right way of practising their religion and solving their problems. Furthermore, this institution (Dawah) is mainly carried out by means of books, lectures, and media. Experts in psychiatric, Education, and psychology use these methods are given lectures, hold seminars and answer queries through the media to the whole community.

2.4 Economy

The economy of Saudi Arabia was initially extremely difficult because of the lack and limitation of resources of the country. Each region depended on their own resources. For instance, Hijaz region was depended on the trade activities generated by pilgrimages. However, after oil was discover in Saudi Arabia the situation changed totally from poverty to wealth ,which gave the government an possibility to improve the country. They called it a five year development plan. The First five year plan was in 1970 and the focus was on developing defence, transportation , education , and oil revenues; the Second five year plan became effective on July 9 ,1975 which focused on improving social services such as free medical services and introduced free Education and develop new institutions.; the Third five year plan was put into effect in 1980 and was structured differently focusing on industrial development, infrastructure, and social development; the Fourth five year development plan was between the years 1985-1990 which improved the transportation

and expanding the agricultural plans and improved new technology such as new communications; the Fifth five years development plan focused opening more institutions and developing health systems, social services, housing and municipalities; the Sixth five year plan covered the period between 1995-2000. Constrained resources shaped this plan programs most effected were communications, new villages, health institutions, and vocational training (National Report Statistics, 2001).

New developments in Saudi Arabia have had an impact upon the social life of the Saudi society. Changes are observable in every part of the Saudi community. However, these changes in the social structure are still circumscribed by the Islamic, traditional values, and rules. Furthermore, these changes in the structure of the social setting have definitely had an effect on the people of the region and affected their behaviours with every day activities. Changes are evident in family structure, economic resources, Education, and health.

2.5 Health services in Saudi Arabia

The Ministry of Health (MOH) is the major government agency entrusted with the provision of preventive, curative and rehabilitative health care for the Kingdom's population. The Ministry provides primary health care (PHC) services through a network of health care centers (comprising 1,751 centers) throughout the Kingdom. It also adopts the referral system that provides curative care for all members of society from the level of general practitioners at health centers to advanced technology specialist curative services through a broad base of general and specialist hospitals (182 hospitals). The MOH also undertakes the overall supervision and follow-up of health care related activities carried out by the private sector.

On the other hand, the Security and Military agencies provide primary, secondary and advanced levels of health care directly for their staff and segments of the public, while school health units provide immediate primary health care for students. The General Organization for Social Insurance and the General Presidency of Youth Welfare provide health services categories of the population. The Royal Commission for Jubail and Yanbu provides health facilities for employees at the two industrial cities. Moreover, the private sector provides health services through its health facilities including hospitals, dispensaries, laboratories, pharmacies and physiotherapy centers throughout the Kingdom. However, Health care is not limited to preventive and curative aspects only; it also extends to the domain of medical research. The King Faisal Specialist Hospital and Research Center uses highly advanced technologies and acts as a reference hospital for cases that require advanced and specialist treatment, while it also conducts research on health issues in general and those related to the Kingdom in particular.

2.6 Summary

In this chapter the general features of the Saudi Arabian culture system were clarified, to aid understanding of the situation of culture, and identifying some related obstacles and problems. It was clear that as Saudi Arabia is considered as developing country a great deal of effort has had to be made in order to provide mental health in such a society, where more than 90 % of the population were illiterate just over forty years ago. In response to that, the last four decades or so witnessed a massive health movement so that nowadays, the government claims that health for every one.

However, this claim cannot be examined in the light of the lack of statistical evidence. Ministerial statistics, generally, can be criticised for clarifying explicitly the figures

achieved, without giving even implicitly an indication of what has not been achieved, or what should be achieved in the future. Undoubtedly, there has been a great deal of quantitative progression, but, however, with questionable level of qualitative development.

Finally, this chapter clarified the current situation of the Saudi health system and mapping out the status of the mental health services. Both the need for development and the willingness of those responsible to conduct it, indicated in Chapter One, were backed in this chapter. The concern of the next chapter, therefore, is to examine the literature in order to locate the mental health services within the historical background and find a suitable treatment method by which practitioners should be presented and taught.

Chapter Three Mental Health Services in Saudi Arabia

Mental health in Arab culture

Mental Health Provision in Saudi Arabia

Phase One: the non-official stage (Before 1961)

Phase Two: the Official stage (1962 – 1969)

Phase Three: The new services stage (1970-1980)

Convalescence home

Development plan of mental health services

Role of psychologists in the field of mental health institution

Mental Health Nursing Practice

Phase Four: The new treatment stage (1983- the present)

Traditional Treatment

Assessment of mental illness in Saudi Arabia

Modern Mental Health treatment

Chapter Three Mental Health Services In Saudi Arabia

Introduction

The mental health service in the Kingdom of Saudi Arabia (K.S.A) was almost insignificant before 1962, when no psychological treatment or even counselling was available. In contrast, nowadays, we now find a social health services section in the Ministry of Health, with the responsibility to establish and oversee a complete counselling and psychotherapy programme through more than eight government established Universities and institutes, and also private sector services.

This is because Saudi Arabia has a strong economy, which enables the Kingdom to provide the services needed by society. The Ministry of Health and Ministry of Higher Education are given special support by the government, as part of a special care programme established to cover the needs of the population everywhere in the Kingdom of Saudi Arabia. The Kingdom consists of five large regions (Northern, Southern, Central, Eastern and Western) ,further divided into nineteen health districts .The health programme aims at introducing psychological services through health education programmes and counselling and psychotherapy services through Universities and institutes .

3.1 Mental health in Arab culture

The earliest psychotherapeutic intervention recorded was in ancient Egypt. It was the induction of temple sleep, connected with the name of 'Imhotep', the earliest known physician in history. Em.Ho.Tep, "he who comes in peace", was the physician Vizier of the

Pharaoh Zoser, who built the Saggara pyramid around 2980 -2900 BC. He was worshipped at Memphis and a temple was constructed in his honour on the island of Philae. The temple was a busy centre for sleep treatment. The course of therapy depended on the expression and content of dreams, which were mostly caused by the psycho-religious climate of the temple, confidence in the mystical powers of the deity and the suggestive procedures carried out by the divine healers (Okasha, 1993).

The first mental hospital providing psychological treatment in the world was built in Baghdad, Iraq in 705 AD. This was followed by hospitals in Cairo in 800 AD, and Damascus in1270 AD. In the 14th century, Kalaoon hospital in Cairo had a section for psychological treatment (Baasher, 1875).

During the middle ages, in most Middle Eastern countries psychological illness was believed to be caused by curses, possession by devils, failure to follow rituals for avoiding harm, and fate. Moreover, the mentally-ill person was called 'mad' (Dubovsky, 1983).

Many current approaches to dealing with mental illness and psychological problems in Saudi Arabia and other Arab countries still use traditional approaches, in accordance with Muslim culture and religion. For instance, some clients, when they have psychological problems, are treated by Qu'ranic reading; or they might go to a male or female enchanter. Some are given cauterisation, which is applied to the head of mentally-ill clients after the healers have shaved their hair, Among uneducated and illiterate people the client is separated from all human contact (Al-Radi, 1980;Al-Shammri et al- ,1991;Al-Yahya,1991).

3.2 Mental Health Provision in Saudi Arabia

The development of mental health provision in Saudi Arabia can be divided into main phases as follows:

3.2.1 Phase One: the non-official stage (Before 1961)

Before, 1961, no medical provision existed for individuals afflicted with psychological or neurotic ailments. Such sufferers were regarded in Saudi society as criminal elements and, as a result, no effort was made to deal with disorders through medical means. Instead, those who suffered from mental illness were put in prison in order to safeguard the normal members of society from their unusual behavioural patterns .They were interned in " Al-Murostan" prison in the Ajyad quarter of Makkah (the holy city).

Later, Murostan was moved to another city (Taif) under the name of the Al-Haweyeh section (Al-Radi, 1982). Moreover, it was claimed that the incidence of mentally disorders was low for several reasons; the simplicity of life such as family and tribal unity; religious education; ignorance; and strong belief in religious and local healers (Al-Owidha, 1996; Al-Subaie,1994).

In 1959, the government, through the Ministry of Health, contracted with one physician who specialised in the area of psychiatry to supervise this category of illness .This action is now considered as the first serious, official attempt at establishing a system of treatment for psychotic and neurotic ailments in Saudi Arabia (Al-Radi,1980; Al-Owidah,1996; Al-Yahay,1982)

3.2.2 Phase Two: the Official stage (1962 – 1969)

During 1962, in accordance with government directives, the Ministry of Health established the Shehar Hospital for mental diseases, located in *Taif* which has a mild climate.

Although most of the treatment administered at first focused on drug and electro-shock therapy, some professionals decided that psychologists and social workers should be available to work with clients in order to help them to achieve a more complete recovery (Al-Radi, 1980).

Later, in 1962, the hospital was re-named "Taif Psychiatric Hospital". It was at that time the only hospital in the Kingdom of Saudi Arabia providing all psychiatric services to all regions of the country, including the expatriate community (Al-Yahay, 1982). The hospital is still considered to be one of the most leading psychiatric institutions in the entire kingdom, where it receives the most critical case requiring the highest standards of mental health treatment, which can be seen in the table 2.1 that the number of patients treated at the Taif hospital increased significantly the years 1962 – 1969

Table 3.1 shows the number of patients treated at Tife hospital between 1962 and 1969

Year	Number of patients
1962	200
1963	250
1964	400
1965	596
1966	602
1967	1,184
1968	4,184
1969	7,161

The screening procedure for people with mental health in this era followed an established new model, as a first step, people seeking treatment usually go to the clinic where psychiatric resident decide whether the individual needs psychiatric investigation, subsequently, the patients sees a consultant psychiatric who prepares a support and medications, or sends the patients to a psychologist for either an assessment of intelligence

(IQ test), and back to the psychiatric again for final assessment, which depending on the patients diagnosis.

However, during this period, clients were admitted in five different categories:

1. acute cases
2. chronic cases
3. paediatric mental clients
4. epileptic clients
5. Mental clients arrested for any criminal offences (Al-Radi, 1980).

Inevitably, psychological treatment and counselling in phase two were limited by the shortage of facilities and lack of awareness at that time. Nevertheless, *Taif* hospital received more visits from people as awareness of mental health grew.

3.2.3 Phase Three: The new services stage (1970-1980)

The third phase of mental health service in Saudi Arabia witnessed the development of mental health services both quantitatively and qualitatively, to meet clients' needs. During this period, there were problems of overcrowding in the psychological facilities at the first hospital in the kingdom (*Taif* Psychiatric Hospital) so the government sought to boost the number of qualified health personnel in the psychiatric hospital. One approach was to award overseas scholarships to any person interested in this field. At the same time the government recruited foreign staff qualified in this area of health, most of them are from Egypt and Syria (Al-Tawil, 1984; Al-Radi, 1980).

Interestingly according to a Ministry of Mental Health report (1979),only 11% of the total manpower in mental health services were Saudis and 89% were expatriates; Egypt supplied

55% , the Philippines 12%, Pakistan 10%, Syria 6% ,and other nationalities 6% (Ministry of Health,1979.p.98).

Thus, in 1981, the government offered some financial incentives in order to raise national interest in the mental health services and to support employees in this field; the salary was increased to exceed the basic salary of personnel working in any other jobs.

However, the treatment methods used during phase Three relied solely on medication. Al-Radi (1980) notes that " *a Saudi client , especially a psychiatric client , and also client's family are eclectic in dealing with the mental illness phenomena , A client may be taken first to a religious healer and ,if this fails , he may be taken to an exorcist and if this fails , he may be taken to a psychiatric hospital .The client may stop the medical treatment after discharge if advised to do so by another exorcist or religious therapist , and he may spend years of travelling with no fixed basic concept about what is going on , except for the educated people who have a more stable outlook" (p.2)*

In 1972 clinical psychology, social work, and psychotherapy services were established in the cities of: Riyadh, Hofuf, and Al-Madinah. With all these services were annexed to the relevant general hospital to which they referred. Among the provisions for improving efficiency, services and staff distribution among the mental health services, was a provision that there should be at least one psychiatrist to every ten patients; one social worker to every fifty patient and one psychologist to every two hundred patients (Al-Radi, 1982).

3.2.4 Phase Four: The new treatment stage (1983- the present)

By 1983, the number of psychiatric health facilities had increased by 67% and by 1991 they had increased by 123% compared to the base year (Al-Radi, 1980), with a distribution over such widely divergent regions as Riyadh, Jeddah, Makkah, Qatief; Hayil, etc (Annual statistical report M.O.H, 1990). This reflects a desire to meet the need and demands for mental health services in large country where the cities and regions are widely scattered. The Ministry of Health believed that if the mental health services were available and easy for people to reach in the long term the services would save money, that is, because psychiatrically ill people would be motivated to visit them early which would not be the case if treatment was too far distant, and that would establish and political problem in the mental health institution in Saudi Arabia.

As part of the Ministry of Health's efforts to expand services and treatment, during the period 1992-1996 the Ministry established 16 new mental health clinics in various hospitals and regions, to reach a total of 22 hospitals and clinics for the entire Kingdom. In this same period, the number of psychologists was increased. Table 3.2 presents more specifically the distribution of the categories of manpower in Mental Health services as at 1996, in terms of the various regions of Saudi Arabia.

Table 3.2 Satff in Mental Health Services

No	Region	Physicians	Social Worker	Psychologist	Nurses	Tech	Total
1	Tabouk	7	1	3	48	3	62
2	Hayil	9	-	4	35	5	53
3	Araar	6	2	3	20	3	34
4	Al-Jouf	8	2	4	70	6	90
5	AlQurayat	4	2	1	15	3	25
6	Abha	11	6	6	79	12	114
7	Bishah	4	-	2	12	-	18
8	Jizan	14	3	3	63	18	101
9	Najran	8	2	4	31	7	52
10	Baha	9	1	1	44	7	62
11	Dammam	8	1	5	25	-	39
12	Hassa	14	3	3	103	5	128
13	Al-Bateen	3	-	-	15	-	18
14	Makkah	5	4	3	20	-	32
15	Jeddah	16	8	3	157	23	207
16	Taif	42	19	8	334	32	435
17	Madenah	16	7	4	90	15	132
18	Riyadh	29	13	23	125	13	203
19	Qaseem	11	5	7	90	17	130
20	Other Clinics	51	-	5	-	-	56
21	Consultant	-	5	9	-	-	14
22	*G.D.P.S.S	1	5	6	-	-	12
	TOTAL	276	89	107	1376	169	2017

'Source: Annual Statistical Report General Department of Psychiatric and Social Services, Ministry of Health, Saudi Arabia, 1997.;*This Department is within the Ministry of Health, which is located in Riyadh.

From Table 3.2 it can be seen that the total number of professional people who served many clients in a different areas in the Kingdom, was 2017, including physicians, social workers, psychologist, nurses and technicians.

It may be worth mentioning and talk closer look at the number of patients, gender, and nationality of patients who seek mental health services in this era, which the table bellow compile the statistical according to the patients' nationality and gender.

Table 3.3 Patients Nationality and Gender

GENDER	SAUDI	NON- SAUDI	TOTAL
MALE	27,211	4,211	31422
FEMALE	21,126	2,666	23792
CHILD	3,991	7,324	11315

* M.O.H general department of psychiatric and social services (1999).

From the table 3.3 it can be seen that there is a high number of patients who using the facilities of mental health in 1996, while the total number of patients using the facilities in 1982 was 8350 for male, 10570 female, and 6210 for a child. The great different between the numbers of patients in 1982 and in 1996 may be attributed to the following reasons: first, the availability of the mental health services in the regions and the most of the counties in Saudi Arabia; second a possible increase in the incidence of psychiatric diseases, because of the pressure and stresses of modern life and social changes.

Further, the government increased the percentage of Saudi professionals who worked in mental health services. The salary of physicians working in the psychiatric field was increased by SR2,000 -3,000 for residents, specialists and consultants; the salary of psychiatric nursing staff and psychologists was increased by SR 1,500 and the salary for paramedical personal was increased by SR500,depending on their jobs and qualifications (Al-Tawil,1997).

Indeed, the past 40 years have seen enormous quantitative and qualitative development in mental health services in Saudi Arabia, in keeping with the government policy of improvement in health services in general. But, during this period, most treatments used psychiatric medicine, and less attention was paid to psychological counselling and social work .Moreover, the social services department in the Ministry of Health has largely ignored the differences between counselling and social work, which has led to the people who work in professional health becoming confused and frustrated (Al-Subaie & Alhamad,1999; Al-Subaie,1994).

3.3 Convalescence Home Services

In 1976 the Ministry of Health established a convalescence home staffed by corps of handicrafts instructors and other experts in the field of rehabilitation techniques, to deal with mental patients whose confinement in psychiatric environment has been a protracted one. The home provided different facilities and activities in the home include reading, writing, typing, gardening, carpet making, sewing, painting, and other practical skills (Al-Radi,1982)

Thus, the rational idea behind the establishment of these activities was that patients of this type have lost contact with the real world, by virtue of a long confinement, and need some stabilising skills if their re-integration into normal society is to be successful and complete (Ministry of Health, 1980).

However, Ministry of health and Ministry of Labour and Social Affairs emphasised to establish new proposals for improving mental health services, which the following agreements were reached:

- Ministry of health would establish a psychiatric and social services department to plan and develop the mental health services of the kingdom.

- More psychiatric centres should be established in all the Kingdoms major cities.

- Convalescence home should be set up whereby psychiatric patients can work, under supervision, according to established guidelines.

- Mental health centres in the kingdom should use training programme for all health professional in an effort to boost the current situation of mental health services.

3.4 Development plan of mental health services

The 1975-1980 five year Development plan specified the following goals in term of mental health services

a) One physician to every twenty patents.

b) Total number of psychiatrists to be 80% of the total number of physicians.

c) One nurse per a patient

d) One psychologist to every two hundred patients

e) One social worker to every fifty patients.

f) One technician and assistant technician to every twenty five patients.

g) One technician trainer per ward (Annual Report, M.O.H, 1980).

According to the 1975-1980 Five year Development plan, in the medical model there should ideally have been one physician to every twenty patients, and at least eight percent of the physician staff should be psychiatrists. The five year plan also extended to psychologist; requiring one psychologist for two hundred patients, however, in practice there was one psychologist to every 480 patients, which represented a very large discrepancy between the planned projected targets and the actual provision (Al-Tawil, 1989).

3.5 Role of psychologists in the field of mental health institution

In 1972, a psychology services was established as extra therapeutic facility for mental patents at Taif psychiatric hospital. It was argued that since a large proportion of mental disorders are results of psychological problem.

However, the role of psychologists focusing in many areas; for instance, the psychiatric in and out patients; the admission and discharge unit; the convalescence home for work therapy; the section for psychiatric patients who have been charged with a criminal offence; the section for inhabitation; and the section for handicapped and chronically ill mental patients (Al-Radi, 1982).

3.6 Mental Health Nursing Practice

The history of psychiatric and mental health nursing practice in Saudi Arabia can be linked to the beginning of psychiatric services in 1962. At that time, a small number of physicians with no psychiatric qualifications provided psychiatric treatment. In fact, it was not until 1968 that the first psychiatrist was appointed. Like general physicians, nurses who provided care for mentally ill people were not trained in mental illness. Their role was purely custodial and often involved providing mentally ill people with basic physical needs, preventing them from discharging themselves too early and keeping them safe(Al-Subaie &Alhamad, 1999).

Following the introduction of educational nursing programs in the early 1980s, trained psychiatric nurses began to replace untrained staff they were taught and trained by physician's not psychiatric nurses and educated to carry out physicians' orders only. The stigma of working in psychiatric settings and the authority of medical colleagues also disadvantaged nurses. The Saudi Arabian public's attitude toward working in mental institution was negative attitude (Al-Subaie 1994).

In the 1991, the number of beds and patients in psychiatric hospitals increased, as did the need for psychiatric nurses. To respond to this situation, the first training program in mental

health nursing began in 1995. These students did not complete a general nursing program. They were fully funded and needed four years of elementary schooling to enrol in this program. These nurses trained for the most part by psychiatrists, failed to have well-defined roles; they were expected only to carry out medical orders. They were not prepared sufficiently to play psychotherapeutic, social or educative roles. Further and most importantly, these training programs were not well planned, having little input from expert psychiatric nurses. Few registered nurses or baccalaureate educated nurses worked in mental health.

Many factors have continued to influence the current status of this branch of nursing. Among these factors is a shortage of qualified teaching and research staff in the area of mental health nursing and the lack of financial resources and institutions to prepare not only mental health nurses but also general nurses. The influence of the critical shortage of general nurses and the priority that must be given to meeting the demands of general hospitals has had a direct bearing on the preparation of mental health nurses. Against this background, the future of mental health nursing in Saudi Arabia remains uncertain. It also seems unlikely that mental health nursing and nurses will have a strong sense of identity within this decade, unless more independent and appropriate psychiatric nursing training is put into place. However, in general, psychiatric nursing is considered a low-status profession in Saudi.

3.7 Traditional Treatment

The medical profession in Saudi Arabia has remained all along adamantly opposed to granting legitimacy of any kind to popular healers. In large part, the strength of this resistance is undoubtedly due to the fact that such healers still constitute an active and

pervasive threat to professional medicine. Furthermore, aside from the question of competition for clientele between physicians and healers, the latter exemplify cultural values which are antithetical to modern scientific thought. By representing very different cultural values, these healers challenge modern medicine's striving for cultural dominance.

Traditional healers and the continuing belief in power of jinn is simply a case in point. This dispute exemplified the tension between modern medical opinion and Islam as a cultural resource from which popular healers draw their legitimacy. With the revival of Islamic believe, the jinn may become a factor to be reckoned with in other medical disputes. Although laws restrict the practice of medicine to persons qualified in recognized medical schools, the whole question of what constitutes healing has not been resolved (Al- zamil, 2001). The precariousness of the medical "monopoly" over healing in Saudi society is expressed by the relative laxity of the government to suppress popular healing. When they are arrested, healers are typically arrested for swindling rather than for practicing medicine without a license.

Mental health treatment in Saudi Arabia before the introduction of modern medical model had a rich heritage based on the social culture foundation of the Saudi society (Al-Subaie &Alhamad, 1999). However, the traditional psychological treatments in Saudi Arabia also used Islamic materials as a resource. These methods are still in use. Hussein (1989) found that 50 to 70 per cent of mental ill outpatients in psychiatric units have sought help from traditional healers and 21 per cent to 50 per cent have undergone some traditional form of treatment.

Healers are generally middle aged religious men who have no medical education or knowledge and do not use psychotropic drugs. Shared language and social traditions between healer and patient make traditional healing widely used in Saudi society (Al-Subaie & Alhamad, 1999). Al-Subaie (1994) maintains that more woman then men seeks

help from traditional healers, but these are no difference in relation to age, social class and level of education. The main ways, of healing are Qur'an recitation, Zar, cautery (Kayy) and herbs. In a recent study of Al-subih et al (2002) carried out in three cities and seventy five villages for instance, for a population of 97,000 people, 215 popular healers were "discovered". The healers included 98 Quranic recitations, 75 Zar specialists, 18 Cautery or (Kayy), 9 dreams analysing specialists, 7 herbs specialists, 6 magicians, and 2 specialists in Seclusion and chaining. Furthermore, the vast majority of people who seek traditional healers were in rural Saudi Arabia.

3.7.1 Qur'an recitation

This is the most common technique by healers and has wide social acceptance. The healer may use many rituals. For instance, sometimes the healer might just read the Qur'an while touching the client's head, chest, or any part of the body.

Another method of Qur'an treatment the healer writes excerpts on a piece of paper which is then dipped in water and the client asked to swallow it, to protect him from Jinn. Most healers believe in Jinn and they try to drive them out of the client's body by beating him, sometimes until he loses consciousness. Al-Subaie and Alhamad point out that *"the Jinni is first asked by the healer about the reason and circumstances of possession and then the Jinni is asked about his or her religion and domicile. The typical answer of the jinni is that he or she is not a Muslim and lives far away. The jinni then says what he or she does to the patient and answers questions asked by the healer. Before the session ends the jinni is asked to convert to Islam (or he or she will be beaten)" (p.213).*

3.7.2 Cautery (Kayy)

This method is used for both mental and physical disorders; Healers conduct the treatment using iron rods of different size. The principles of diagnosing the disorders and which part of client's body the treatment should be applied are a closely guarded secret.

3.7.3 Zar

Zar are spirits that possess someone's body and manifest themselves in certain forms of madness such as hysteria (Al-Fahad, 2001). They are claimed to have been found in Hijaz region on a wide scale, mainly among women. In the late 19th century in the Holy city Makkah, zar seemed to be an epidemic among women; every woman expected to develop such a disease.

Zar was described by Al-Fahad (2001) as a jinni spirit which takes over the will of the individual. The person who is under the spirit's influence is thrown to the floor and lies for hours with no control over his/her body and mind. When relieved, the person is wide eyed and pale. In the old Hijaz, a Zar ceremony was performed in which the female client was dressed up beautifully and escorted by her servant and female healer to perform a Zar dance. During the ceremony the client would be relieved of the possession after an agreement in Zar language passed through the healer to the client family. Many people in Saudi society do not accept Zar as a methods of healing and believe that the Zar is an ancient way of healing that is not acceptable in a Muslim society Ibn-Baz (1987) concludes that *"The ancient world believed in mythical treatment, such as sorcery, witchcraft, spells, incantations, amulets, folk medicine, or magic charms etc., and Arabia was no exception to them. Since Islam had to bring reform in every walk of life" (p.35).* Mental disturbances are certainly not the only type of disorder for which Saudi society turn to popular healers. A wide variety of other popular healers such as bonesetters, surgeons,

traditional specialists in eye disease, sunstroke, children disease, skin infections, and deliveries continue to offer their "services", particularly in the villages sections of urban areas (Al-yahia, 1988). However, the treatment differs from one healer to another; some healers recite the Qur'an until the jinni departs from the possessed, and others fill a cup of water, recite special verses, spit in the cup and ask the person to drink it.

The traditional approaches to mental illness may have been crude and harsh, but in some cases were successful. Al-Fahad (2001) found that some healers encourage clients to relieve such feelings as guilt, stress, and strain of life by using physical relaxation .Surprisingly the literature of mental health treatment in Saudi society has a rich traditional past. The problem is an acute lack of historical documentation. Al-issa et al (1999) emphasise that more studies are needed to aid understanding of traditional healing in Saudi society.

3.8Assessment of Mental illness in Saudi Arabia

When Saudi medical professionals assume a position face to face popular healer, it is usually to express their disdain. Most physicians tend to assume that recourse to popular healers threatens a sick individual's chances for recovery since "proper" medical attention is delayed. Other physicians, particularly Ministry of Health officials, typically deny that popular healers exist at all or, at any rate, on any significant scale (personal interview, 2004). In general, ignorance or antipathies colour the medical profession's attitudes toward popular healers in Saudi Arabia. This is no less true of psychiatrists as general roles. While academic psychiatrists have expressed interest in the psychopathological manifestations in Zar and the phenomenon of "Saher" (psychogenic impotence caused by sorcery), the issues they raise, by implication, bring into question the entire set of relations between modern medicine and traditional healing in Saudi society (Al-Subaie& Alhamad, 2000).

Initially, Saudi psychiatrists were concerned with whether symptoms and disease entities differed between East and West. Saudi psychiatrists investigated "Zars" and the phenomenon of Quranic recitations, with an eye to determining the existence and identity of mental disturbances, which could be considered peculiarly Saudi. Early investigators attempted to establish correspondences between psychiatric diagnosis and popular etiological explanation of various disturbances, assumed to be clearly mental in nature. In other words, they have been concerned to correlate specific symptoms which differ from Western patterns with specific mental disorders assumed to be universal.

In a landmark study conducted in 1995, Al-Subi (1994) studied 100 patients who attended traditional healers. He claimed to have found that 52% showed evidence of hysteria--fluctuating superficial affect, mood swings, dramatic acting out and 12% showed distinctly obsession tendencies. He observed that the "presenting symptoms" which "caused" the patients to attend Zars included, in rank order of frequency, hypochondrias, insomnia, depression, irritability, delusions, phobia, anorexia, loss of interest and self-deprecation.

By reducing symptoms to physical manifestations, and cultural interpretation of disorder to irrelevance, early investigators such as Al-Subi (1995) avoided seriously challenging the universalistic claims of either psychiatry or medicine. The basic psychiatric categories remained well in tact. The attempt by psychiatrists to "treat" persons suffering from anxiety neurosis (evident in impotence or signs of spirit possession) was, in turn, validated. However, most Saudi psychiatrists would conclude along with Al-Subi (1995) that *mental diseases are basically the same in Western and Saudi culture although symptoms are more or less modelled by cultural factors.* (p.22).

Thus, academic research on popular healing among psychiatrists can be interpreted as part of their overall effort to obtain medical legitimacy. By reconfirming the universal applicability of psychiatry, psychiatrists preserved their professional legitimacy within Arabian and Saudi medicine. Yet their position remains more problematic than their Western colleagues for all the reasons that have collared its development since Warnock--insufficient government support, the ambiguous social function of the mental hospitals, as well as competition from popular healers.

On the other hand, psychiatrists have been concerned with determining the reasons why patients resort to other healers before coming to a psychiatric clinic. As such, these studies reveal an immediate practical concern.

Ministry of Health (1998) study of 120 randomly selected patients (70 males and 50 females), at the outpatient unit at Tai'f Mental Health Hospital, noted that only 23 patients had not gone to a sheikh or Zar, used amulets or attempted to undo the sorcery assumed to be causing their condition. The four primary interpretations given by patients for their disorders related to spirit possession, sorcery, the evil eye and general physical weakness. Moreover, it was found no association between significant social factors (e.g., degree of literacy) and ritual assistance sought or between type of disorder and folk interpretation of illness.

Another study, Alhomidi (1999) revealed similar patterns of patient strategy and similar professional concerns on the part of the investigator. In his study, families of 60 randomly selected patients admitted to Dammam Mental Hospital, were questioned. The investigator, a psychiatric nurse, found that 13% of those financially responsible for the patient attributed the patient's illness to spirit possession or the evil eye, and 40% to sudden trauma. The hospital was clearly perceived as a place of last resort. However, it was found

that families kept patients at home for at least 6 months before any attempt was made to hospitalise them, and during this time, families typically sent their sick relative to sheikhs, traditional healers, and only once these failed, to general practitioners and finally, psychiatrists. The author clearly perceived this strategy as causing undue delay creating an obstacle to receiving proper treatment.

Treatment of Zar betrayed the same basic concerns. Al-Subi (1995) noted, for example, in his study of the ear that while 64% of the women had had little, if any, formal elementary education, 28% of the women had finished secondary school and 8% had obtained university degrees. These were potential clients who, he implied, should have more readily turned for psychiatric help than resorted to popular healers. His data suggested that middle and even upper class women continue to participate. In zars, especially private ones despite access to modern education. Some 8% attended Zars as a prophylactic measure against future illness.

Such Patients resorted to Zars presumably because they believed they were effective in inhibiting or preventing the recurrence of such symptoms. Al-Subi (1995) in the end agreed that Zars could be quite effective in hysterical reactions, anxiety states, mildly depressed cases and organic neurosis. Relapses were common and unless the patient attended Zar regularly her symptoms recurred. Patients with obsession confessional states, schizophrenia or severe depression and melancholy did not improve, but the tension accompanying their states was relieved to a certain extent.

At the same time, the apparent "effectiveness" of the zar had to be explained since it was patently unscientific. The Zar's relative success challenged basic psychiatric premises concerning the causes of psychiatry's therapeutic efficacy. Rather than explore the

implications such a dilemma posed, Al-Subi (1995) tried to explain away the effectiveness of the Zar in "scientific" terms.

The drums and dancing induce a state of nervous excitement and the patients are worked into a frenzy, exhaustion, and finally collapse, followed by the paradoxical inhibition, after which they lose many of their abnormal patterns and return to healthier ones.

Al-Subi (1995) concluded that while this "line of therapy" was "naive and primitive" and "based on no scientific grounds", yet its effectiveness lay in the fact that it relied on clearly recognizable psychotherapeutic principles *"reassurance, persuasion, suggestion, abreaction, out, dream interpretation of individual and group therapies"*. While Al-Shanwy (1999) disclaimed any intention of encouraging the Zar cult, *"We know that there are not enough psychiatrists throughout the world to give adequate time and care to all patients. Until they are able to do this, there will still be a place for the traditional healer and it is our duty to know what they do". (p.2).* The implication, of course, of his words was that once psychiatrists were sufficient in number, there would no longer be any "need" for popular methods of healing. However, it suggesting that psychiatrists place their efforts in a particular social cultural context. A modus with popular healers was absolutely necessary given the limited resources of the psychiatric community in Saudi society.

Claims that the relative unavailability of modern medical services compels people to resort to traditional healers, while partly true, belies the role of cultural beliefs in determining action considered appropriate to alleviate symptoms of distress. In point of fact, people continue to resort to popular healers in spite of the availability of alternative medical services. For example, rural and many urban women prefer traditional midwife (Dayas) to the medical service available at government health services to deliver their babies. And people with "mental" difficulties frequently turn to traditional healers despite the

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availability of psychiatric expertise in general and district hospitals, university clinics, mental hospitals, private practice and mental health counsellors. They do so because local social networks and specific cultural assumptions continue to operate.

In any case, the apparent success of the Zar in dispelling signs of illness serves to buttress the validity of the etiological assumptions concerning their cause. If catharsis is not of therapeutic value in and of itself, the symbolic structuring of the Zar experience is. However, participation in Zar transforms an otherwise chaotic and inarticulate experience (stress, mental disorder, and trance) into an intelligible and intensely meaningful one (possession). Zar helps substantiate the reality of jinn in the world regardless of the degree to which participation in it alleviates symptoms since signs of illness are thought to depend on the will of the possessing spirit rather than on an identifiable and predictable disease process. Thus, the very unpredictability of mental disorders helps to confirm popular etiological assumptions concerning the cause of mental disorder.

Psychiatrists, meanwhile, try to explain away the efficacy of Zar by interpreting it in terms of psychiatric practice. For example, they note that the Zar provides a setting in which group support can be expressed, where conflict can be dramatised, acted out and resolved. If popular therapies essentially possess the therapeutic elements thought to be active in current modern therapy, then the next question which one would expect Saudi psychiatrists to ask is why persons who share in popular culture ever turn to psychiatrists for help at all. And it is clear that they do. Many, if not most, of the patients attending university and government psychiatric clinics are from ruler villages (Al-yahia,1996).

Recent studies at King Saud University Psychiatric Department have focussed precisely on this issue of patient therapeutic strategies and the extent of popular practices for mental disturbance. (K.S.R.C, 2000). In two notable studies, patients were closely questioned as to

the treatment they received prior to coming to the psychiatric clinic at Riyadh Hospital which is attached to university medical school. The clinical encounters documented in these studies point to the continuing importance of traditional modes of treatment and the process of deliberation in the minds of those seeking aid from the traditional sector and modern health care

3.9 Modern Mental Health treatment

In spite of all the efforts made by new mental health workers and the availability of modern technology, people's beliefs and attitudes towards modern mental health treatment are still influenced by traditional and cultural values. However, certain Saudi personality characteristics may be misconstrued when viewed by non-Saudis, the Saudi personality has different characteristic even from other regional Arab cultures. For example, Shallby (1995) maintains that each culture in the Arab world has a value derived from that culture past and present. Similarly, Al-Subaie (1989) indicates that therapists, psychologists, social workers, and psychiatrists need to demonstrate both knowledge of and respect for client's religious beliefs, values, moral outlooks, and assumptions.

Nevertheless, modern mental health treatment in Saudi Arabia is more similar to the American model than the British model. In the American model alternative services were set up through community mental health centres, unlike the British model whose services originated out of the mental health hospitals using staff from the hospital to care for clients in the community with an emphasises on medical forms of treatment and training. Psychiatrists contact with other medical practitioners has created avenues for other medical disciplines. Al-Subaie (1989) emphasises that, psychiatrists provide invaluable public education on mental health issues for the Saudi public and contribute to education to

remove the stigma of mental illness. Nevertheless, some of practitioners such as clinical psychologists and counsellors in mental health hospitals in Saudi Arabia are limited and Psychotherapy is brief and plays only a supporting role (Al-Fahad, 2001).

Most users of psychiatric services in Saudi society are between 25 - 45 years old, El-Gaaly (1987) notes that most psychiatric clients have multiple stresses and intergenerational conflict. Furthermore, social phobia was recorded by Al-Shaniwy and Shaleby (1986) as a prevalent disorder in Saudi Arabia. The lack of culture awareness was noted in Al-Shaniwy and Shalebys study; they asserted that non- Saudi practitioners failed to recognise the social significance of difference and intentional passivity of the Saudi personality disorders.

The most noteworthy psychological problem in contemporary accounts is depression in the Saudi community, which is found more often in females and males between 20 – 40 years old (Dubovsky ,1983; A-Subaie , 1991 ; Al-Yahya, 1991 ; Al-Fahad , 2001). Indeed, there are psychological illnesses in Saudi Arabia that may have similar symptoms and cause the same difficulties for the clients, and, these psychiatric clients may be helped by the treatment in mental health hospital under psychiatric supervision, but as the researcher noted above, some forms of treatment practitioners such as counselling services would be more effective if there was more awareness of them within the mental health context.

3.10 Summary

As this chapter has shown, the past 50 years have seen a development in mental health services in Saudi Arabia, which most of the regions now have their own mental health institutions, whether a psychiatric hospital, Convalescence home, or a ward in general hospital. Thus, these significant efforts, such as financial incentives, have also been made to prepare and motivate individual personal to work in the mental health services. However,

qualitative and quantitative development in the services are shown many evidence, such as a variety of treating mental health patients are available, which include, psychiatric, psychological testing (IQ), counselling, and social workers. Since then, several other treatments, including religious counselling, have been introduced in many mental health institutions in Saudi Arabia.

However, comparing developments of mental health services in Saudi Arabia with those in the west, it can be said that Saudi Arabia too began with a psychiatric model and entered therapeutic phase in the late 1980s and early 1990s. It has not yet followed the West in closing down the big psychiatric hospitals in favour of community care, and increasing awareness of counselling in mental health setting.

Chapter Four Mental Health Services In the West

Vagrancy Act

New Sight

Social Beliefs

Change of Concept

Challenge to the New Movement

Chapter Four Mental Health Services
In the West

Introduction

In the 18th century, there were hardly any special services for the mentally ill in the west, although a few counties had established hospitals for the mentally ill .For instance, in Britain there was only one place called, Bethlehem or Bedlam, in London established in 1247, which accepted anyone who might be a danger to himself or others (Jones, 1972; Parry-Jones, 1977). It was considered the only hospital dealing with mentally ill people who were normally regarded as *"pauper lunatics"* in this period (Barker&Baldwin,1991; p.28). Bethlehem represented a unique attitude in an era in which Daniel Hack Tuke in 1776 wrote this poem show how much the people are suffered brutal and unwarranted treatment:

Far other views than these within appear

And woe and Horror dwell forever here;

Forever from the echoing roofs rebound

A dreadful Din of heterogeneous sounds.

From this, from that, from every quarter rise

Loud shouts and sullen groans and doleful cries ...

Within the Chambers which this Dome contains

In all her 'frantic' forms, Distraction reigns ...

Rattling his chains, the wretch all raving lies

And roars and foams, and Earth and Heaven defies.

(Tuke in Jones, 1972; p.15)

However, not far from Britain, European countries faced a comparable environment in mental health services, although, some countries had created more awareness of this issue; Spain in the 15th century had seven hospitals dealing with mentally ill people, starting with Valencia Hospital, which was established in 1409,then Zaragoza Hospital founded in 1425 (Parry-Jones,1977). However, between 1939 and 1942 up to half million patient has been killed by German doctor, when the German medical association proposed a new policy for killing people with learning difficulties, physical disabilities, and mentally ill ,under the policy of life devoid of meaning (Rogers and Pilgrim ,2001).

4.1 Vagrancy Act

The first step in mental health services was established in Britain with the enactment of the Vagrancy Act in 1744 which made the first legal distinction between paupers and lunatics. Special places were established such as a lunatic ward at Guy's Hospital in 1728, and this was followed by St.Lukes' Hospital (established in 1751) in order to cope with overcrowding at Bethlehem Hospital in London. A large endeavour was a Lunatic Hospital established in Manchester in 1766 (Rogers&Pilgrim2001;Parry-Jones,1972; Jones,1955).Further, private madhouses (places for the mentally ill) were established in 1770 for those mentally disordered people who could afford to pay, and some paupers who normally supported by their parishes.

4.2 New sight

At the end of the 18th century, many Western countries improved their services for mentally ill people. For instance, in Britain, an eminent Quaker philanthropis, William Tuke, founded the Retreat in York in 1732 (Jones, 1955). Moreover, at the Retreat, there were pleasant facilities for occupation and recreation. This site, provided a new moral approach and management built on respect for the mentally ill people, rather than the bleeding and purging favoured by medical professionals at that time (Gelder, 1989; Jones, 1972).

Further, in 1808 , the County Asylum Act in Britain provided for the building of mental hospitals in all of the English counties, the Lunatics Act (Jones,1955),until 1890 ,resulted in the first asylums being built, which provided enough space for patients and staff and attempted to base treatment on moral principles. Indeed, this liberal approach was encouraged by the non-restraint movement. These steps were soon followed however, by a new restrictive approach, with many patients from the community begin transferred to the new asylums, which resulted in pressures of overcrowding, staff shortages, and increasing public intolerance of mental disorder. However, these changes were affirmed by the Lunacy Act, and that Act made it difficult to discharge mentally ill people from hospital (Rogers&Pilgrim, 2001; Gelder, 1989).

4.3 Societal Beliefs

After the Asylums Act it was believed that there no hope for cure. Professionals as well as the general public believed that mentally ill people were unable to care for themselves, and should be cared for at public expense (Olick, 1992).

During that time in Europe many hospitals were often located in rural settings away from town preferably out of sight. This idea of physical isolation reflected society's view towards the mentally ill (Jones, 1972). Treatment was crude, if it existed at all. Facilities were crowded, barren and inadequate, patients were unkempt and shabby, poorly paid and untrained staff acted as watchdogs over patients, who were seen as a kind of subhuman species (Hofling, 1980).

No doubt, there were several factors that contributed to the growth in the number of those with mental health problems. Firstly, patients began to be drawn not only from jails and poorhouses, but also from families who for many reasons would not care for their mentally relatives. The idea of sending a burdensome relative to a hospital because more acceptable. Secondly, because many patients remained in mental hospitals for a long time, admissions soon outnumbered discharges. And thirdly, once the idea of mental health hospitals was formalised it served many other professional, political, moral and personal aims (Hofling, 1980; Rogers & Pilgrim, 2001).

4.4 Change of Concept

Early in the 20th century, the mood on mental health began to shift, and many new ideas appeared. For instance, in the U.K an early indication of the liberal policies after the First World War was the opening of the Mudsley Hospital in 1923. This provided a different

kind of service and voluntary in-patient treatment provided in a hospital where normally teaching and research were pursued. Moreover, in the 1930, the Mental Treatment Act repealed many of the restrictions imposed by the Lunacy Act of 1890 and gave more authority to County Asylums to accept patients for voluntary treatment. Furthermore, the MTA also encouraged local government authorities to set up many more outpatient clinics and establish after care facilities (Gelder,1989).

The advent of the National Health Service (NHS) paved the way for recognition of the value of medical services, and then in 1952, new optimism was created by the introduction of Chlorpromazine as a treatment, which made it easier to control disturbed behaviour and therefore discharge more patients into the community (Pearson, 1994).

In the U.S, the National Mental Health Act in 1946, played a very important role in the development of new treatments and new approaches in mental services including psycho-social treatment and psychiatric consultation techniques for use in mental settings. At the same time, mental hospitals opened after-care clinics to serve an increasing number of discharged patients and general hospitals opened acute psychotherapy and counselling units to provide care inside and outside the mental health hospitals (Mora, 1967).

However, in the U.S during 1963, and under the leadership of President John F.Kennedy, Congress passed the Community Mental Health Centre Act, which provided funds for the construction of Community Mental Centres with specified catchments areas. Moreover, each community mental health centre provided five basic mental health services : research and education; in-patient care; emergency services ; community counsellor ; and day care (Kapplan et al,1994).Thus, by the early 1980s, the movement for community mental health centres in the U.S was strongly influencing mental health services. At that time, about eight hundred centres were in operation, more than half of them in urban areas. The basic concept behind the community mental health movement was that people would have the

best chance of developing their ability to function independently of institutional supports, thus making the mental health hospital obsolete (Kapplan,et al,1994).

Obviously, the view of mental health services in the United States and United Kingdom has changed to developed more civilised ways of helping mentally ill people and has prompted the move from mental hospital to community care, Furthermore, this pattern of events is likely to be followed in other industrialised countries such as Japan (Rud &Noveik, 1982; Iseda et al, 1990). However, the United States and United Kingdom mental health models evolved during the 1950s in the UK as community care and during the 1960s in the USA as adeinstitutionalisation, as a formal policy of the federal Government (Rose, 1979). However, the similarities in origins in both countries both emerged from commissions of inquiry set up by their respective political directorates. In the UK it was the Royal Commission on the law relating to mental health illness and mental deficiency of 1957 (Pearson, 1994), while in the U.S.A it was the joint commission on mental health illness and health action for mental health of 1961 (Bennett, 1979). In the West medical models increasingly emphasised on forms of treatment , training ,and social services which can be given without bringing clients into hospitals as inpatients , or made it possible to discharge them from hospital sooner than in the past. Nevertheless, the recent trends in mental health care have not been without their problems and challenges.

4.5 Challenge to the New Movement

The aims of closing psychiatric hospitals in U.S were to help the patients adapt to the environment and at the same time to reduce costs (Kaplan, 1994). However, the idea of closing public mental health centres and having community mental health centres instead, has so far proved not easy to carry out, the overall number of public of psychiatric hospitals has remained stable. Furthermore, the hospitals not only remain in existence but continue to

dominate mental health costs, which representing 23% of U.S national mental health expenditure.

In the same way in Britain, there has been a gradual shift in the mode of mental health care. For example, the services moved from psychiatric hospitals to specialised psychiatric wards in general hospitals (Iseda et al, 1990; Rogers&Pilgrim, 2001). It is clear that in the past 40 years there has been a tremendous shift in the philosophy relating to the care for the mentally ill has been witnessed (Sayce, 2000). However, this change in society's attitude has fuelled the perception that the incarceration of mentally ill people in remote institutions is dehumanising and denies them the opportunities of talking their place within their society.

Indeed, the result of changing attitudes has been reduction in the number of mental health hospitals, and an increase in the range of services for mental health. Mason (1976) pointed out, that in England and Wales the number of mental health hospitals decreased from 2.81 per 1000 population to 2.03 between 1964 to 1973. Moreover, the need for new services has increase in psychiatric hospitals increased. It was reported that between 1960 to 1985 , there was an almost 51 per cent reduction in the resident population of psychiatric hospitals while nursing, social work, and counselling service grew. However, since the early 1960's, a government have aimed to continue to reduce of Britain's mental health hospitals by the year 2000 (Rogers & Pilgrim, 2001).

4.6 Summary

Mental Health services have a very long history. Even in ancient times societies recognised mental health disorder and tried to derive ways to treat it. Over many years there have a number of distinct trends in the way mental health disorders have been perceived and treated. For instance, during the eighteenth and nineteenth centuries, the emphasis was on

the custodial care of "Lunatics" with no hope of curing such people; the basic idea of mental health in that era was to protect the whole society from their aberrant behaviour.

In the early part of the last century the treatment of mental health has been moved to a new idea using a more therapeutic approach which changes towards care mental health treatment, rather than as evil an scandal to be hidden and restrained.

Since the middle of last century in western society a new paradigm has been evident, marked by a shift in emphasis toward community health care (Rogers & Pilgrim, 2001). there has been a conspicuous trend in the Western society towered the closure of psychiatric hospitals ,in replaced by community support with community mental health centres. However, this change has been fraught with different problems, such as the persistence of old attitudes and perceptions. There have been funding constraints; the full level of support need for car in the community has not always available.

Experience of the West in mental health services can inform the Saudi Arabian mental health services in many way of improving their services. Firstly, psychiatric hospitals can not be immediately closed down , until there is provision for adequate care in the community. Secondly and most importantly, mental health workers in the hospitals should provide a new service such as counselling and social work. Lastly, enough finding should be available such that all mental health workers should be trained to support anyone who discharged into the community.

Chapter Five

Chapter Five Counselling Movement

Definition of Counselling

Client – Centred approach

Psychoanalysis

Cognitive Behaviour Therapy

Counselling Practice in Mental Health Provision

Counselling Services in Saudi Arabia

Mental health Counsellor in Saudi Arabia

Improvement the services

Chapter Five Counselling Movement

Introduction

This chapter will detail an overview of the limited textual sources available on the contemporary counselling movement in an attempt to present current theoretical perceptions of counselling practice in both Western society and Saudi Arabia.

The accounts presented in this chapter will be primarily normative. They will examine how various theorists have constructed their view points of counselling by examining what they propose ought to be its central constituents and aspects. There are many problems with current theoretical perceptions of counselling, and there are conflicting elements that continue to add to the existing confusion in the field.

Part One Counselling in the West

5.1 Definition of counselling

Counselling, rather than simply being something innovative and completely new is often described as a return to the ancient roots of the practice of psychotherapy.(Rogers,1957,1961,1969;Truax&Carkhuff1967;Egan,1998;Nelson-Jones, 1982; Nelson-Jones, 2000:Dexter and Wash, 1995;McLeod, 1998; Dexter and Russell, 1997).

Most attempts to define exactly what counselling is generally begin with an explanation of what it is not. For example the British Association for Counselling*[1] (1993) offer this definition:

" The overall aim of counselling is to provide an opportunity for the client to work towards living in a more satisfying and resourceful way .The term counselling includes work with individuals, pairs or group of people often, but not always referred to as clients. The objectives of particular counselling relationships will wary according to the clients needs but may well be concerned with developmental issues, addressing and resolving specific problem, making decisions, coping with crisis, developing personal insight and knowledge working through feeling of inner conflict or improving relationships with others. The counsellor's role is to facilitate the client's work but in ways which respect the clients values, personal resources and capacity for self determination. "(P.6)

Indeed, this definition offers different way of meaning in comparative to what are the out comes of counselling (Dexter, 1996). Consequently leave those who wish to work in the field both confused and frustrated. Equally Burnard (1989) states *" We are all counsellors, anyone who works in one of the health professions and comes into contact with people who are distressed in anyway "(p.1)*

Burnard (1989) goes on to state that it is time for counsellors to turn themselves to the problems of everyone, rather than merely the problems of counsellors. He advocates that counselling should be less academic and more about the problems that confront a person in their daily lives. On the other hand, the British Association for Counselling's (BAC) definition claims, among other things, to help the client to identify and clarify hidden assumptions and emotions; to recognise leaps of abstraction and assumption; to deal with

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[1] *The British Association for Counselling (BAC) now British Association for Counselling and Psychotherapy (BACP).

questions about meaning and value in life; ethical problems; questions regarding the right thing to do in given situations; good decisions and best choices to make; to learn the art of living. By helping clients to find for themselves, the BAC claims to offer the answer the question, How should I live my life?. They advocate that this can be achieved by clarifying roles and responsibilities; developing intellectual tools to aid in examining problems from various perspective; recognise options, to anticipate consequences; to develop the intellectual tools necessary in the constructive examination of the clients own thinking; construct a life narrative in line with the client's own values and goals, and to critically examine the relationship between beliefs held by the clients and the life they live.

In positive terms it has been argued that counselling is the care of the self. It is also conceived of as an autonomous (counselling) discussion about whatever a client wishes to discuss with a counsellor (McLeod, 1998). Equally, Rogers (1961) argues that It is seen as referring to face to face discussion, in which a counsellor thinks along with a client about problems in decision making, and about existential questions (Egan, 1998) In a session with a client the counsellor attempts to understand the nature of the client's problem; clarify what is at stake, rather than to offer practical solutions (Rogers, 1961). Furthermore, the counsellor prime function is to help his client better understand the situations and problems that touch upon his/her life. More specifically the issues with which she or he is currently struggling. The counsellor's intention is to conduct a thorough hermetic of the client's text, as orally presented, before helping the client attempt his own critique (BAC, 1993). In this sense then, counselling is client-centred in so far as the client is necessarily involved in participatory dialogue with the counsellor that requires the client's self-scrutiny within the context of the client so called *"core conditions"* (Roger's, 1951,1961;Truax and Carkhuff, 1969;Dexter, 1996; McLeod, 1998;Nelson-Jones, 2000).

From the above counselling is seen to be multi-faceted as it is described as concerned with personal development as defined and desired by the counsellors themselves (Irving & Williams, 1999). At other times counselling is said to restore equilibrium; thereby helping individual develop through first order skills and second order level of thinking. It is considered by some practitioners to be useful therapy (Wilkins, 1997;Nelson-Jones, 2000). Therefore a definition of counselling is said to teach client's who have had major difficulties in life how to live life by reducing their life disturbing problems (Egan, 1998), can not only be self-mitigating but avoided. Indeed, counsellors seem to be fighting on two fronts, so to speak when they define themselves in autonomous terms, first against psychotherapists who force upon their client's a rigid diagnostic and therapeutic system, and second against those who apply counselling in an advisory capacity by hiring themselves out as ethics issues to work with.

5.2 Client – Centred approach

The most important and frequently used therapeutic methods in Britain are client-centred and psychodynamic counselling approaches (McLeod and Wheeler, 1995). Consequently, most of counselling training courses in counselling use a client centred approach (Dexter, 1996). The term "client-centred" was coined by the psychologist Carl Rogers in the 1950s,

Rogers started what he called "nondirective counselling" in the 1940s as a reaction against classical Freudian and directive psychoanalytic approaches to individual therapy in use at that time. This approach directly challenged the long standing paternalistic presumption that the therapist knows what normal is; that he knows how the client's state differs from normal, and that he, therefore, knows what is best for the client's in order to bring them to the state of normalcy. In the next decade Rogers developed what he called client-centred

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therapy which is based on the assumptions that people are essentially trustworthy, i.e., that what they say to the therapist can be believed, and is not merely an unconscious cover up of the truth that they have a vast potential for understanding themselves and resolving their own problems without direct intervention from the therapist, and that they are capable of self-directed develop within a therapeutic relationship (Rogers, 1961).

Today many counsellors share Rogers view that the best vantage point for understanding how people behave is from their own internal frame of thinking (Thorne, 1991; Mearns, 1997; Purton, 20002). Thus, the client is seen by the counsellor, not as the host of isolated illness needing treatment, but rather as whole person, a self-directing moral agent whose dignity and autonomy deserves the respect of the counsellor (Rogers, 1989). While the counsellor may certainly be empathetic to the difficult choices and complicated dilemmas experienced by the client, thereby is better able to assist the client finding a satisfactory resolution the BAC (1993) maintain that the counsellor should resist making decision on behalf of the client. Not only to avoid infringing on the client's autonomy, but to avert the possibility of client's developing a dependency on what may be perceived as the counsellor's superiority in reasoning ability and decision making expertise.

Both the client-centred aspect and the nature of counselling requires of the client a perspective that some may find difficult if not impossible to achieve (Ellis, 1994). For instance, Egan (1998) maintains that seeking a help from counselling should be seen not as the client giving up his/her independent thought, but rather as a means of dealing with problems or concerns through a discussion with a "wise person". He points out that there is, of course, a crucial difference between the client and the counsellor, and between the kinds of discussion one might have with a friend and the kind of discussion, which occurs between client and counsellor. Namely, both the focus of the discussion, which is always on the client and his/her concerns. Some writers such as Dexter and Russell (1997) warn

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that this difference in specialised knowledge can easily lead the counsellor into trap, that of allowing the relationship with client's to take on the less desirable asymmetry found in a client –counsellor relationship.

5.3 Psychoanalysis

In classical psychoanalysis, or Freudian therapy, the assumption is that human beings are basically determined by psychic energy and by experiences. Unconscious motives and conflicts originating in past experiences are central in present behaviour. Irrational, and largely uncontrollable forces, are said be strong, and the person is understood to be driven by sexual and aggressive impulses. Naturally, early development is considered to be of critical importance, because later personality problem are believed to have their roots in repressed childhood conflicts, It is maintained that Freud's assumptions about the person were that he/she was not a knowing person but rather a psychoanalysis person better characterised by multiplicity, disunity, and self-deception, and as being decentred fragmented, irrational, and incapable of objective reasoned arguments. This seems like a rather extreme depiction of Freud's theory, which may no longer be hold by contemporary psychoanalysis (McLeod, 1998).

Thus, psychoanalysis focus on the client's development on the first six years, as it is considered that early years experiences shaped the development of personality and motivate behaviour .The focus is on addressing deviation from personality development based on successful resolution and integration of psychosexual stage of development. When faulty personality development occurs it is the result of inadequate resolution of some specific stage. (The Id, the ego, and the superego constitute the basis of personality structure, all of which are said to have a normal state in the healthy individual) 1. For instance, anxiety

results from the repression of basic conflicts, and ego defences are developed to control that anxiety.

On the other hand, one of the primary skills of the psychoanalysis and the counsellor or therapist is his/her ability to make a diagnosis based on symptomatology found in the latest diagnostic tool available, such as the fourth edition of the Diagnostic and statistical Manual of Mental Disorders (DSM-IV). The psychoanalyst must be able to diagnose major depression from such symptoms as suicidal ideation. Feelings of helplessness, hopelessness, etc. but the counsellor does need to possess such diagnostic skills.

5.4 Cognitive behaviour therapy

Rational Emotive Therapy (R.E.T) is one from of cognitive behaviour therapy developed by Albert Ellis in the early 1950s. Ellis took psychology as his main pursuit and hobby from age 16. Elli's decided to incorporate psychology into his counselling approach after coming to the conclusion that Freudian psychoanalysis was a relatively superficial and unscientific from of treatment (McLeod, 1998).

Ellis' (R.E.T) or Rational Emotive Behaviour Therapy (R.E.B.T) as it is known by today (Ellis, 1994) is often criticised as being too exclusively cognitive therapeutic modalities and ineffective in dealing with emotional problem. However, Ellis (1994) points out that in R.E.B.T the therapist teaches his client the "A.B.C" model of changing their emotions," A" is the existence of a fact, an event, or the behaviour or attitude of an individual and "C" is the emotional and behavioural consequence or reaction of the individual, (the reaction can be either appropriate or inappropriate), Ellis sees A as the activating event and not necessarily being the cause of C, the emotional consequence. Instead, he maintains that B, that is the person's belief about A. largely causes C, the emotional reaction. Therefore, if the emotional reaction at C is, for example, depression an R.E.B.T therapist will work with

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the client to examine, and if necessary alter the beliefs at B, which caused that emotional reaction.

Thus, in R.E.B.T the therapist is said to function as a teacher, and the client as a student. Therapy is seen as an educational process. The therapist is highly directive and teaches clients the "A-B-C" model for changing their cognitions mentioned above. The therapist aims at providing the client with the tools to restructure their behaviour styles, to enable them to deal more effectively with not only the present problem or situation, but also many other current problems in life, and those in the future.

In the other hand, Cognitive therapy although similar to R.E.B.T focuses on a collaborative relationship between the client and the therapist. The therapist uses the challenge of thinking in which the client's is guided by means of questions in discussion, to assist them to identify dysfunctional beliefs, and thereby discover alternative rules for living. After the client gains insights into their problem the client is expected to actively practice changing his/her self-defeating thinking and acting (McLeod, 1998).

Furthermore, the theoretical foundation of Ellis' R.E.B.T is similarly based on the assumption that human thinking and emotions are not two disparate and antipodal processes. They significantly overlap and are in some respects, for all practical purposes, are essentially the same, Ellis also contends that a client's emotional or psychological disturbances are largely a result of his/her thinking illogically or irrationally, and that clients can rid themselves of their emotional or mental unhappiness, ineffectuality and disturbances if clients learns to maximise their rational and minimise them irrational thinking (Ellis, 1994).

The assumption then, in both counselling and psychotherapy broadly construed, is the person is a rational autonomous agent capable of addressing emotional disturbances on a

conscious cognitive level. This indicates that the counsellor must recognise an inherent value in the active and collaborative participation of the client in the counselling process.

5.5 Counselling Practice

There seems to be gap in relevance between counselling theory, practice, and research (Connor, 1994;Clarkson, 1998;) This incongruence maybe equally disconcerting for everybody involved in the counselling field. The links between theory, practice, and research is the very hallmark of the endeavour. Yet, counselling has difficulty in gaining admission to the realm of science and scientifically acceptable research. More precisely, counselling does not fit in the prevalent paradigm of science and research as it has been established, accepted, and practiced during the past half of the last century.

Equally, the relationship between practitioners and counselling theory has not been easy one either; Practitioners seemed to get disenchanted with the divisive theoretical war (Irving & Williams, 1995); with the claims of superiority of the rival theoretical explanations and approaches, and with the demands on a rigid loyalty to one particular school of thought. Moreover, most practitioners recognise that not a single school of thought provides a sufficient theoretical framework to guide their daily work. Norcross (1986) noted that between one–third to half of practising clinicians classified themselves as eclectic. Indeed, nowadays this proportion is thought to be higher (Palmer et al, 1998).

Thus, professionals are mainly concerned with the congruity of theory, research, and practice, and have virtually ignored the voice of the protagonist the client. It may well be that the distance between the client perspective on the one hand, and the counselling theory, research and practice on the other hand, is in fact much bigger than that among the theory,

research, and practice. And it may well be that this is the major contributing factor to the fore mentioned lack of congruency in counselling field.

5.6 Counselling Practice in mental health

The ambiguities in the theoretical literature, the inconsistencies, and the often outright contradictions in the descriptive reports of practice are liable to leave those who wish to work in the field both confused and perturbed. What is also unclear, due to disagreements in the literature, is whether talk about method is even an acceptable topic for discussion within the field of counselling. All this serves to make new practice less credible rather than more (Farrell, 1996; McLeod, 1998; BAC, 1984; Sutton, 1987).

Sutton (1987) has called for counselling to be delineating to a common set of models and principles across theories. Moreover, he encourages more attention to what counsellors _do_ rather than what they _say_ they do. In fact, counsellors appear to be closer to each other in their doing that in their proclaimed theoretical and models stances. Sutton has expressed the belief that this may lead to the creation of a new model of counselling practice as he argues that the use of client evaluating of the service received from the counsellor is most important, because it is the client who seeks for help.

Hill and Corbett (1993) examine Roger's extraordinary influence on counselling, and observe *"perhaps because Rogers emphasised the process of change most of the research generated from nondirective theory involved evaluation of the process rather than of outcomes of therapy"* (p.5). They emphasised the practice and the process of counselling where counselling training the process cannot *escape* the outcome (Cowie and Salm, 1998). Whereas, Hill and Corbett (1993) pay more attention to conditions and skills "Carl Roger's theory led on a proliferation of studies on facilitative conditions and skills" (p.8). They

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quote reviews of research both supporting and questioning the relationship between the Rogerian "necessary and sufficient" conditions and skills, and the therapeutic outcome.

Truax and Carkhuff (1967) found that warmth, empathy, genuineness, and non-possessive most were the skills for counsellor. This increased sensitivity that is essential to the modern day counsellor, who must practice in a society steeped in different gender and ethic issues, helps the counsellor become aware of their own thoughts, beliefs, and personal development. (Russell, 1999; Douglas, 2000). Moreover Bimrose and Bayne (1995) emphasise that the module of social context is more useful in counselling practice as is also the multicultural angle that is importance for counselling and its future development in this field.

However, Irving and Williams (1995) suggests that we need *"identified a clear difference between the assumptions and beliefs that actually govern our behaviour (termed theories in use) and what we say about why we behave in the way we do"* (p.32). This angle it is even more obvious in Irving and Williams (1995) review of other literature on counselling practice and training setting. Indeed, the counsellor needs to reflect on his /her own thinking in order to be effective. Irving and Williams (1995) consider the agenda for establishing effectiveness of counselling practice is in place. Whilst, Connor (1994) proposes a model of training counsellor, she enrich the area of counselling training by using model where she argues that counsellor training programmes can play a major role in helping trainees to become a good counsellor through development of attitudes and values, knowledge and skills, client work and supervision, and reflection and evaluation.

Some studies in U.K have been mainly concerned with the observation and the manipulation of the concept of counselling theories as related to process. Whereas, the mental health counsellor have not been critically questioned. In fact, the practicing counselling in mental health context has been often delineated in terms of the concept

investigated in the counselling theory that may be viewed as the affirmation of practice and tied to a specific theory. Research suggests that it is not easy to win with this particular paradigm of practice in counselling as it directly reflects the counsellor practice and critical thinking within his/her theory or framework.

One criticism often levelled against counselling is the assumption that approaches are inappropriate if they fail to address the client's feeling or emotions. Ellis points out that, while beliefs do not themselves constitute emotions, beliefs are still to be included in emotions. If beliefs or cognitions influence change in our behaviour as well as in our psychological states, then it is easy to see how counselling works on cognitions, thereby, on emotions. The assumption that counselling cannot deal with the client's emotions is unfounded according to Roger's, Ellis and others. Equally, the counsellor must assume that the feelings of the client are not beyond the scope of counselling inquiry. In order to effective assist the client.

Part Two Counselling Service in Saudi Arabia

The legitimacy of a new method of counselling is often perceived to be directly proportional to the degree of separation and differentiation between this new method and other methods in its field. The new counselling practice within mental health context in Saudi Arabia society is no different in this respect.

Counselling practitioners have made a rigorous attempt to establish counselling's legitimacy by arguing for its uniqueness. Abu-Rasain (1999) asserts that because of the interpretation of the problems inherent in counselling in Saudi Arabia. There are many views expressed in Saudi Arabia literature:

" But can be classified into three main views. The first and second views constitute an extreme polarity. On the one hand, there are those groups who totally believe that counselling and psychological theories and concept, although they are a Western product, can be applied as they are in Saudi culture. Supporters of this view are those who either welcome any Western idea or who had their early training in counselling and psychology mainly in the United States, and were impressed with the idea. One the other hand, there is a view that there is no need for counselling and psychology, not only in Saudi society, but also in all Muslim countries. Their argument is that there are Islamic teaching principles, which are the best sources in solving one's personal problem in life"(Abu-Rasain, 1999.p.219-220).

Whilst some researchers agree with Abu-Rasain depiction, others strongly disagree. Because they see counselling and psychology, as having a specific subject is clearly teachable that requires certain abilities, skills, and tools. This does not, however mean that those who disagree with Abu-Rasain's view of counselling in Saudi society, are guilty of not viewing counselling in Saudi Arabia as being a sincere and legitimate effort to implement Western Counselling techniques.

5.7 Mental Health Counsellor in Saudi Arabia

In his book Theory and Practice of Counselling and Psychotherapy, Al-shenawi (1994) selected and translated ten therapeutic approaches giving an overview on each as well as offering a number of general summaries in which he gives a clear, succinct synopsis of the theories and approaches found in Western literature. He divides these ten therapeutic approaches into four general categories: analytic approaches, which includes psychoanalytic or Freudian methods; experiential and relationship oriented therapies, which includes the existential, Person-Centred, and Gestalt approaches; action therapies, which includes reality therapy, behaviour therapy, rational-emotive behaviour therapy (R.E.B.T), cognitive therapy; and lastly the systems perspective, which includes family therapy.

Despite similarities in these approaches, counselling certainly cannot be understood in terms of proof of either procedural or substantive elements in these approaches. They do not identify substantial theoretical and methodological overlaps. For instance, there is disagreement about psychological problems, which may be rooted in childhood that can be perpetuated unchanged in to the present. Moreover, a close resemblance of the ideas can be found between counselling in Saudi Arabian counselling and cognitive behavioural therapy (Shaleby, 1992) The suitable of the rational emotive behavioural therapy for counselling practice in Saudi society is not clearly apparent and it is therefore neither evident where to draw the line of similarity between R.E.B.T and Saudi's society. Nor is it clears how distinct such a line might be once it is drawn.

Another approach, such as the client–centred approach resembles to Saudi society attitudes and values, Abu-Rasain (1999) pointed out that client–centred can be a safe climate

conductive to the Muslims clients needs safe for exploration of their problems. Hence, the client–centred method; practices active listening and hearing; reflection of feeling; clarification and being there for the client are practising Western counselling skills. There is a striking similarity between the client–centred approach and the general attitudes in Saudi society about human life. However, Roger's theory could face two difficulties within Saudi's culture, these are the stresses upon counsellors who are not trained in Western culture and secondly, using counselling values that can be identified with *"certain religious principles"* (Williams and Irving, 1994,cited in Abu-Rasain, 1999,p.212). These will help to assimilate borrowed techniques from others approaches, which can be incorporated into any religious framework, such as a Muslim framework. On the other hand Williams and Irving (20001) describes counselling as a *"Western religion"* (p.7). However, these cannot be effective unless clients needs and wishes are respected.

Clearly counselling theory in Saudi's society is still not acceptable on three levels, (a) Practical level which includes hospitals, because in Saudi these are little consensus about what is counselling for, (b) social level and the ability of the counsellor of claim the understanding that counselling is more relevant to help and treatment for daily life than psychology is. This is because counselling is viewed as more socially acceptable than treatment for psychological disorders. And finally (c) the socio-political climate is such that the government needs to encourage citizens to use their skills and expertise in a number of areas, such as religion, art, politics, mental health, and even counselling psychology.

5.8 Improvement the Services

In Saudi Arabia, because of its strong economy is able to provide most the services needed for its citizens, The Ministry of Health has been given special support by the government to establish, a social services programme to cover the needs of the population everywhere in

the kingdom (Annual statistics report, 199p,K.S.A). Through this policy the government has established a Social Services Department in health centres. Due to the fact that staff from the Saudi community was low, the government offered financial incentives in order to increase national interest in the social services profession, and to strengthen employment in this field. Furthermore, the government recruit's foreign staff qualified in mental health services. Most as there are from Egypt (Al-Radi, 1982; p.283; Al-Tawil, 1984, p.20; Al-msallam, 1999). A minor criticism of this practice is unfortunately that because these new employees were trained in their own country, their own values, attitudes, and their own particular theory may not be in accord with Saudi needs.

Within these attitudes mental health counselling was established in Saudi Arabia. However, existing Saudi culture is not compatible with many of these practices. For instance, Al-yahya (1991) notes that "... *The majority of Saudis, especially in rural areas, attribute mental illness primarily to possession by demons (jinn) .The evil eye and to a lesser extent, black magic, especially in cases of marital discord and psychosexual problem, is believed to cause mental illness. The traditional remedy is a mixture of herbal remedies, Koran verses, and religious phrases, using cauterisation and often the patient will be beaten up during exorcism*" (p.101) The most popular diagnosis in the Saudi mental health Services was the "evil eye", plus the most sensible healing reading of the Koran (Al-subale, 1994, p.83) To counteract the serious imbalance of this position it is crucially important to establish efficacy of counselling services and at the very least guidelines to follow in the practice of counselling .

Consequently, counselling services in Arab countries need to prove their work, have relevant models and effective their practice. Soliman (1986) concluded that: ". Counselling services are not provided in many Arab countries. To my knowledge, only three (13.6%) of the twenty-two Arab countries offer counselling services in their psychiatry hospitals

"(p.68). In Saudi Arabia counselling has been serviced for some time by religious counsellors. Some mental health hospitals see it as a new addition to their existing psychology approaches, as counselling is designed to help the client acquire inner understanding and peace through a painstaking approach towards his /her complete recovery through teachings and the philosophy of Islam, patients, in this rehabilitation process, are assured, because of their profound belief in Allah's help. Whereas, Shaleby (1992) offers an extreme answer to this situation when he state ".. *Most psychotherapy techniques involve abstract concepts. The non-directive model, the free association, the insight oriented psychotherapy, are all abstract concepts, and the ability of the patient to comprehend and integrate formal operation thinking, is necessary in this kind of psychotherapy" (p.19).*

Indeed, he argues that practitioners are people who have experience and development their own particular way of thinking. He further suggests that the level of technique should be evaluated for mental health counsellor because of relevance to counsellor thinking. However, Shaleby would include, *"the diagnostic specification with the exclusion of supportive therapy, that would fit any culture and any diagnostic category, patients fitting the classical model of exploitative therapy will be primarily non-psychotic .For instance, diagnoses of anxiety disorder, depressive disorder, adjustment disorder, and difficulty in adjusting to the developmental stage in their lives."*(p.19) Shaleby specifies the active components and procedures of treatment in Arab culture, but unfortunately he does not discriminate between the distinctive effects of therapy and the distinctive effects of therapists. Al-Radi (1982) concurs when he states that this religious counselling is usually administered by means of group seminars, which have been shown to be very beneficial to mental and spiritual well–being. Thus, mental health counsellors in Saudi's society will need special skills that include a working knowledge of its culture, along with an

understanding of the guiding rules of the community, Counsellors, therefore, need to be conversant with all social and moral attitudes of Muslim society.

5.9 Summary

First part of this chapter describes the historical panorama of specific rationalities of counselling and mental health and the interactions between them through the services and other institutions concerned with the knowledge and mental health services in Western societies and Saudi Arabia. This description shows that, from a certain time in counselling history, the definition of counselling has often been negatively defined that is by means of a recounting of what it is not. Positive definitions have been conflicting, contradictory, and often mutually exclusive, for instance, counselling theories, skills, and the way to use these elements for different culture.

The second part described counselling services in Saudi Arabia, with highlight the complexity of treatment for the patients. A conclusion can be drawn from this discussion; it suggests strongly that the counselling services can play a major role in patient's lives, and patients in mental health hospitals in Saudi Arabia could receive counselling for numerous treatments, vocational, personal, material, developmental, and social concerns

Therefore, this chapter has described the developments whereby the counselling approaches were created in the Western culture. Their practices were described and note made of significant similarities and differences with practitioners in Saudi Arabia. This may help conclusion to be more easily drawn when considering the implication and generalisability of the results described later in this thesis.

Chapter Six Methodology

Initial Research Methodology

Philosophical Assumptions

Research Methodology

Qualitative Enquiry

Quantitative Enquiry

Strategies of tools

Samples

Data Conducting Protocol

Pilot study

Chapter Six Methodology

Introduction

This chapter describes the research strategies and argues their appropriateness for a study which aims to identify and prioritise the mental health services in Saudi Arabia. In first section, explain the initial research methods and paradigms used to develop framework. This is accomplished by providing an overview of the philosophical assumptions in the context of mental health research, highlighting the main research methods; including paradigms, approach and techniques which are used to conduct this research, as well as their benefits and limitations. This also includes our research strategy, as well as the phases of narrative paradigm, the techniques used, and the problems faced during conducting them.

In the second and third sections, introduce the impact of empirical work environment on the research techniques. This includes a discussion of the research paradigms adopted in the context of mental health research, and the main techniques for gathering facts including how they were influenced by the environmental factors. This section ends by introducing the analysis methods used in this research. The final section summarises the methods and outlines the content of the following chapters.

6.1 Initial Research Methodology

This section will describe the initial research methods and paradigms used during developing the research method. In the section two and three further discussion will take

place in the research method in the context of qualitative and quantitative inquiries and how it influenced in the research paradigm and data collection methods.

6.2 Philosophical Assumptions

The answer to the question what constitutes researching mental health depends on how we define mental health services in the first place. Selecting the research approach is one of the hardest decisions a researcher can make (Elliott, 2000; Bryman, 2001). Furthermore, there is no single approach, which encompasses the knowledge needed for the study of mental health, and this is a key message, which needed to take in this research when embarking on mental health research. In this context, McLeod (1994) mentions that it is unlikely that there is a universal counselling research approach.

However, a research paradigm has come to mean a set of overarching and interconnected assumptions about the nature of philosophy. A paradigm provides the largest approach within which research takes place.

According to Denzin (1998), a paradigm is the basic set of believes that guide action. It comprises of three elements namely epistemology, ontology, and methodology.

Table 6.1 Research Paradigms

Paradigm	Believes
Methodology	The focus of methodology is on how we obtain knowledge about the world.
Epistemology	Epistemology is concerned with how we know the world and what the relationship between the inquirer and the known is
Ontology	Ontology raises the basic questions about nature and reality.

6.3 Research Methodology

Research methodology concerns choosing the most appropriate techniques to collect the data needed to achieve the research aims. Indeed, the nature of the data to be collected determines the research method or methods that should be followed in scientific research. In the present case, the need was first, to gain a greater understanding of the wide area of the mental health, and then to determine valid and accurate developing of the services through surveying a relatively large number of people involved in the field of mental health practices. The survey approach is suggested to be the best, if not the only, method which, according to Cohen and Manion (1994) *"gathers data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events"(p.83).*

However, qualitative and quantitative research methods are more than just different between research strategies and data collection procedures, these approaches represent fundamentally different frameworks for conceptualising the nature of knowing.

In survey counselling research, the first issue to be decided is which approach should be adopted for data collection: qualitative or quantitative, especially bearing in mind that, as Lewin (1990) put it, *"Each has its own advantages and disadvantages"* (p.46).

In distinguishing between qualitative and quantitative data, Verma and Mallik (1999) commented: *"These labels do not represent discrete categories or clusters, but are merely*

endpoints of a continuum (p. 43).   ...there was an even greater overlap between the research tools used (p. 111).

The intention of this study, therefore, is twofold; first, to gain qualitative data from participants in different sample categories *(clients, counsellors, psychiatrists, and staff)*, regarding their experience of counselling within mental health services and opinions on how the mental health services should be developed; to this end narrative interview was chosen. This would facilitate the gaining of a sensitive detailed understanding of the current situation of the mental health counselling services and incorporate a wider variety of suggestions of how it can be improved. Narrative Interviews make it possible to gain a broader picture by asking further probing questions, should an initial response lack detail. Secondly, to collect quantitative data to evaluate the suggested recommendations, thoughts and advice for developing the counselling services.

6.4 Qualitative Enquiry

Although quantitative research methods were originally developed in natural sciences to study natural phenomena, they are also well-accepted methods in social sciences. These include for example, survey methods, laboratory experiments, formal methods (e.g. psychology) and numerical methods like mathematical modelling (Myers, 1997). According to Henwood (1996), quantitative research becomes just one approach to science, namely, manipulating, measuring and specifying relationships between specific variables, in order to test hypotheses about casual laws.

Since the 1960s qualitative research as an alternative approach to human and social science inquiry has grown and developed steadily. It has now entered the practice in educational research (Bryman, 1988), and other branches of social science such as counselling (McLeod, 1999).

According to Myers (1997), qualitative research involves the use of qualitative data such as interviews, documents, and participant observation data, to understand and explain social phenomena. The main concern of other authors discussing qualitative research is presenting methods of conducting research (see for example Berg, 1989; Bogdam and Taylor, 1975; Burgess, 1985; Patton, 1990). Qualitative research as Potter and Wetherell (1987), Parker (1992), Wetherell and Potter (1992) describe, lays down its claim to acceptance by arguing for the importance of understanding the meaning of experience, actions, and events, as these are interpreted through the eyes of particular participants, researchers and sub-cultures, and for a sensitivity to the complexities of behaviour and meaning in the contexts, where they naturally occur.

Grafanaki(1996) defines qualitative research as a *"process of systematic inquiry into the meanings which people employ to make sense of and guide their action (p.329)*. While Creswell (1998) reminds the qualitative can be defines as *"an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and the study in a natural setting (p.15)*.

At this statement of the research there was complete agreement with Bell (1993, p. 6) that *"Researchers adopting a qualitative perspective are more concerned to understand individuals' perceptions of the world. They seek insight rather than statistical analysis"*. Furthermore, Vulliamy (1990) recommended that *"Qualitative research is holistic, in the sense that it attempts to provide a contextual understanding of the*

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complex interrelationships of causes and consequences (p. 11) ... qualitative research can also play a useful role in identifying the most appropriate questions to address in larger-scale quantitative research studies (p. 25).

However, the dispute and the controversy between the two kinds of research are reflected in the literature of psychology research as well as counselling research. For many researcher (e.g., Guba & Lincoln, 1981; Bryman, 1984; Denzin and Lincoln, 1994; McLeod, 1994; Grafanaki, 1996; Creswell, 1998; Elliott,2000;Bryman, 2001) the controversy is not only related to the actual and potential advantage and disadvantages of quantitative and qualitative methods, but also involved in a fundamental clash between two paradigms.

At the start of the study, the outline information about the situation of the mental health services in Saudi Arabia. It was apparent, through reviewing the related literature, that attainment in mental health practice is reported as unsatisfactory (Al-Subaie and Alhamad, 2000). However, detailed current information was lacking, regarding clients treatment, the current practising of the mental health services and the views and opinions of the counsellors and other practitioners of how improve those services. Additionally, the information collected from the literature was not a sufficient basis to understand counselling practice in mental health institutions in Saudi Arabia

According to Creswell (1998), one of the key factors of qualitative research is that the researcher constructs versions of the world through activities as social and political subjects, and does not merely reflect facts with a self-evident objective reality. This position is known as a narrative.

However, in accordance with the advantage of the qualitative research mentioned by Vulliamy (1990); Bell (1993); Grafanaki (1996); Creswell (1998). Qualitative

methodology was used in this stage of the research. The question emerges, then, which research instrument/s should be thought of and adopted for this part of qualitative study? Elliott (2000) points out that *"different qualitative researchers influenced by different research traditions have tended to develop quite idiosyncratic strategies for gathering and analysing data" (p.58).* The challenges of qualitative research have been discussed by several authors, such as Winter (2000), who mentions that unlike quantitative research, there are no standardised or accepted 'tests' within qualitative research, and that often the nature of the investigation is determined and adapted by the research area itself. There may not be any hypothesis or even any findings as such. Instead, the validity of the research resides with the representation of actors, the purposes of the research and the appropriateness of the process involved. The validity depends on how representative the description is, and how justifiable the findings are. However, there have been lots of efforts, such as using displays for qualitative research to overcome these limitations (Miles and Huberman, 1994). This is further discussed, when proposing the analysis method by the end of this chapter.

Elliott and Williams (2001), discusses qualitative research and paradigms using statement that qualitative research is a field of inquiry in its own right, and that it is surrounded by a complex, interconnected of terms, concepts and assumptions. As Bryman (2001) continues, this complex and sometimes contradictory issues has arisen because qualitative research is informed by a variety of intellectual traditions including: views of scientific method as a way of producing knowledge that reflects an objectively present empirical world; and studies of culture.

6.5 Quantitative Enquiry

Quantitative research is concerned with data which can be presented in the form of discrete units. The chief purpose of such research is to accumulate information that can be quantified and compared with each other by using statistical techniques.

Bryman (2001) suggested that such research should use scientific techniques to produce quantified and generalise able conclusions. However, the choice of a particular perspective according to Verma and Mallick (1999, p. 26) *"has implications for the type of evidence to be collected and the mode of analysis used in the investigation of a research question or issue".*

The time involved, bearing in mind that he hoped to gather information as much as he can from different respondents in different categories. Munn and Driver (1995, p. 2) pointed out the advantages of the use of the quantitative approach suggesting four advantages. They are: *"an efficient use of time; anonymity (for the respondent); the possibility of a high return rate; and standardised questions."*

Recognising the special characteristics of the study, the rationale of designing the quantitative appraoch was as expressed by Bryman (2001) *" in quantitative research the researcher is usually concerned to be able to say that his or her findings can be generalized beyond the confines of the particular context in which the research was conducted"(p. 75).*

The quantitative approach would enable to gather a substantial amount of data, from a larger number of different categories. However, questionnaires would complement and a good method of quantitative approach. Consequently, the questionnaire was believed to be very important technique for this study. However, produce the questionnaire is the most crucial stage in doing a questionnaire-based survey. Bell (1993, p. 75) made it clear that *"It is harder to produce a really good questionnaire than might be imagined".*

Verma and Mallick (1999, p. 117,118), recommended that the first step in constructing the questionnaire is a review to identify clearly the general information needed and the objectives of the study, to afford a touchstone against which the first draft of the questionnaire can be tested. They added: *"Care should also be taken to ensure that, so far as can possibly be foreseen, the questions cover all aspects of the study. On the other hand, in designing a questionnaire, the researcher must be wary of making excessive demands on the people for whom it is intended"*.

6.6 Triangulation

Data triangulation means the use of a variety of data sources in a study. The second type of triangulation is the investigator triangulation, which is the use of several different researchers or evaluators. Theory triangulation refers to the use of multiple perspectives to interpret a single set of data. Methodological triangulation means the use of multiple methods to study a single problem.

According to Cohen and Manion (1985) describe triangulation in the following words; *"Triangular techniques in the social sciences attempt to map out, or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint and, in so doing, by making use of both quantitative and qualitative data"*(p. 254).

The relationship between quality and quantity research is that quality research plays the role of discovery whereas quantity research confirms the discoveries of quality research (Miles and Huberman, 1994). Biddle and Anderson (1986) state that *"comparison of the relative efficacy of quantitative and qualitative research is inappropriate because they each have different purposes."(p. 239)*. Slavin (1992) emphasizes that *"qualitative research is research intended to explore important social phenomena by immersing the investigator in the situation for extended periods."(p. 65)*. Qualitative research is best

able to correctly represent respondents' actual views, as Mason and Bramble (1997) point out: *"Qualitative research represents a point of view more than it does a particular methodology" (p. 334).*

Qualitative and quantitative methodologies are employed in this study. The reason for this is, as remarked by Bryman (2001), that in any research of social phenomena, one should not depend on only one method of data collection. Rather, the most appropriate method should be chosen for each category of information. Furthermore, using a combination of both qualitative and quantitative methods provides the researcher with a number of sources of information, thus allowing data which are not available through one method to be gathered via another.

In research relating to social phenomena, where social behaviour or institutional aspects are explored, no strict rules regarding choice of methodology are maintained. There may be instances of measurable variables as well as descriptive magnitude and factual events. Therefore, in social science research, strict rules of cordiality are not expected. Triangulated measurement tries to pinpoint the value of a phenomenon more accurately by viewing it from different methodological viewpoints. The distinguishing feature of the triangulation method is that it generates multiple data sets about the same research problem, each set being collected by a different type of method. Further, Miles and Huberman, (1994), explain that the chief advantage of the multi-method approach is not the quantity of data that it provides, but rather the diversity of data and the opportunities for comparison that this diversity affords.

6.7 Research Strategy

In this section, will discuss which research methods have been used to conduct this study, and how the organisational factors influenced by method. In the context of organisational research and mental health hospital, This is relevant to this research because the empirical study takes place in organisations.

6.7.1 Organisational Research and Research Paradigms/Methods

According to Elliott (2000), qualitative research has emerged as an important strand in counselling inquiry, and can help researchers to understand human thought and action in social and organisational contexts. Moreover, it has the potential to produce deep insights into mental health service. However due to the mental health hospitals in Saudi Arabia nature, which are investigating the mental health services, as well as dealing with psychiatrists, counsellors, patients, and staff members, in the social, and organisational contexts.

As Bryman (2001) state, what is important to social scientists is how people understand their worlds and how they create and share meanings about their lives. In social research, the emphasis is not on categorising and classifying, but figuring out what events mean, how people adapt and how they view what has happened to them and around them.

In addition, as Miles and Huberman, (1994) state, the qualitative and quantitative approach argues that not everything that is important can be measured with precision, and that trying to do so is a distracting inappropriate task. Likewise, searching for universally applicable social laws can distract from learning what people know and how they understand their lives. For these reasons, the social researcher examines meanings that have been socially constructed and consequently accepts that values and views

differ from place to place and from group to group. In the organisation thinking there is no one reality out there to be measured: objects and events are understood by various people differently, and those perceptions are the reality that social sciences should focus on.

In the context of organisational research, Doyle (2003) argues that organisations and psychology should be different from the pure and applied science. This is because psychology in organisations (their selection, use, failures, etc.) remains solidly in the domain of social sciences. However, the strict scientific paradigm is of limited use in the study of counselling and psychology. The scientific approach is useful only as much as it is useful in studying social behaviour.

According to Winefield (1991) positive attitudes regards knowledge not as necessarily true, but postulates instead that what is constructed as knowledge is that which is accepted by the community. Concerning knowledge about organisations the 'truths' are true only until a better explanation comes along. As Winefield (1991) continues, organisations should therefore not be viewed as objects to be worked upon, as a machine or process that has to be intervened and dissected before it can be understood.

6.8 Method of Enquiry (Tools)

This section, discuss the techniques of data collection as this research have been through several stages of gathering data. The techniques of data collection have been influenced by the many factors. As Bryman (2001) discuss, gathering data, which is a key activity in a research project, must be managed in two aspects. On the one hand, there is a technical component concerned with why data are collected and how to do so; and on the other hand, there is a variety of tasks connected with successful data gathering, which must be carried out effectively. Miles and Huberman, (1994) argue that, the invention of new methods of collecting data or the improvement of existing

ones can have substantial impact on the research done in particular field. The development of new methods of analysis is often a good route to success.

As Bryman (2001) argues, there is no single technique that has a complete advantage over all others. On the contrary they are complementary. A good approach will therefore want to use as many sources as possible. Among the main principles of gathering facts during a qualitative and quantitative are: a) the use of multiple sources of evidence, that is evidence from two or more data sources, but conveying the same set of facts or findings, b) a chain of evidence, that is explicit links between the question asked, the data collected, and the conclusions drawn. As Miles and Huberman, (1994) explain primary data is gathered for one purpose; however, they might be of value for totally different purposes. As will be clear in the next chapter, this research data gathering for research purposes might also be useful for the organisations which investigating in mental health services .

6.8.1 Narrative Enquiry

The term of narrative in this study appears in different contexts, and it has general and specific meanings. A general meaning is described by Richardson (1990) "narrative is both a mode of reasoning and mode of representation. People can apprehend the world narratively and people can tell about the world narratively" (p.21). A more specific meaning is that a narrative is the description of experiences and meanings during the research (McLeod, 1997). It is the story of reflective processes and conversations which Etherington (2001) put it succinctly " narrative inquirers are receptive to learning from participants as the expert on themselves, paying attention to the power dynamics in the relationship, and attempting to suspend nations of expertise"(p.121).

Thus, narrative as a methodological tool is a storytelling approach that permits interviewees to speak from experience about situations that illustrate points important

for the researcher study (Bryman, 2001; Josselson, 2002). A diversity of discussion about narrative is found in the work of Creswell (1998), who reviews the embedded rhetorical structures in five traditions of inquiry: biography; phenomenology, grounded theory; ethnography; and case study.

However, Creswell (1998) indicated *"the overall narrative structure in some traditions is clearly specified (e.g., a grounded theory study, a phenomenological study, and perhaps a case study), whereas it is open to interpretation in others (e.g, a biography, an ethnography"* (p.189).

Creswell (1998) statement shows two relevant issues for this research. First, *"the narrative structures are highly related to data analysis procedures"*. Second, the emphasis given to writing the narrative, especially the embedded narrative structures, varies among the traditions. This variation reflects *"the more structured approach versus the less, overall, among the five traditions of inquiry" (Creswell, 1998, p.189).*

Bryman (2001) suggests the narrative is the most suitable instrument at this stage, saying:

"Narrative analysis is an approach to the elicitation and analysis of data that sensitive to the sense of temporal sequence that people, as tellers of stories about their lives or events around them, detect in their lives and surrounding episodes and inject into their accounts" (p.401).

6.8.2 Interviews Method

According to Guba and Lincoln (1981) state that *"interviewing itself should be thought of as an almost indispensable tool in the tactics of the naturalistic inquirer. Of all the means of exchanging information or gathering data known to man, perhaps the oldest and most respected is the conversation" (p. 153).*

Miles and Huberman, (1994), most social scientists would see the interview as providing higher quality information that is freer from bias than many other methods

that are available to them. As they continue, a programme of interviews may be the only way of obtaining a realistic picture of the way people view it. Bryman (2001) add that social researchers prefer to let ideas emerge from the interviews, from life and the examples of the interviews. In the context of qualitative research, Elliott(2000) believe that one of the most important sources of qualitative information is the interview. Fraenkel and Wallen (1996) state that *"the purpose of interviewing people is to find out what is on their mind—what they think or how they feel about something."(p.447)* In addition, sometimes an interview between two persons having different views on a particular topic may generate new knowledge through interaction.

However, in the meaning of interview Kvale (1996) clarifies the meaning that, *"The interview is a situation of knowledge production in which knowledge is created between the view of the two partners in the conversation."* (p.296).

Rubin and Rubin (1995) argue that interviewers cannot be completely neutral, and need to consider their own beliefs, needs and interests as they work out questions and try to understand answers. In the context of interviewee's selection, Rubin and Rubin (1995) argue that one has to choose with whom one talk depending on the theme one is trying to test. Qualitative interviews are trying to learn about complex phenomena, and capture some of the richness and complexity of their subject matter and explain it in a comprehensive way.

According to Marshall and Rossman (1999), an elite interview is a specialised case of interviewing that focuses on a particular type of interviewee. Elite individuals are those considered to be influential, prominent, and or informed people in an organisation or community. They are selected for interviews on the basis of their expertise in areas relevant to the research. The advantage of elite interviewing is that valuable information

can be gained from these participants because of their positions. In addition, elite can usually provide an overall view of the organisation or its relationships to other organisations.

Slavin (1992) found interview is expensive methods, "In an interview, respondents can be asked to clarify or expand their responses, making the data from an interview potentially richer and more complete than that which can be obtained from a questionnaire. Interview data, however, is certainly much more difficult and expensive to collect and analyse."(p.87). Moreover, the disadvantages of elite interviewing are that it is often difficult to gain access to elite because they are usually somewhat elusive and busy people. In addition they are also difficult to contact initially. The interviewer may have to rely on sponsorship, recommendations and introductions for assistance to have appointments with individuals.

6.8.3 Questionnaires

In social science research, the use of the questionnaire is agreed to be the most productive technique for tapping information. Hopkins (1989) defines a questionnaire as a *"more informal instrument that may not be reliable in the technical sense but has a high degree of validity, i.e., it measures what it intends to measure"(p.54).*

According to Bryman(2001), questionnaires differ from other methods of data collection because of their unique structure and their position in social research. They are one of the most popular methods used in the social sciences and they provide a type and an amount of information that other methods cannot.Black and Champion (1976) have claimed that the questionnaire is probably the most widely used data collection tool in social research and that, used alone or in conjunction with other data collection methods, it must be considered the most popular of the many methods available.

Slavin (1992) point out that *"questionnaires are a convenient means of collecting attitudinal and perceptual data, but they require that the researcher reduce his or her research questions to a set of items that may be too limited or limiting."* (p.87).

The questionnaire is considered to be one of the main ways of collecting data and is particularly useful when information is to be collected from a large number of people. In this regard, Bell (1993) makes the point that *"questionnaires are a good way of collecting certain types of information in a quick and a relatively inexpensive manner provided that subjects are sufficiently literate and the researcher sufficiently disciplined to "abandon questions that are superfluous to the main task."(p.76)*. McMillan and Schumacher (1997) state that the questionnaire is the most widely used technique for obtaining information from subjects because it is relatively economical, contains the same questions for all subjects, can ensure anonymity, and may contain questions written for specific purposes. Borg and Gall (1989) point out that, in carrying out a satisfactory questionnaire study, the first step is to determine your problem, listing the specific objectives to be achieved or hypotheses to be tested by the questionnaire. The questions included in the questionnaire must be suited to the problem under study. Thus, the problem needs to be well defined and imparted to the respondents without ambiguity.

Nisbet and Entwistle (1970) add that in addition to the foregoing instructions, it is desirable for the researcher to define from an early stage, *"to whom the questionnaire is to be directed and to decide the nature to the sample to be drawn."(p.45)* Scott and Usher (1996) point out that a good questionnaire is not merely a collection of questions but a coherent document taking account of the characteristics of the respondent, the nature and the volume of data to be collected, the format of data-gathering, and plans for analysis.

Mason and Bramble (1997) state that questionnaires offer certain advantages. The first advantage increases the ability of generalization of the data. The second can result in people being more willing to respond openly and honestly to the questions. Moreover, Fraenkel and Wallen (1996) point out that one of the advantages of questionnaires is that they can be distributed to a large number of people simultaneously and another advantage of this technique is that the researcher can be more specific by framing questions in such a way as to elicit only the answers relevant to the topic of study. It is the most simple and direct method of collecting first-hand information.However, some of the disadvantages, on the other hand, are that unclear or seemingly ambiguous questions cannot be clarified and there is no opportunity for the respondent to expand on, or react verbally to, a question of particular interest or importance. Bryman(2001)) argue that using a questionnaire ensures that the researcher cannot influence the respondent's opinion, but this view is at least debatable.

6.8.4 Documentation

As Yin (1994) states, except for studies of preliterate societies, documentary information is likely to be relevant to every organisation research topic. The usefulness of types of documents is not based on their necessity or lack of bias. In contrast, the documents must be carefully used and should not be accepted as literal recordings of events that have taken place. However, the most important use of documents is to corroborate and augment evidence from other sources.

Documents are helpful in verifying the correct history of mental health services in Saudi Arabia. In addition they can provide other specific details. Also, inferences can be made from documents.

6.8.5 Observation

Although this technique was not aimed to be one used to collect data, due to the long duration of this study, and while meeting people (and even while waiting outside to meet the psychiatrists and counsellors), some minor observations was noticed. Observation might be thought useful as a research instrument. However, since its main value is *'when data are being collected on non-verbal behaviour'* (Cohen and Manion, 1994, p. 110),

In addition, some seminars was attending with the mental health hospital Team and doing some joint work with them to have an understanding of the services.

6.9 Strategies of Tools

6.9.1 Interview Validity and reliability

Validity and reliability are always problematic and even more so in qualitative research (Bryman, 2001; Creswell, 1998; McLeod, 1996; Burman, 1994; Bryman, 1994). Gall et al (1996) raises the question *"How does a researcher arrive at valid, reliable knowledge if each individual being studied constructs his or her own reality"* (p.572). Moreover, Wragg (1994) stated that *"These concepts apply to interviews as much as to any other data-gathering device"* (p.278). It is thus essential, according to the research methodology; researcher must face and get some statement of validity and reliability for both qualitative and quantitative research methods.

Regarding the validity or the question of achieving validity, Cohen and Manion (1994, pp. 282-3) advise that *"Perhaps the most practical way of achieving greater validity is to minimize the amount of bias as much as possible. The sources of bias are the characteristics of the interviewer, the characteristics of the respondent, and the substantive content of the questions"*

However, qualitative research focuses on three types of validity: descriptive; interpretive; and theoretical or explanatory (Maxwell, 1992). Descriptive validity determines the obvious existence or occurrence of an act or event; interpretive validity is identifying the nature, quality, and meaning of an act or event; theoretical validity establishes through theoretical constructs or causes that generates and explains the act or events (Maxwell, 1992; Maxwell, 1996).in the other hand, Bryman(2001) describe two main type of validity "internal validity" which refers to the level of congruence between researcher and theoretical framework; "external validity" which concerned with level of finding in qualitative research and the degree of generalised this finding, but Bryman(2001) warns that *"unlike internal validity, external validity represents a problem for qualitative researchers because of their tendency to employ case studies and small sample"* (p.272). Additionally, Ratner (1997) defined the validity of qualitative research as a check on the objectivity of observations and concept. Moreover, Ratner (1997) explained that the different types of reasoning processes engrained in research methods structure the way the validity of the finding of a study gets established. Maykut and Morehouse (1994) described that the validity of finding *"ultimately rests on whether the participants or people who know them will see a recognizable reality in the propositions of the study"* (p.176).

Indeed, for purposes of this research, validity is seen as the adequacy with which, researcher understands, interprets, and reports participants with accurate description of their experiences of mental health services. Obviously, the participants *(clients, counsellore, psychiatrists, and staff administrative)* becomes one of the instruments to establish the validity of the researcher understanding and explanation of the narrative study. As Denzin and Lincoin (1998) explained *"validity in qualitative research has to do with a description and explanation, and whether or not a given explanation fits a given description"* (p.50).

However, the clear view of validity explained by Gee (1999) *"..Validity does not consist in how one tool of inquiry work on its own. Rather, validity primarily consists in how our various tools of inquiry work together. What we test when we worry about why we should trust the analysis of some data is not each claim or the result tool separately. We test the whole analysis in terms of how much data it covers, how well it works on new resources of data, how much agreement we can gather from others "(p.7).* He adds more statement *"Validity is communal: if you take the risks and make mistakes, your colleagues will help you to clean up the mess- that's they are for. The quality of a research often resides in how our mistakes are, that is, in whether they open up paths that others can then make more progress on than we have "(p.9)*

In traditional research, reliability is a scientific requirement (Bryman, 2001; Creswell, 1994; Mason, 1994; Huberman and Miles, 1994). Data obtained in traditional qualitative research methods should have reliability in two senses. Firstly, independent observers should agree in their description of what they find out Bryman (2001) and that call *internal reliability.* Secondly, external reliability, which refers to the successful replication of a study to determine consistency, stability, and dependability of the finding or observations (Bryman, 2001). Therefore, replication takes the form of exploring the same issue in different event to reinterpret or analysing finding from different point without expecting reliable accounts.

However, psychological research emphasis that if there is no intent to develop generalsable results, then the study can address only the thought of a group of participants. Indeed, researcher in this study is not intended to be generalised. For it documents only how the experience of mental health services in Saudi Arabia. As Maykut and Morehouse (1994) explained *"what can be discovered by qualitative research are not sweeping generalizations but contextual findings" (p.21).* The contextual findings of this research are recognisable reality, which, this reality will be

new to individual's participant who have not test the mental health services, and validated by those who have experienced it and reflected their evaluation.

6.9.2 Questionnaire Validity and Reliability

Regarding reliability and validity, Neuman (1994) warned that *"Perfect reliability and validity are virtually impossible to achieve. Rather, they are ideals researchers strive for. Researchers want to maximize the reliability and validity of indicators" (p. 127)* Two types of validity were considered. First, **content validity**, which refers to the degree to which the measure adequately represents the content or conceptual domain, it purports to measure (Bryman, 2001). To assure the content validity of the questionnaire the various aspects of the definition of the mental health services were specified. The questionnaire items were than developed to cover all various parts of the definition. Second, **face validity**. This validity is believed to be the easiest and the most basic type of validity. According to Neuman (1994) it is *"a judgement by the scientific community that the indicator really measures the construct (p. 131).*

Although this technique has been criticised by some researchers such as Oppenheim, (1992), and Munby (1982), it is accepted by others such as Bell (1993); Neuman (1994) ;(Bryman, 2001). Youngman (1994) also justify this technique as he argues that *"Validity is typically assessed in terms of face validity, more often than not a euphemism for doing nothing. If any objective measure is available then it should be considered" (p. 263).*

For the current study, in view of the lack of a similar instrument, this type of validity was accepted. Fourteen people of the first stage sample were considered to be the 'the scientific community' as five of them were university lecturers in the field of the Psychology (King Saud university); four former psychiatrists (in four different hospitals); three of them were university lectures in the field of psychiatry (knig Saudi

university), and two were a former staff member of Riyadh mental health hospital. There was a complete agreement among them that the questionnaire was suitable to identify the mental health services in Saudi Arabia, which indicated the face validity of the questionnaire.

In order to improve the questionnaire reliability, all questions were refined qualitatively to ensure they were unambiguous, clear and uncomplicated. The instruction for the questionnaire was written clearly on the top of each page. The stages of piloting were felt to maximise the reliability as some items believed not to be clear were replaced. The type of response categories was considered to assure reliability, as each respondent must think carefully before ticking any item, which can be taken as an indicator of the reliability of the questionnaire. To assess the reliability of the questionnaire, representative reliability was suggested by Neuman (1994) as it addresses the question *"does the indicator deliver the same answer when applied to different groups? An indicator has high representative reliability if it yields the same result for a construct when applied to different subpopulations" (p. 128)*

The data obtained were analysed to determine whether the questionnaire has this type of reliability. It was found that there was a high level of similarity in the answers of samples as it can easily be seen in the responses of the each group.

In relation to assuring a greater possible level of correctness and accuracy of the translation of the research instrument, a strategy which was thought of in the early stage of the questionnaire construction was 'translation-back-translation'

However, three points should initially be made clear. First, there was, as far as it is known, no similar study or instrument neither in Arabic nor in English, which could be taken as a base for the structure of the questionnaire. Second, the questionnaire items were drawn from both Arabic and English literature and from the interviews which were in Arabic in origin. Third, the first version of the questionnaire had to be produced in

English to be discussed at the academic supervision level, and in Arabic to be used in the stage of piloting. Therefore, at that time the researcher needed to ensure the correctness of the translation of both the Arabic items into English and vice versa. The researcher gave two English copies and two Arabic copies to four professional people (two lectures in the school of linguistic at king Saudi university, and two lectures in Al Amam Mohammed Bin Saudi university), asking them to translate them, and when the researcher had them back he phoned all of those who had translated the English version and discussed some of them suggested translation.

In addition to getting some helpful ideas, the researcher came to the conclusion that, in the light of the difficulty of achieving absolute accuracy of translation, due to practical and, perhaps, linguistic reasons, it was necessary to recognise either English or Arabic as the 'original' version and the other as the 'translated version'. Because Arabic is the first language of the researcher and also the questionnaire had to be administered in Arabic, the Arabic version was adopted as the original questionnaire. The amendments that emerged from piloting the questionnaire were made only in the Arabic version.

The job then was to assure that the items analysed and presented in the study really represented the questionnaire items answered in Arabic by the respondents. After collecting the questionnaire, the English version was amended to reflect the changes that emerged from piloting the questionnaire, and two copies were given to be translated into Arabic again using the mentioned strategy, 'translation-back-translation'. There were some differences in both vocabulary and language style, but the researcher could make sure that the ideas and meanings were correct. Benefiting from this strategy, some small changes were conducted.

6.9.3 Rigor of the Interview Method

The literature in suggested that qualitative research should evaluated and judged by different criteria such as *"trustworthiness"* and *"authenticity"* (Bryman, 2001; Lincoin

and Guba, 1985). However, several steps were built into the present research to increase its trustworthiness.

The literature in qualitative research (Bryman, 2001; Elliott, 2000; McLeod, 1999; Maykut and Morehouse, 1994; Lincoln and Guba, 1985) indicates the relevance of describing the provisions for trustworthiness. Four steps summarise the process. Firstly, a specific interview question addresses participant's experience of the interviews. Second, each study participant should ask whether the transcript are accurately captured the interview information, which, the participants received a copy of their interview transcript, and corrections should made before analysis began. Third, the committee should act as a research team. Finally, attention should concern itself with the language in which the interview conduct.

6.9.4 Anticipated Reactivity, Reciprocity, and Different Power

Qualitative research considers and addresses reactivity, reciprocity, and differential power between the research and the participants (Creswell, 1998). However, these consideration because part of this research process and this section narrates the reflections that emerged.

Differential power refers to the luck of reciprocity in a research interview between the researcher and participant (Kvale,1996). In general, the perception of differential power in a research interview comes from the viewpoint that the researcher defines the context, introduces the themes, follows an agenda, and though additional questioning guides the conversation's course.

As stated by Kvale(1996) a qualitative interview inquiry brings a moral and ethical responsibility because " *the personal interaction in the interview affects the interviewee, and the knowledge produced by the interview affects our understanding of the human situation" (p.109).*

Considering issues of differential power in a qualitative study requires understanding the power imbalance between the researcher and the participants and that despite the use of democratising practices and the efforts of the researcher to disown the role of expert the power imbalance exists. Tindall (1994) indicated that the researcher is firmly positioned by participants as knowledgeable "sets the process in motion, decides the theme and research issues, the framework to use, the potentials participants to contact and how to organize and present the final product" (p.155). in the same context, Tindall (1994) emphasised that public visibility is given to the researcher's version of reality and achieving mutuality and equality is not possible. Thus, the intent of addressing and considering differential power is to ensure that there is no exploitation of participants, moreover, considering power is a form of protecting participants. The goal is to balance the power relationship by considering and anticipating the subtle ways in which exploitation can occur (Tindall, 1994).

Reactivity means that the researcher should consider and evaluate the possibility that the results of the study may bring negative consequences for participants or for the community (Maykut and Morehouse, 1994). In this research, negative consequences for participants and communities, field of mental health in Saudi Arabian, are not expected. The research was considered carefully the ethical issues that could arise at the different stages of an interview including informed consent, confidentiality, and consequences.

Reciprocity refers to the process in which the researcher identifies what the community, site or research participants will receive in this study. This research is design as an evaluation and experiences for participants as well as assessing their awareness of mental health situation in Saudi Arabia. Finally, giving a copy of the final finding is a form of reciprocity.

6.10 Sample

Prior to discussing the research sample, a distinction should be made between the two terms: population and sample. As a research term, population refers to a discrete larger group of units from which a sample is selected for study. Although only the sample participates, generalisations are made about the population. So, a sample is always assumed to be representative of the population, and treated as though it were the population (Bryman and Cramer, 1996).

The choice of sample was guided by the need to interview and questionnaire samples of four categories: psychiatrists, counsellors, patients, and staff members of hospitals who normally dealt with patients, using the mental health services as who have the main responsibility for services. The need was for a proportional sample of these four categories, to get different views toward the issues under investigation.

The current study was applied in four cities, Riyadh, the capital city of Saudi Arabia. Jaddah the second largest city in Saudi, Taif, the city who have the oldest mental health hospital in Saudi, and Dammad the capital city of the western region.

As this study aimed to identify the mental health services in Saudi Arabia, data would be obtained from two categories of sources: Practitioners and patients.

Practitioners: This source encompasses three categories:

    a.   Psychiatrists :

    b.   Mental health counsellors;

    c.   Staff members of mental health hospitals in Saudi Arabia.

Patients: this source obtained to show who the patients receives the services and how the services deliver to them. The rationale for selecting the three practitioner categories was that they are the people most involved with mental health services.

Although they have some theoretical knowledge, as they working for ministry of health , their main experience comes from their practical work as they are either currently practicing or, according to the Saudi health system, , therefore, they are more likely to determine and evaluate the importance of the services for developing it. Psychiatrists and counsellors have wider experience of different view and experience of the mental health, which may enable them to recognise the services from broader viewpoints.

Regarding patients, although they may have experience while they receive treatment from different practitioners, their experience generally is most important as they are involved with pure and deeper treatment of mental health. The main rationale for selecting this category is, partly, that the patients are more likely to be aware of the characteristics and high aspects of the service. On the other hand, they had been at last one session with each practitioner. This would enable patients to evaluate the outcome of the services, at least during the last time of treatment. Thus, the researcher defined these four categories to be the population of the study.

6.10.1 Sample Consideration

It was suggested by Robson (1994) that *"It is usually necessary to reduce your task to manageable dimensions by sampling from the population of interest" (p. 237)*
Therefore, the study had been planned to involve all practitioner and all people who seek treatment of mental health in the kingdom of Saudi Arabia as the sample of the study. However, because of some issues emerging from ministry of health in Saudi Arabia and time limit of the research, the plan was amended to include four psychiatric hospital in Saudi, which has been chosen randomly, and each hospital has four categories, as the researcher will discus in the next section.

However, the actual sizes of the research population and sample of the four categories are illustrated in the following table:

Table 6.2 The Actual Sizes of the Research Population and Sample

Category	The population	Notes
psychiatrists	300*	The number of hospitals are5**
Counsellors	185**	The number of hospitals are5**
Patients	900***	The number of hospitals are5**
Staff	370****	The number of hospitals are5**
Total	1755	

Sources:

*The Ministry of Health, Riyadh District (2003) (Unpublished document). ** The Ministry of Health, Riyadh District (2003) (Unpublished poster). *** The Ministry of Health, Riyadh District (2004) (Unpublished list provided to the researcher on request). **** The Ministry of Health, Riyadh District (2004) (Unpublished list provided to the researcher on request).

Regarding the selection of the target sample, most of the methodologists agree that random sampling is the most powerful technique of sampling. However, Oppenhiem (1992) considers a random sample to be representative since *"every member of the population has a statistically equal chance of being selected"* (p. 39).The simple random sampling technique involves selecting at random from a list of the population. According to Bryman (2001), this sampling is *" The most basic type of probability sample"* (p. 88), moreover, he included that " *with random sampling each unit of the population has an equal probability of inclusion in the sample"* (p.88).Which, Neuman (1994) pointed out, *"Both the easiest random sample to understand and the one on which other types are modelled"* (p. 201).However, one of the problems associated with this type of sampling, as Cohen and Manion (1994) suggest that "A complete list of the population is needed and this is not always readily available"(p. 89).

Nevertheless, as lists of all the hospitals population were attainable, the simple random technique was applied for selecting representative sample. On the generation of simple random samples Munn and Driver (1995); (Bryman, 2001) advise the researcher that

First, you must define as clearly as possible the population you are interested in. ... You then acquire or create a list of all the members of the population. Then you prepare a set of random numbers corresponding to the size of sample you want, and select individuals from the list accordingly. You can select random numbers from commercially produced tables or generate them using a computer program.

6.10.2 Sample Location

The biggest psychiatric hospitals in the kingdom of Saudi Arabia namely Taif, Riyadh, Jeddah, and Dammam psychiatric hospitals, which all have more than 5000 patients, and all comes under the authority of the Ministry of Health, which the hospital services are provided free of charge for everyone.

Theses four psychiatric hospital have different characteristics, the following will provide information regarding the location and characteristics of the two hospital, which was randomly chosen by the researcher.

6.10.2.1 Riyadh Psychiatric Hospital

In 1970, there was only one clinic in Riyadh central Hospital providing psychiatric services, treating cases just requiring relatively short and non complex medical care. However, patients who need more attention and care were transferred to Taif psychiatric hospital, which was considered at that time, the only psychiatric or mental health institution in the whole kingdom as the researcher point out in chapter three.

In the year 1981 Riyadh Central Hospital opened its first psychiatric ward with a capacity of 12 beds, which providing for both male and female patients, then, in the middle of 1983, the psychiatric services in Riyadh central hospital ceased with the new establishment of Riyadh Psychiatric Hospital.

In the end of 2002 the Riyadh Psychiatric Hospital moved to new building, which increase number of staff, which including Psychiatrists, Counsellor's, Clinical Psychologist, and Social worker.

6.10.2.2 Taif Psychiatric Hospital (Western Region)

Taif psychiatric hospital commenced its services for the people who live in the kingdom of Saudi Arabia; however, in 1962 it was the only hospital in the whole of Saudi Arabia to provide free mental health treatment at that time. It is located in the square called 'Shehar', on Taif city. When it was opened, its name was Shehar Hospital for Mental Diseases, while most of Saudi people called 'Majjaneen Hospital' and this name was very well know to the public throughout the country (Al-Radi, 1980).

The hospital started with two hundred and fifty patients who visited the hospital seeking treatment in the first year, the increasing demands and number of patients each year, have seen the capacity off the only psychiatric hospital at that time, reached as many as 2000 patients (Al-thawil, 1988).

In 1996 , with more than ten psychiatric hospitals operating in other regions of Saudi Arabia, the capacity of Taif hospital is 640 beds, a monthly average of 2,300 patients were treated at that time. The hospital employs 1,120 staff comprising psychiatrics, nurses, technician, counsellors and administrative workers, in addition more than 540 helpers subcontracted with a non medical operation company such as cleaners, gardeners and maintenance staff. Within the hospital, there is a counselling treatment, art therapy and psychological tests (Ashowor, 1998).

6.10.2.3 Dammam Psychiatric Hospital (Eastern region)

Al- Hassa country lies in the Eastern region at the intersection of 25 degrees horizontal and 49 degrees longitude. It is 340 kilometres from Riyadh, the borders with Quarter state and the United Arab Emirates make its Eastern and South eastern limits.

In 1970, psychiatric services were available from a clinic in King Faisal General Hospital, which was very small clinic and had insufficient staff (Almazrou, 1990), there was only one psychiatric, a nurse and a clerk at that time, and any serious cases were sent to Taif Hospital. In 1980, the ministry of Health established a new hospital in the Al Hassa called Dammam General Hospital, it is the biggest general hospital in the region with a 502 bed capacity, and it has a psychiatric section which consists of an out

patient department, a ward and an in-patient psychiatric ward with 20 – 30 beds for admission (Al-Mulhoom, 1999).

In the period between 1982 to 1983, the M.O.H then established the first psychiatric hospital in the Eastern region with a capacity of 50 beds, however, Dammam hospital is the only psychiatric hospital in the whole eastern region, specialising in treatment of people who have mental or psychiatric illness. the hospital has a total of 480 staff distributed between psychiatrists, counsellors, nurses administrative and ancillary workers(M.O.H,2003).

The location of Dammam makes the hospital very important, even crucial , being surrounded by its neighbouring countries such as the state of Qatar, United Arab Emirates, kingdom of Bahrain and the State of Kuwait within close proximity, the hospital serves these other nationalities in addition to their own countrymen. These patients may have come from the cities, the villages or may be nomadic (Al-Sowayee, 2002).

6.10.2.4 Jeddah Psychiatric Hospital

Jeddah psychiatric hospital is the only one of its kind in the Jeddah region, which specialises in dealing with psychiatric and neurotic disease, located in the west of Saudi Arabia. The hospital was established in 1986.

However, the western region as the research noticed in chapter two has many cities such as Makkah and Taif, but Jeddah the most modern city in the country because its located in the Red sea and have the most different race of population (Hawee, 2001).

The M.O.H established this hospital to swerve the needs of the mentally ill people from the neighbouring cities and also in the villages. However, in the 1997 the capacity of the hospital was 120 beds, and from 1998 to 2002 the total number of employees in this hospital was increased to 450 professionals, from both male and female (M.O.H, 2003).

6.11 Data conducting protocol

This section describes the procedures used for collecting the data. The steps in data collection included obtaining approval and ethical consideration for administering the study.

6.11.1 Ethical Issue

The Ministry of health in Saudi Arabia Code of Practice related to confidentiality in research will be fully adhered too. *"All names will be changed, and all non-essential identifying features will be changed or disguised through coding that will be only known to the researcher"* (M.H, 2003). These changes will be discussed and reviewed with participants, and their wishes will be respected. The data will be kept under lock and key by the researcher. Upon completion of this research project, all taped recording of interviews, and all written materials such as transcripts and notes will be erased. All percipients were asked to singe consent form as a part of their agreement to be participant in this study.

After obtaining the approval of the Ministry of Health in Saudi Arabia. Two letter submitted with a full of questionnaires and interview questions to the director of mental health hospitals in the ministry of health, and to the ethical and research committee in the Ministry of Health requesting their approval to conduct the study. After receiving the Ministry of Health approval, four letters sent to the head of the mental health hospitals in four cities granting approval along with questionnaires and interview questions to the heads of the psychiatric, counselling, and staff units in order to secure their cooperation. Once the approval from the heads of mental health hospital was secured, the heads of all divisions were expected to cooperate with the research process.

6.11.2 Conducting the Interviews

Having determined the form of the interview and the period within which it would be conducted, the researcher began to make a timetable of interviews. The researcher approached each prospective interviewee separately to arrange a mutually agreeable interview time and date.

First sample was conducting in Riyadh hospital and then three cities (Jaddeh, Taif, and Dammam). Each prospective interviewee was contacted firstly, by telephone, and

visiting them in their offices to introduce the purpose of research and to request an opportunity for an interview lasting between 20-30 minutes at a convenient time.

As some of the work places of the interviewees were several miles from the researcher's accommodation, it was important to arrange interview schedules carefully, so as not to waste time or money, visiting an area twice.

At the beginning of each interview each interviewee was told of the purposes of the interview with brief but relevant background of the interview. Each one was given explicit assurances that all information provided would be treated confidentially and used for research purposes only, and that anonymity would be maintained in the final findings of the study, and all the interviewee were sing for the agreement to be part of this research.

6.11.3 Interview methods (tools)

Regarding recording the interviews, the advantages of tape-recording are that it *"has the benefit of providing a much fuller and more accurate record of what was said" (Vulliamy 1990, p. 104)* .Which, the researcher came to appreciate the point of view of Verma and Mallick (1999) that, *"a tape recording is likely to be the favoured option, since it not only provides a record of the interviewee's actual words but the inflections of his or her voice which can be an additional and valuable source of information. It also means that the researchers will be able to give all their attention to the interview process and concentrate on the interviewee's expressions and body language when responding to questions"(p. 127).*

Nevertheless, that does not mean tape-recording is beyond criticism. In the other hand, Turner (1997) indicated three main disadvantages of recording; the long time needed in eventual analysis, the fact that some people are not at ease or they feel restless when a tape recorder is used and the limits imposed on the choice of venue for the interviews.

It was expected that if respondents were asked to reveal sensitive or confidential information, using tape-recording might distract them or prevent them from giving valid information.

An alternative approach to tape-recording is that of note-taking. Bell (1993) advises interviewers to learn to devise shorthand systems of their own. Bell (1993) continues *"as long as notes can be written up immediately or very soon after the interview ends, it is possible to produce a reasonable record of what was said in the key areas" (p. 96).*

On balance, the researcher was of the view of many researchers such as Gall et al. (1996) Vulliamy (1990), Bell (1993) Bryman(2001), that using a tape-recorder would save time and avoid stopping the interviewees in order to complete some notes. It also can be useful to check the wording of any statement the researcher might wish to quote and to check that notes are accurate. It enables the researcher to listen several times in order to make full understanding and to identify all the ideas given. Tape-recording can also be useful to analyse the interview content and ensure the reliability of the analysis by asking someone else to analyse the forms.

Therefore, each interviewee were asked if he could tape-record the interview, assuring each person complete anonymity. Unfortunately, although the issues being researched are not particularly sensitive ones, all interviewees, except three, preferred not to be recorded. As the researcher knows the situation in S.A, and its social-political circumstances, he understood and appreciated their views.

As some of the interviewees was not happy to tape-record, the alternative approach had been used, note-taking. Benefiting from the advice of Bell (1993); Gall and his colleagues (1996); Bryman (2001), however, shorthand system developed and wrote up immediately as much as it could of the interviews. Sometimes it was necessary to stop the interviewee, asking him to allow his idea to be written down. At the end of the

interview, all transcripts have been read backs all the notes for the interviewee's approval. Soon after the interview, with the reviewed each interview memorandum, recording in full what had been said, while it was still fresh in mind.

In carrying out interviews, a very flexible approach was adopted. The researcher varied the order of the questions according to the exchange with the interviewees. Respondents were not asked embarrassing questions or forced to answer every question. There was no fixed sequence of questions and no suggestion of the responses. The strategy was to follow the interest of the interviewee himself in order to collect as many ideas and responses as possible, because at this stage, it wanted to obtain a broad, general picture of the mental health services in Saudi Arabia, rather than concentrate deeply on particular or single issues. Open ended questions allowed interviewees the opportunity to put forward their own thoughts and ideas, in some cases going off the point completely stating, in details, their own, and sometimes personal, daily problems. Although sometimes the researcher tried unobtrusively to draw their attention back to the main issues, this information was valuable in another way, partly to gain broader understanding of the situation and problems which, while beyond the scope of the current study may be needed in the future, and partly to create empathy with the interviewees.

Regarding the locations and times of the interviews, the majority were conducted during there off-work hours, as contacted with each one with a clear time of an appointment, which interviews could be held in interviewees' offices, without few interruptions.

Forty interviews were conducted. Another five prospective interviewees declined to be interviewed or cancelled an appointment because they were busy. All the interviews were conducted in February and March 2004. More details of the sample will be included in Interviews chapter Analysis.

6.11.4 Questionnaire Design

On starting to construct the questionnaire, a decision had to be made regarding the type of questions that would be asked. In the light of the nature of the investigation, closed questions were believed to be the appropriate form. This type of question was selected in accordance with the advice of Oppenheim (1992) who suggested they are" *easier and quicker to answer; they require no writing, and quantification is straightforward, this often means that more questions can be asked within a given length of time and that more can be accomplished with a given sum of money". (p. 114)*

A large number of items and questions were assembled which required reviewing, refining and reducing. For each item an examination was conducted against the following criteria suggested by Bell (1993)"*Is there any ambiguity, imprecision or assumption? Are you asking respondents to remember? Will they be able to? Are you asking for knowledge respondents may not have? Any double, leading presuming, hypothetical or offensive questions?"(p. 88).*

Undoubtedly, it was a difficult process to select and improve the most suitable items. Therefore, in addition to the researcher own refining and great deals of consultation with the researcher supervisors and with some colleagues who share the same interest were conducted. The piloting and the advice that emerged from them helped also in assuring better quality of the items included in the actual questionnaire.

The response categories suggested in the early stage of questionnaire structure were five: *'strongly agree', 'agree, 'not sure', 'disagree',* and 'strongly disagree'. Respondents were asked to locate each items of the questionnaire into one of them. Furthermore, it was recognised that the response categories or sets of the questionnaire are of crucial importance. They can cause invalid responses in which, as Gall et al. (1994,) suggest that, "an individual's responses reflect a general predisposition rather than a careful response to the content of each item" (p. 271)

6.11.5 Questionnaire Development

Developing the questionnaires, the first decided step is to get the general types of information about mental health services in Saudi Arabia. Secondly, it was necessary to determine, in general, the sort of people from whom data would be obtained. Four categories were suggested as sources of the information wanted: clients, counsellors, psychiatrists, and staff administration in mental health institutions. Thirdly, in accordance with the research sample, the main body of the questionnaires was arranged in four sections in order to cover the mental health services in Saudi Arabia. They are:

a. The mental health objectives and aims;

b. The mental health roles and awareness;

c. The mental health effectiveness and referral;

d. The mental health practitioner personal development.

Having deciding the subsidiary topics and the information necessary, the potential research population, and the general theme of the questionnaire, the task then, as recommended by many researcher such as Cohen and Manion (1994, p. 93), involves the structure of the questionnaire itself, collecting its items and questions. However, as Bell (1993, p. 75) made clear *"Care has to be taken in selecting questions type, in question-writing, in the design, piloting, distribution, and return of questionnaires".* Undoubtedly, within each step, as Youngman, (1994,) pointed out, *"for worthwhile results a much more rigorous procedure is necessary (p. 249)*

Prior to constructing the questionnaire, identifying the sources of the questionnaire items or questions is of crucial importance. The first source for the questionnaire, as recommended by Youngman (1994,), was relevant literature which he described as *"the prime source"*, presuming that *"This implies two possibilities; either the literature study*

will have revealed specific questions, or more generally it will have suggested important areas needing more detailed investigation (p. 249)

However, five areas of the literature were examined with the hope of collecting the appropriate services. They were:

- The main characteristics of the Saudi Arabian society, and of the methods of its mental health treatment in various historical periods. (Chapter two and three)

- The current situation of mental health services in modern Saudi Arabia and Methods and models of mental health services in Saudi Arabia. (Chapter three)

- The current situation of mental health in western society. (Chapter four).

- The methods and approaches of counselling in Saudi Arabia (chapter five).

This was recognised to be the most important aspect of the literature as a source for collecting the questionnaire items.

6.11.6 Questionnaire Stages

Regarding the questionnaire layout (see Appendix 3) the first page was a coloured covering sheet with the title of the study and related information. The second page contained an introductory letter, explaining the purpose and aims of the research, presenting clear instruction for filling the questionnaire, and thanking the respondents for their co-operation with the full address of researcher. The following page covered the four sections mentioned earlier, which include 17 questions (Aims and objectives 3 questions, roles 2 questions, awareness 3 questions, effectiveness 3 questions, referral 3 questions, and personal development 3 questions). The last page of the questionnaire was devoted to classifying and personal questions following the idea suggested by Oppenheim (1992) who emphasis that *"personal data questions should always come near the end of a questionnaire and should be preceded by a short explanation such as*

'now, to help us classify your answer and to make our statistical comparison, would you mind telling us..." (p. 109).

In order to gain some qualitative information the last section of the questionnaire was left for the respondents' comments and advice. It was an open section asking respondents to feel free to add any advice and explanations that they believed would be valuable and important to the researcher. Furthermore, respondents were asked to turn the page if they needed more space. At the very end of the questionnaire, there was a brief thanks for their participation and an offer to send a short abstract of the major findings when the study is completed.

Four versions of the questionnaire were produced to be suitable for the four categories of the research. The content of the four versions was exactly the same, except the general (personal) information sheet which was set to be suitable to each category such as patients which researcher adds different questions (see Appendix). The covering sheet was coloured to make the appearance of the questionnaire look better, and each version was a different colour to facilitate classification.

6.11.7 Questionnaire Distributions

Questionnaires can be given to respondents directly or mailed to respondents who read the instructions and questions and then record their answers (Bryman, 2001). Therefore, the psychiatrists, counsellors, patient's, and staff was persuaded samples, the self-administering method was more appropriate and, therefore, was adopted for all categories, while the postal method of questionnaire was suggested to be suitable for all the categories, after the researcher visiting each hospital.

The public mail system was not to be cost-effective compared with practitioner pigeon-holes, which were permitted to be used for academic research purposes. So, for the psychiatrists and counsellors pigeon-holes were used to distribute the questionnaires. For the other two categories, staff members of hospital and patients, the researcher was

desirous to meet them and hand them the questionnaire. Which the researcher decided to establish three pigeon-holes for the staff in each hospital, and they located in the main areas in each hospital. While, researcher established two pigeon-holes in the waiting area for the patients, twenty pigeon-holes was built in four hospitals, and all of them come from the researcher own financials cost. However, in some cases, especially with the psychiatrists, it was not possible to meet the selected respondents as they were out of their offices, which left no choice but the use of their pigeon-holes, and a follow-up call to their offices to meet them later.

The researcher started to distribute the questionnaire in the end of January 2004. The following steps were followed for distribution and collection of the research questionnaires:

1. The researcher had an interview with committee of research and practice in ministry of health, were they had a copy of the research proposal, with full questionnaire for each category, and ethical consideration for the whole research.

2. The questionnaires were given personally, put in the prospective respondent's pigeon-hole or sent to the psychiatrists, counsellors, staff, and patients pigeon-holes (Riyadh Psychiatric Hospital during the first and second weeks of January, Jaddeh Psychiatric hospital during the third and fourth weeks of February, Taif Psychiatric Hospital during the first and second weeks of March, Dammam Psychiatric Hospital during the third and fourth weeks of March).

3. The researcher phoned the hospitals, called into psychiatrists, counsellors, and staff, and visited each hospital back to check that the questionnaires had arrived and encourage the sample to reply.

4. Questionnaire collection was begun for all four categories. By the end of this stage (the fourth week of March), around 30 % of the questionnaires were collected in Ryadh hospital, 25% of the questionnaires were collected in Jaddeh, 30%. Of the

questionnaires were collected in Taif, and 10% of the questionnaires were collected in Dammam.

5. Reminder letters were sent to those who had not replied, encouraging them to send the questionnaire back (in the first week of April).

6. The psychiatrists were phoned five days after sending out the first reminder letter (in the fourth weeks of March and the first week of April).

A second reminder letter was sent suggesting a deadline for replies of Wednesday 20th April.

The staff were checked either through phoning head of the hospital or calling in their offices, and encouraged to reply.

The patient's pigeon-holes in all four hospitals were checked either in each single visit to the hospital (only the researcher who has the authority to have access to them).

The last collection of questionnaires was made on Wednesday 25th April.

As mentioned earlier, the questionnaires were sent through the hospitals pigeon-holes which are supposed to be checked every day by the Head of the psychiatric unit, except for the patient pigeon-holes were checked by the researcher himself. However, due to shortage of counsellors, their pigeon-holes were not checked when the questionnaires were distributed. Therefore, 32 questionnaires did not get to the Riyadh hospital intended, 26 questionnaires did not get to the Jaddeh hospital intended, and 22 questionnaires did not get to the Dammad hospital intended. Five of the psychiatrists in Riyadh hospital were off work (training programme and sick-leave), Six of the psychiatrists in Jaddah hospital were of work, Ten of the psychiatrists in Taif hospital were off work, and Seven of the psychiatrists in Dammam hospital were off work, (study-leave or holiday). Consequently, the overall number of questionnaires presumed to be delivered to the prospective respondents was 1495. Regarding the return rate Cohen & Manion (1994) recommend that: *"A well planned postal survey should obtain*

at least a 40 % response rate and with the judicious use of reminders, a 70 per cent to 80 per cent response level should be possible" (p. 98).

The total number of questionnaires returned was 670. This represented around 61 per cent of the total number presumed to be received by the respondents. Although as Munn and Drever (1995) state that: *"Obviously the larger the sample the better"* (p. 15). However, the time available for the research did not offer the chance to do more follow up trials. Nevertheless, the researcher was pleased with the response rate and found some of the questionnaires returned to be full of comments which were analysed and compared with the interview findings. The main problem was that not all the questionnaires collected were valid or useable. In chapter questionnaire finding, a more detailed discussion of this issue will be provided.

6.12 Data Analysis

According to Miles and Huberman (1994), the distinction of research practice is critical and leads to a substantially different approach to analysing one's data and arriving at one's findings. The process of qualitative data analysis takes many forms, but it is fundamentally a nonmathematical analytical procedure that involves examining the meaning of people's words and actions. Qualitative research findings are inductively derived from data Miles and Huberman (1994).

6.12.1 Interviews Analysis

According to Miles and Huberman (1994), the most serious difficulty in the use of qualitative data is that the methods of analysis are not well formulated, However, Qualitative data are usually analysed by arranging them in the form of text written in words and phrases with few or even no, numbers. According to Neuman (1994), it is

often less standardised and inductive and aims to create new concepts and theory. He comments *"Qualitative analysis is less abstract than statistical analysis and closer to raw data. Qualitative analysis does not draw on a large, well-established body of formal knowledge from mathematics and statistics. The data are in the form of words, which are relatively imprecise, diffuse, and context-based, and can have more than one meaning."(p. 405)*

The purpose was to arrive at a general picture of the mental health services situation and how it can be tackled. So, after the interviews were completed, the researcher decided to go through the transcripts of each interviewee and highlight the answers relevant to each question asked. Sometimes the researcher found comments relevant to one question were answered as part of another, so the researcher rearranged the interviewees' ideas by question. Having done this, the researcher drew up a matrix of comments made by each category of the sample against questions asked and the main ideas that emerged. However, within and between the four categories of the interviewees the researcher highlighted agreements, similarities and differences among these ideas and viewpoints of the services.

One strategy followed was to quote explicitly some sentences of the interviewees as to present their views more clearly. The researcher, also, highlighted the source of the idea, i.e. either psychiatrists or counsellors or patient's or staff trying to interpret any differences of view among them. Finally, although numbers were not important for this stage the researcher mentioned, sometimes, the number of respondents who voiced a particular idea, to give a general indication of the issues of interest to the respondents. The findings of this stage confirmed the need for identifying and evaluating the mental health situation in Saudi Arabia. They also provided the researcher with valuable data which represented a solid basis for the construction of the questionnaire, the instrument of the second, i.e. quantitative, inquiry of research. In the next section, the second part

of the research devoted to the collection of the quantitative data will be examined in some depth.

6.12.2 Questionnaires Analysis

Social science research relies heavily on data gathering for the advancement of knowledge. Indeed, in quantitative research, the most objective and carefully collected numerical information does not and cannot speak for itself (Bryman, 2001). The data must be organised, evaluated and analysed in order to be useful and to make sense of it. So, the appropriate statistical technique for collecting, presenting and analysing data must be used effectively. Healey (1996) put it clearly: *"Without a good understanding of the principles of statistical analysis, the researcher will be unable to make sense of the data. Without the appropriate application of statistical techniques, the data will remain mute and useless." (p 1).*

Therefore to make sense of the quantitative data collected, four main stages were followed: data preparation, describing the data, analysing the differences and similarities, and interpreting data (Bryman, 2001).

In the data preparation stage, the need was to put the data into a form that is easy to work with. Hardman (1994) advises that *"At this stage in the research process you should have data pertaining to all the relevant variables you wish to examine for each case to be included in the study"(p. 330).* However, in the current study the data were coded using a word processor then transferred to the SPSS program, because it is one of the most powerful statistical software packages for social research(Pallant,2003), and also because the researcher has some experience of using this software.

The main job of the second stage, describing the data, according to Munn & Drever (1995) was *"Counting the number of times each code appears on a column and checking that all the respondents are accounted for" (p. 44).*

The data were statistically described staring with the questionnaire return rate, the general characteristics of the research sample and than the main data of the four categories mentioned earlier, as will be apparent in Chapter questionnaire finding.

The researcher was concerned in the third stage to make some comparison between the views of the research samples according to various variables such as categories (psychiatrists, counsellors, patients, and staff). For this purpose, the analytical statistical techniques and their findings are presented in Chapter questionnaire analysis.

The fourth stage was devoted to interpreting the data described and analysed. According to Munn and Drever (1995), two questions are of interest at this stage: *"what do the numbers mean? What is their importance?" (p. 37)*.

Therefore, in a later chapter, the significance and coherent meaning of the data expressed in numbers will be illustrated to tell how they relate to other numbers and to the general questions of the research.

The comments made by the respondents at the end of the questionnaires were analysed qualitatively using the same techniques used for analysing the interviews.

6.13 Piloting the Questionnaire

Standardising the questionnaire is believed to be a difficult part of the construction of the questionnaire. Although it was a continuous process since the beginning of constructing the questionnaire, it is presented in a separate subsection to highlight three crucial issues: piloting, validity and reliability, in addition to the translation process of the questionnaire.

Piloting, as Youngman (1994) believes, *"Is an integral part of any research and questionnaire survey is no exception" (p. 262)*.

Undoubtedly, to get the right questionnaire, *"careful piloting is necessary"* (Bell, 1993, p. 11), as *"The investigator will get valuable feedback,"* (Johnson, 1994, p. 176), but the

question is what should be piloted? Which Oppenheim (1992) makes it obvious that *"In principle, almost anything about a social survey can and should be piloted, When in doubt – and especially when not in doubt – do a pilot run"(p. 48).*

Therefore, a first stage of piloting was conducted in the period from 20th Dec 2003 to 21st Jan 2004 to try out the questionnaire with similar samples to those to be used in the main study. However, the aims of this pilot study were:

1. To improve the validity of the measure through seeking opinions toward it and applying a type of face validity: "panel of judges".

2. To ensure the clarity and correctness of the questionnaire.

3. To identify possible problems and dilemmas that may occur in the main study.

4. To consider what statistical tests may be appropriate for use on the data intended to be collected.

The sample of pilot study included 32 people, who were living in the Saudi Arabia. And the sample divided into four groups (psychiatrists, counsellors, staff, and patients). Although the sample was relatively small, and from a sample similar to but not the same as the main study, it is accepted by Verma and Mallick (1999) that questionnaires should be piloted in *"A group similar to the sample for which it is destined. This need not be large: a dozen or 20 is usually adequate" (p. 120).*

The researcher asked respondents if they would complete the questionnaire and tell him whether they believed that the questionnaire was appropriate to identify the mental health services in Saudi Arabia. They were asked to let the researcher know if any of the items were *'ambiguous'* or not incisive and asked if they would time themselves completing the questionnaire. The respondents reported that they found it easy to understand and were able to complete the questionnaire within fifteen to twenty five minutes. Valuable suggestions and corrections that arose from this pilot study included splitting some items into two and moving some items from one section to another, in

addition to summarising and shortening the instruction letter. When the questionnaires were collected, six respondents were interviewed (2 psychiatrists, 1 counsellors, 2 staff member, and 2 patients), however, consuming the time (around 40 minuets each) to discuss the points emerging from their advice.

6.14 Summary

In this chapter we described the research methodology undertaken for this research. The first part of the chapter began with introducing the philosophical assumptions underlying research methods to further introduce these methods and why they were selected. Further, the initial research methods of the research were described

The second part of this chapter discussed the impact of the empirical work in the research methodology; this part included an introduction about organisational research and the suitable research methods.

The second part of this chapter has focused on the main methodological issues arising from the research question for the empirical part of the study. The research strategies employed have been outlined and consideration has been given to the way in which the first stage *"Qualitative"* enquiry of the study methodology influenced the following stage *"Quantitative"* enquiry. Within each stage a discussion was presented of the advantages and disadvantages of using the appropriate technique, how the research techniques were constructed and conducted, and then, how the data were analysed.

In the data collected stage of the study, the interviews were conducted. Through reviewing the related literature in the mental health services in Saudi Arabia was suffering from serious problems. This pointed to a need to make sure of the seriousness of this problem, investigate its causes and identify how it can be solved. Interviews and

questionnaire were suggested as most appropriate for doing this job. The interviews were analysed and their findings set the base for the second stage of the study.

The questionnaire was selected to be the most appropriate technique for the last stage of the study. The rationale for selecting this instrument was the need for quantitative data from a large number of specialists and practitioners in the field of mental health. The interviews had suggested many issues in mental health. However, a questionnaire was constructed, developed and distributed. The data collected were then analysed to come to generaliseable findings of the services, for developing mental health in Saudi Arabia especially with psychiatrists, counsellors, patients, and staff.

In sum, the researcher attempted to travel progressively from the examination of documentary evidence about the past and present situation of the mental health in Saudi Arabia, through initial interviews with the most involved people to a questionnaire survey with a large number of psychiatrists, counsellors, patients, and staff members of mental health hospitals. It is believed that the methodology adopted was appropriate and adequate for understanding the issue of mental health in Saudi Arabia.

The following chapter reports and analyses the results of the questionnaire survey data will be presented and discussed, and the next chapter, the interviews data gathering. The last chapter, will be devoted to a summary of the study, conclusions and the implications for practice and further research.

Saudi Arabia

International boundary
Province (*minṭaqah*) boundary
★ National capital
◉ Province (*minṭaqah*) center
Railroad
Road
Track

0   100   200   300 Kilometers
0   100   200   300 Miles
Lambert Conformal Conic Projection, SP 14N/32N

CYPRUS — ★ Nicosia

SYRIA — Hamáh, Himş, Dayr az Zawr, 'Akáshát, Damascus, As Suwaydá'

LEBANON — Beirut, Tyre, Haifa

ISRAEL — Tel Aviv-Yafo, Jerusalem

IRAQ — Kirkuk, As Sulaymániyah, Sámarra', Baghdad, Karbalá, Al Kút, An Najaf, Al 'Amárah, Al Başrah, Umm Qaşr, De Facto Boundary

IRAN — Tehran ★, Hamedán, Kermánsháh, Qom, Dezful, Eşfahán, Ahváz, Bandar-e Emám Khomeyní, Büshehr, Bandar 'Abbás, Ra's al Khaymah, Jásk

JORDAN — Amman ★, Ma'án, Turayf, Kál

Elat, Al 'Aqabah, Haql, Al Bi'r

Sinai

EGYPT — Sharm ash Shaykh, Dubá, Tabúk, Al Wajh, Umm Lajj, Mína' Baranis, Administrative Boundary

TABÚK

AL JAWF — Al Jawf, Sakáká, ◉ 'Ar'ar, AL HUDÚD ASH SHAMÁLIYAH, Rafḥá

HÁ'IL — Jubbah, Taymá, Baq'á, Há'il ◉, Bur- aydah

AL QAŞIM — Unayzah, Al Qaşim, Al Majma'ah

AL MADÍNAH — Medina ◉, 'Afif, Ad Dawádimí

Hafar al Bátin, King Khalid Military City, Al Jubayl, Ras Tanura, Ad Dammám, Dhahran

KUWAIT — Kuwait ★, Ra's al Khafji

Persian Gulf, BAHRAIN, Manama ★, QATAR, Doha ★, Abu Dhabi ★, Dubai, Al 'Ayn, Şuḥár, Muscat ★

Riyadh ★, As Sulaymániyah, Al Hufúf, Salwá, Ar Ruwayş, Haraq

UNITED ARAB EMIRATES, no defined boundary, De Facto Boundary

OMAN — 'Ibrí, Nizwá, Şür, Haymá', Duqm, Thamarít, Salálah, Raysút, Al Ghaydah, Sayḥút, Al Mukallá

AR RIYÁD — Laylá, Ḥalabán, Al Khamásin, As Sulayyil, Ash Sharawrah

MAKKAH — Jiddah, Mecca, Aţ Ţá'if, Ar Rawḍah, Rábigh

ASH SHARQÍYAH (EASTERN REGION) — Sabkhat Maţţí, Umm as Samim

Red Sea

AL BÁHAH — Al Báhah, Qal'at Bishah

'ASIR — Khamis Mushayt, Abhā, Al Qunfudhah

NAJRÁN — Najrán ◉, Ash Sharawrah

JÍZÁN — Jízán ◉, JAZÁ'IR FARASÁN

SUDAN — Port Sudan, Sawákin

ERITREA — Kasala, Ákurdet, Keren, Massawa, Teseney, Asmara ★, Ádigrat

ETHIOPIA — Mek'elé, Gonder, Bahir Dar, Desé, T'ana Háyk', Blue Nile

YEMEN — Sa'dah, Sanaa ★, Ma'rib, Say'ún, Al Hudaydah, Dhamár, 'Atáq, Zabíd, Ta'izz, Ibb, Lahij, Mocha, Aden

Arabian Sea, Socotra (YEMEN), Gulf of Oman

Gulf of Aden, Boosaaso, Berbera

DJIBOUTI — Djibouti ★, Assab

SOMALIA

Boundary representation is not necessarily authoritative

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Chapter Seven

Quantitative Data

Tabulation and Discussion

Part One Sample Characteristics

Part Two: Psychiatrists questionnaire

Part Three: Counsellors questionnaire

Part Four: Administrative Staff questionnaire

Part Five: General Summary of Finding

Part Six: Patients questionnaire

Chapter Seven Quantitative Data and Tabulation

Introduction

This chapter describes the coding of the quantitative data, with the four groups of participants (Psychiatrists, Counsellors, Patients, and Administrative Staff members of mental health hospitals).

7.1 Method

The present research is exploratory and descriptive in nature, designed to evaluate the mental health services in Saudi Arabia. The questionnaire for this study was designed keeping in mind the limitations of quantitative method. In particulars, the questions were prepared and arranged taking into consideration the level of awareness of respondents.

7.2.1 Materiel

The first part of questionnaire collected demographic data. The second part of the dealt with psychiatrists', counselors, patients, and administrative staff view of mental health services. Likert scales were used in these items.

Likert scales are most commonly used in social research Forsyth *et al.* (1999: 8). They are particularly useful for situations in which measuring respondents' attitudes or opinions are targeted. Respondents were asked to mark a 5-point Likert-type scale, from strongly agree (5) to strongly disagree (1), which, a higher score indicating a more favourable opinion.

7.2.2 Questionnaire Distributions and Procedure

Questionnaires can be given to respondents directly (self-administered) or mailed to respondents who read the instructions and questions and then record their answers (Bryman, 2001). The decision as to which method is to be adopted, according to Bell (1993); and Bryman (2001) should be made at an early stage. Youngman (1994) emphasised that *"Cost, effort, delay and willingness are just a selection of the factors affecting choice of distribution method and therefore no single ideal procedure can be offered"(p. 263)*.

In the light of such considerations, the plan before the piloting had been made to adopt a self-administered method with all research categories. However, while the researcher was conducting piloting it was noted that, first, it was not possible to meet the psychiatrists, counsellors, and administrative staff as they were occupied with working and administrative duties. Additionally, some Heads of psychiatric units did not allow the researcher to meet the psychiatric practitioners, and asked the researcher to allow them to distribute questionnaires for him. Second, although the researcher met the Head of psychiatric units and explained the purpose of the study and asked them to do their best to encourage response, the rate of response was relatively low. The researcher thus had to contact the Ministry of Health for the second time, in order to have different authoritative letters to each approved unit.

Therefore, as the participants were "persuaded" samples, the self-administering method was more appropriate and, therefore, was adopted for these categories, using a postal method. Questionnaires were distributed at the end of January 2004, using the following procedures.

- Pigeon-holes were set up in each hospital for staff and patients.

- The questionnaires were, put in the prospective respondent's pigeon hole or sent to the psychiatrists, counsellors, staff, and patients via pigeon-holes (Riyadh

Psychiatric Hospital during the first and second weeks of February, Jaddeh Psychiatric hospital during the third and fourth weeks of February, Taif Psychiatric Hospital during the first and second weeks of March, Dammam Psychiatric Hospital during the third and fourth weeks of March).

- Telephone calls were made to psychiatrists, counsellors, and staff members, and a return visit made to each hospital to check that the questionnaires had arrived and encourage the sample to reply.

- Questionnaire collection was begun for all four categories. By the end of this stage (the fourth week of March), around 30 % of the questionnaires had been collected in Riyadh hospital, 25% of the questionnaires were collected in Jeddah, 30%, of the questionnaires in Taif, and 10% in Dammam.

- Reminder letters were sent to those who had not replied, encouraging them to to return the questionnaire (in the first week of April).

- The psychiatrists were phoned five days after sending out the first reminder letter (in the fourth week of March and the first week of April). A second reminder letter was sent suggesting a deadline for replies of Wednesday 20th April.

- Staffs were checked either through phoning the Head of the hospital or calling in their offices, and were encouraged to reply. Also, the patient's pigeon-holes in all four hospitals were checked either in each single visit to the hospital (only the researcher had the authority to have access to them).

The last collection of questionnaires was made on Wednesday 25th April, 2004.

The questionnaires were sent through the hospitals' pigeon-holes which are supposed to be checked every day by the Head of the psychiatric unit, except for the patient pigeon-holes which were checked by the researcher himself. However, due to shortage of counsellors, their pigeon-holes were not checked when the questionnaires were

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distributed. Therefore, 32 questionnaires did not get to the Riyadh hospital as intended, or 26 to the Jeddah hospital and 22 questionnaires did not get to the Dammad hospital. Five of the psychiatrists in Riyadh hospital were off work (training programme and sick-leave), six of the psychiatrists in Jeddah hospital were off work, ten of the psychiatrists in Tai'f hospital were off work, and seven of the psychiatrists in Dammam hospital were off work (study-leave or holiday). Consequently, the overall number of questionnaires presumed to be delivered to the prospective respondents was 970.

7.2.3.1 Questionnaire Reliability

The instruction for the questionnaire was written clearly on the top of each page. The stages of piloting were felt to maximise the reliability as some items believed not to be clear were replaced.

Cronbach's alpha is widely regarded as a good index of inter-item consistency reliability and its use for computing test score reliability is widespread (Borg and Gall, 1996). According to Borg and Gall (2003), reliability scores of .80 or higher are acceptable for most research purposes.

For psychiatrists, standardised alphas ranged from .8615 to .9422 respectively. Counsellors alphas ranged from .6532 to .9722, Patients' alphas ranged from .6745 to .9751, and Administrative staff alphas ranged from .5569 to .9976. Since, generally values of Cronbach's alpha were above .7, scales can be considered reliable.

7.3 Response Rate

The use of the term: 'practitioners' in this study will be classified as those who work in the mental health hospitals, which includes psychiatrists, counsellors, and administrative staff members who are dealing with patients on a daily basis. The Ministry of Health requires them to spend at least 75% of their work time inside mental

health hospitals. Patients are considered as treatment seeker rather than 'practitioners'.

Table 7.1. gives a detailed account of the distribution and response rate to the

questionnaires.

Table 7.1 Detailed Numbers of Questionnaires Distributed and Collected

| Category | The ques. Distributed | Ques. collected | Invalid Ques | | Valid Ques | Percentage (%) |
			Blank	Returned uncompleted		
Psychiatrists	300	203	17	28	158	52.66%
Counsellors	185	147	20	27	100	54.05%
Patients	640	358	54	96	208	32.5%
Administrative Staff	370	262	35	23	204	55.13%
Total	1495	970	126	174	670	44.81%

The number of questionnaires collected (n=970) was satisfactory, as it represented more

than 64.88% of the original sample; the number of questionnaires analysed is (n=670),

representing 44.81% of the questionnaires administered.

Not all questionnaires returned were useable. As the questionnaires were collected, they

were classified into four groups according to their suitability to be used. (126) were

blank. Perhaps some respondents returned the questionnaires blank, to indicate their

unwillingness to fill them in, avoiding receiving further reminders. In addition, 174

questionnaires were uncompleted. These were excluded from the analysis.

7.4 Sample profile

Practitioners in this study are those most directly involved with the mental health

services in Saudi Arabia.

Chart 7.1 The size of respondents (%).
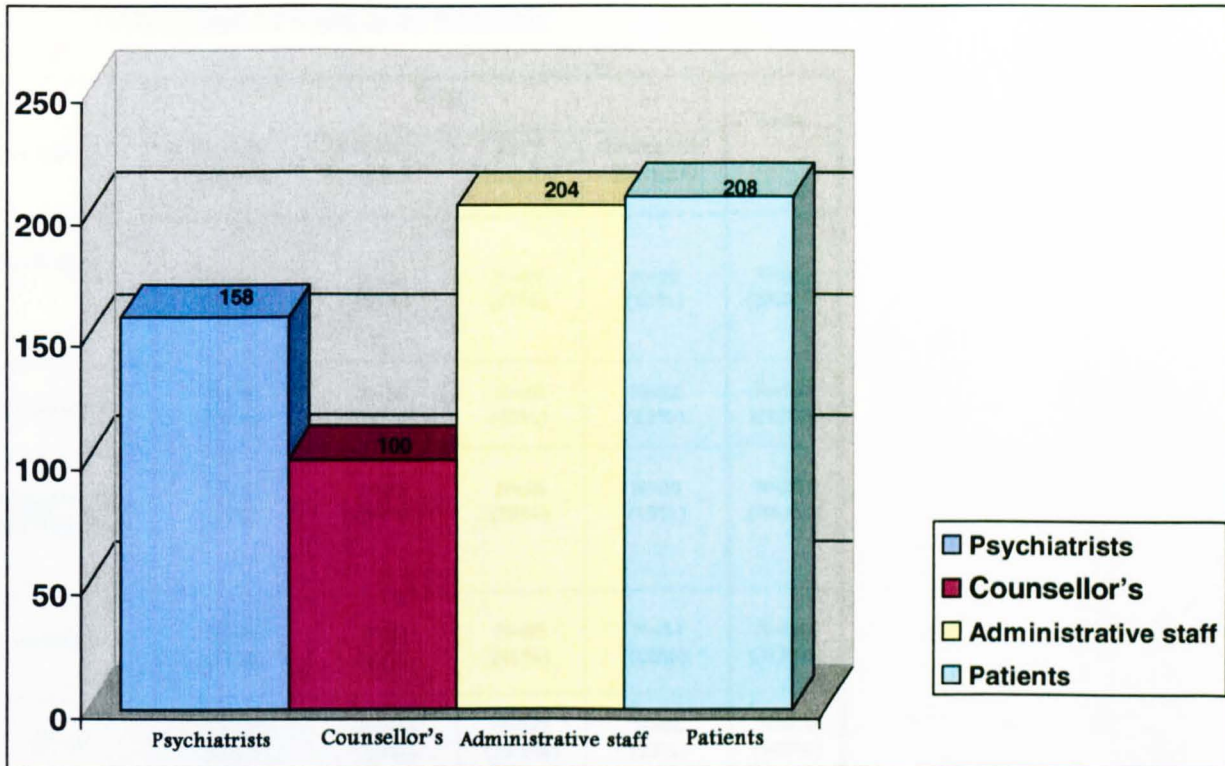
The bar chart (7.1) shows the four sample groups. The psychiatrists' population was 23.6% (N=158), for the counsellors 14.9% (N=100), for the staff members of mental health hospitals 30.4% (n=204), for the patients who seek treatment from four mental health hospitals in Saudi Arabia 31.0% (N=208).

This bar chart shows the small proportion of the counselling sample, which represents 14.9% of the overall sample. This reflects the small number of counsellor practitioners in Mental Health Hospitals in Saudi Arabia.

Mental Health Hospitals in the Ministry of Health are divided into 5 district areas which are called 'sub-district hospitals'. Table 7.2 illustrates the distribution of the respondents within the Hospitals.

7.5 Distribution of Practitioners

Table 7.2Distribution of Sample by hospitals

category	City				Total
	Riyadh Hospitals	Jaddah Hospital	Tai'f Hospital	Dammam Hospital	
Psychiatrists	N=50 (32%)	N=29 (18%)	N=59 (37%)	N=20 (13%)	N=158 (23.5%)
Counsellors	N=28 (28%)	N=20 (20%)	N=40 (40%)	N=12 (12%)	N=100 ((15%)
Administrative Staff Members	N=74 (36%)	N=62 (30%)	N=38 (19%)	N=30 (15%)	N=204 (30.4%)
Patients	N=65 (31%)	N=34 (16%)	N=85 (41%)	N=24 (12%)	N=208 (31.0%)
Total	N=217 (32.4%)	N=145 (22%)	N=222 (33.1%)	N=86 (13%)	N=670 (100%)

From Table 7.2 it can be seen that Riyadh and Tai'f hospitals had the highest proportion of practitioners in all categories. Moreover, they had an extremely high number of patients (Riyadh= 10%, Tai'f= 13%) compared to the rest of the hospitals. Dammam had the smallest proportion of respondents in all categories, a function of the hospitals bed capacity.

The table 7.2 indicate that Tai'f hospital had more mental health practitioners and served more patients than the rest of the hospitals, reflecting the fact that Tai'f psychiatric hospital was the first to be established, and is the headquarters of the psychiatric services. Numbers of practitioners and patients in the other hospitals reflect regional population differences. Which, Riyadh psychiatric hospital covers the central region; Jaddeh psychiatric cover the Western region; and Dammam psychiatric hospital covers the Eastern region. Not surprisingly, that the manpower, in the four hospitals are different, that because each region has different populations.

7.5.1 Practitioners Gender

Table 7.3 Distribution of Sample Gender

category	Gender		Total Percentage
	Male	Female	
Psychiatrists	N=92 (58 %)	N=66 (42%)	N=158 (23.6%)
Counsellors	N=76 (76%)	N=24 (24%)	N=100 (14.9%)
Ad. Staff Members	N=107 (52%)	N=97 (48%)	N=204 (30.4%)
Patients	N=89 (43%)	N=119 (57%)	N=208 (31.0%)
Total	N=364 (54.3%)	N=306 (45.7%)	N=670 (100%)

Table 7.3 display the results relating to the gender worker in mental health hospitals in the four psychiatric hospital, it is clear that the practitioners' sample has both male and female, a unique a mixture of both genders in Saudi society. Feminism will not be tremendously relevant to the research process in Saudi Arabia, because of the religious requirements of not permitting a woman to be alone with a man.

For practitioners the males outnumbered females at 275 (60%) and 187 (40%) respectively women being especially underrepresented in the counsellor sample. The gender disparity among practitioners can be explained by the fact that working in a hospital is still not an acceptable job for women in Saudi society, and there is a lack of job opportunities for women in mental health hospitals.

7.5.2 Practitioners Age

Table 7.4 Distribution of the Sample Age

category	Age				Total
	Less Than 25	From 26-35	From 36-45	More than 45 years	
Psychiatrists		N=43 (27%)	N=67 (43%)	N=48 (30%)	N=158 (24%)
Counsellors	N=13 (13%)	N=27 (27 %)	N=35 (35%)	N=25 (25%)	N=100 (15%)
Ad. members	N=32 (16%)	N=79 (39%)	N=66 (32%)	N=27 (13%)	N=204 (30%)
Patients	N=35 (17%)	N=74 (35%)	N=66 (32%)	N=33 (16%)	N=208 (31%)
Total	N=80 (12%)	N=223 (33%)	N=234 (35%)	N=133 (20%)	N=670 (100%)

The range of age for practitioners was between from 24 to 58 years old. The majority of the psychiatrists surveyed (43%) were between 36 to 45 years old. The largest concentration of counsellors (35%) was in the same age range. The largest concentration of administrative staff (39%) was 26 to 35 (39%). This was also the age group with the largest number of patients (39%).A t-test is showed that there was no significant difference between the age ranges of each group of practitioners.

7.5.3 Practitioners Nationality

Table 7.5Distribution of sample Nationality

category	Nationality		Total
	Saudi	Non-Saudi	
Psychiatrists	N=102 (65%)	N=56 (35%)	N=158 (23.6%)
Counsellors	N=100 (100%)		N=100 (14.9%)
Ad. Staff Members	N=180 (88%)	N=24 (12%)	N=204 (30.4%)
Patients	N=201 (97%)	N=7 (3%)	N=208 (31.0%)
Total	N=583 (87%)	N=87 (13%)	N=670 (100%)

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Table 7.5 displays the results relating to sample nationality. Over a third of psychiatrists (102, 65%) were non- Saudis, reflecting the shortage of indigenous professionals in this field. In addition, all counsellors were Saudi's and reflecting that the numbers of counsellors in mental health hospitals were increased in the last ten years. This distribution, agrees with Al-Subaie and Alhamed(2000). Patients were predominantly Saudi.

7.5.4 Practitioners Qualification

Table 7.6 Distribution of sample by Qualification

category	Qualification				Total
	Intermediate	Secondary	Graduate	Postgraduate	
Psychiatrists			N=60 (38%)	N=98 (62%)	N=158 (24%)
Counsellors			N=71 (71%)	N=29 (29%)	N=100 (15%)
Ad. Staff Members	N=14 (7%)	N=53 (26%)	N=111 (54%)	N=26 (13%)	N=204 (30%)
Patients	N=30 (14%)	N=70 (34%)	N=72 (35%)	N=36 (17%)	N=208 (31%)
Total	N=44 (7%)	N=123 (18%)	N=314 (47%)	N=189 (28%)	N=670 (100%)

Table 7.6 shows the finding of Qualification. The majority of the sample had a graduate degree (n=314) 47%, while 189 (28%) were postgraduate degree holders. Among the practitioners, the psychiatrists were more highly qualified, with a far higher proportion holding postgraduate degrees. On the other hand, the majority of counsellors were graduates. Administrative staffs were the least educated, 7% not having education beyond intermediate school.

The largest concentrations of patients were in the secondary school and degree categories (34% and 35% respectively). Surprisingly, more than 52% of patients were high educated. Four response categories were offered in the questionnaire to reflect the different levels of experience (Table 7.7).

7.5.5 Practitioners Experience

Table7.7 Distribution of the Practitioners' Experience

category	Experience				Total
	5 and Under	From 5-8 years	from 9-15 years	More than 15 years	
Psychiatrists	N=20 (13%)	N=59 (37%)	N=51 (32%)	N=28 (18%)	N=158 (34%)
Counsellors	N=13 (13%)	N=42 (42%)	N=33 (33%)	N=12 (12%)	N=100 (22%)
Ad. Members	N=38 (19%)	N=86 (42%)	N=66 (32%)	N=14 (7%)	N=204 (44%)
Total	N=71 (15%)	N=187 (40%)	N=150 (33%)	N=54 (12%)	N=462 (100%)

This table shows that while the experience of around 37% of psychiatrists was between 5-8 years, only 42% of the counsellors and 42% of the administrative staff had this level of experience.

The highest proportion had between 5-8years experience (40%). A t-test revealed a significant difference between psychiatrists and administrative staff members in the experience levels (p= .003 & t = 2.95), but no significant difference between psychiatrists and counsellors (p= .340 & t = .957), or between counsellors and administrative staff members (p = .113 & t = 1.59). The relative lack of experience of practitioners may be that they have been newly appointed because of the large number of mental health hospitals being established.

Part Two Psychiatrists Questionnaire

7.6 Introduction

The issues of the aims, roles; awareness, effectiveness, referrals, and psychiatrists' development in mental health hospitals are vitally important for treatment services in the mental health system, since the central goal of the services is to provide relevant medical treatment for patients.

It is the intention in this part to evaluate the psychiatrist's view of mental health provision.

The study sought to examine seven major questions,

1) What were the characteristics of psychiatrists in mental health hospitals?

2) Where there any significant different between aims and objectives among psychiatrists?

3) Was there any difference in the roles and responsibility among psychiatrists?

4) Was there a difference in service awareness, as an outcome of the psychiatrists' view of the services?

5) Was there any significant difference between psychiatrists in their view of the effectiveness of the services?

6) Was there any significant difference between psychiatrists in their views of the referral system in mental health provision?

7) Was there any significant difference between psychiatrists in their evaluation of personal development in mental health provision?

7.7 Analysis techniques

Due to the nature and the scope of the present investigation, it was decided to use the following statistical techniques **(the same statistical approach was used with all groups)**:

A. Descriptive statistic (such as, percentages of responses and frequencies) as a part of the analysis of all seven questions related to evaluation of mental health services.

B. ANOVA Analysis of Variance was used in the investigation any significant differences among counsellors in the experiences, age, qualifications, and different mental health hospital. (The reason for using ANOVA is because it deals with three or more variables, and the study had more than three groups. Pallant (2001); Coolican (2004) indicated that ANOVA can be used for comparing the averages of three or more samples).

C. T-Test was performed in the present investigation to determine whether counsellors differed in gender and nationality related to counsellors view of the services.

D. The level of significance was set at the .05 level, where no significant differences were found between groups, tables are not provided.

7.8 Results

The results are presented in six sub-sections. in the first three items are analysed to identify the aims and objectives of services; in the second two items are analysed to identify roles and responsibility; in the third three items are analysed to identify awareness; in the fourth three items are analysed to identify effectiveness; in the fifth, three items are analysed to identify referral, and the last section focuses on three items to evaluate personal development for mental health practitioners in Saudi Arabia.

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7.8.1 Question One

The four hospitals in Saudi Arabia were selected as each of them has a specialised department of psychiatric unit. There are some differences in the administrative arrangements and patient treatment in the four hospitals. Riyadh, Jeddah, Tai'f and Dammam mental health hospital use one-day treatment as a new way of mental health provision, while Tai'f hospital still use the long-term treatment for mentally ill people, which is a part of the hospital policy. Pie-chart. Illustrates the numbers of the psychiatrists in the sample.

Chart 7.2 Psychiatrists distribution
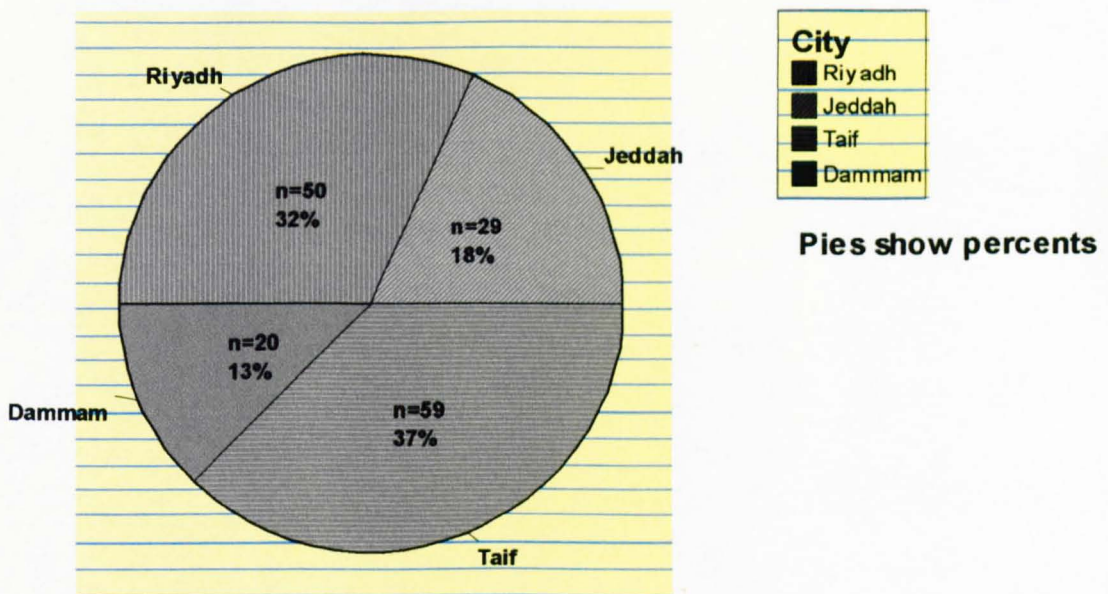
Chart 7.2 is shows that the sample from Riyadh and Tai'f hospitals was around double the size of that of Jeddah and Dammam hospitals. Indeed Riyadh, as the capital city of Saudi Arabia, has more attention from the government, and the capacity of the hospital is double that of Dammam and Jeddah mental health hospital, moreover, Tai'f hospital

was the first hospital established in Saudi Arabia. Riyadh and Tai'f hospitals have ten

psychiatric words, while in Jeddah and Dammam hospitals there are only three wards

(M.O.H, 2003).

7.8.2 Question 2

Table 7.8 the Evaluation Related to Aims and Objectives

No	Questions	St-agree	Agree	Don't know	Disagree	St-disagree
1	Aims and objective of mental health provision are not clear.	7 (4%)	10 (6%)	---	75 (48%)	66 (42%)
2	It is difficult for Psychiatrists to achieve their aims and objectives in mental health hospitals.	8 (5%)	14 (9%)	---	84 (53%)	52 (33%)
3	Psychiatrists have insufficient knowledge of mental health aims and objectives.	2 (1%)	5 (3%)	---	80 (51%)	71 (45%)

The majority (90%) of psychiatrists they had sufficient knowledge of they aim and

objectives which were clear, and they had no difficulty in achieving them. while only

(10%) of responded believed their aims are unclear. Thus, psychiatrists' evaluation of

this aspect of the services was favourable.

A one way ANOVA and t-tests were used to investigate the differences between

psychiatrists in different cities, and with different personal characterises such as

nationality, gender, qualification, and experiences. No significant differences were

found in relation to any of these variables.

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Table 7.9 The Evaluation Related to Roles and Responsibility

No	Statements	St-agree	Agree	Don't know	Disagree	St-disagree
1	Psychiatrists should have specific roles and responsibilities.	54 (34%)	82 (52%)	—	15 (10%)	7 (4%)
2	Roles and responsibilities in mental health provision are less than they should be.	64 (41%)	55 (35%)	—	23 (14%)	16 (10%)

As Table 7.9 shows, 86% of respondents would like to see a clearer specification of roles and responsibilities. While, only 14% of the respondents thought they did have specific roles and responsibilities

14% of respondents did not think their roles and responsibility in mental health provision should be greater than at present. In addition, 76% of respondents saw the proportion of roles and responsibilities as less than it should be. Thus, there was a strong support for the idea of establishing new roles for psychiatrists

7.10 Difference between responses in the four cities in evaluation towards the roles and responsibility
Regarding the test for significant differences between cities in views on roles and responsibility, the relevant data are shown in Table 7.10. below.

R & R	City	N	M	SD	T	P
	Riyadh	50	4.18	1.04	4.57	.000
	Jaddh	29	2.82	1.58		.000
	Riyadh	50	4.18	1.04	8.58	.000
1	Tai'f	59	2.27	1.24		.000
	Riyadh	50	4.18	1.04	7.59	.000
	Dammam	20	2.05	1.09		.000
	Riyadh	50	3.18	1.63	3.05	.003
	Tai'f	59	2.32	1.29		.003
	Riyadh	50	3.18	1.63	2.83	.006
	Dammam	20	2.05	1.09		.002

Table 7.10 Results of t-test for Difference between responses in the four cities in evaluation towered the roles and responsibility, R&R= roles and responsibility.

Table 7.10 shows that psychiatrists in Riyadh scored higher than those in all other cities, on statement one, and higher than those in Tai'f and Dammam M.H.H on statement two.

These differences indicate that psychiatrists in Riyadh hospital disagreed more strongly with establishing specific roles and responsibility in mental health provision, and with introducing additional roles and responsibilities. One possible explanation of these findings is that psychiatrists who work in Taif, Jaddh, and Dammam M.H.H had weaker knowledge of the roles and responsibility of the service.

No significant differences were found between psychiatrists of different gender, age, nationality, qualifications, and experience in their views of roles and responsibility (p=>0.5).

7.8.4 Question 4

Results for psychiatrist's awareness of mental health services are summarised in Table 7.11
Table 7.11 The Evaluation Related to Awareness of the mental health services

No	Statements	St-agree	Agree	Don't know	Disagree	St-disagree
1	Psychiatrists have insufficient awareness of the mental health services.	44 (28%)	92 (58%)	---	17 (11%)	5 (3%)
2	Psychiatrists should have good communication with other professionals.	56 (35%)	76 (48%)	---	20 (13%)	6 (4%)
3	Overall, patients receive the best possible services from Psychiatrists.	35 (22%)	71 (45%)	4 (2%)	42 (27%)	6 (4%)

From Table 7.11 the majority (86%) of the psychiatrists agreed that psychiatrists have insufficient awareness of mental health services. This might be because of a weakness in the understanding of role and responsibility of the services. 83% of respondents

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recognized the need for good communication with other professionals, although (17%) of psychiatrists saw no such need for a communication with other professionals.

The general view (67%) was favourable towards the quality of services given to patients, although almost a third (31%) of the respondents disagreed with the statement on this issue. However, No statistically significant differences were found related to gender, age, nationality, qualifications, and experience, for any of the items ($p = > .05$).

In relation to the statement, *(Psychiatrists should have good communications with others professionals)* one-way analysis of variance followed by a Tukey showed a significant difference between the psychiatrists in Riyadh and Tai'f M.H.H, the former having a higher mean score, i.e. showing greater disagreement with the item.

7.12 One-way Analysis of Variance to compare psychiatrists in two hospitals with their view of the second statement of awareness

City	M	SD	F	P
Riyadh	3.92	1.14	1.114	0.08
Tai'f	3.16	1.24		

Table 7.12 presents a summary of the analysis of variance. The probability value is ($p = .008$) indicating that there is a significant difference among psychiatrists view of awareness in the two hospitals. The means presented in Table 7.12 show that the psychiatrists from Riyadh M.H.H were more supportive of communications with other professionals, and those Tai'f M.H.H have less awareness of services.

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7.8.5 Question 5

Table 7.13 the Evaluation related to effectiveness of the Psychiatrists in mental health services

No	Statements	St-agree	Agree	Don't know	Disagree	St-disagree
1	The psychiatrists should see the patient more than once a weekly	68 (43%)	77 (49%)	—	11 (7%)	2 (1%)
2	Psychiatrists should have regular feedback from the hospital on their performance	55 (35%)	81 (51%)	—	16 (10%)	6 (4%)
3	Psychiatrists services have a very low effectiveness in mental health patients	2 (1%)	9 (6%)	—	87 (55%)	60 (38%)

Table 7.13 shows the respondents' views on their interventions and their effectiveness.

The majority of respondents (92%) favoured the idea of seeing the patients more than once a week, which would mean changing the hospitals' regimes. Only 8% of respondents disagreed with the idea. 86% of psychiatrists generally perceived a need for feedback from the hospital in order to evaluate their treatment outcome. 14% of respondents disagreed with the statement. The disagreement was strongest in Jeddah M.H.H (mean= 3.03 compared to Riyadh M.H.H 3.46, Dammam 3.50 and Tai'f 3.23), although the difference was not statistically significant.

93% of respondents asserted the effectiveness of treatment outcomes with patients. Only 7% agreed that "Psychiatrists services have a very low effectiveness in mental health patients". However, It was found there was a significant difference between psychiatrists in Riyadh (mean=1.62) and Dammam (mean=2.30), in evaluation of the effectiveness of mental health services (p= 0.016).

Table 7.14 way Analysis of Variance to compare two cities with the psychiatrist's view of the of effectiveness

City	M	SD	F	P
Riyadh	1.62	.69	3.53	.016
Dammam	2.30	1.45		

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Table 7.14 presents a summary of the analysis of variance. Tukey-HSD tests showed that psychiatrists in Dammam saw their work and services as more clinically effective than those in Riyadh M.H.H (F = 3.53 and p=.016).

7.8.6 Question 6:

The views of psychiatrists of the referral system in mental health services are summaries in table7.15

Table 7.15 the Evaluation related to referrals system of the mental health services

No	Questions	St-agree	Agree	Don't know	Disagree	St-disagree
1	The psychiatrists referral system needs more flexibility	6 (4%)	9 (6%)	---	68 (43%)	75 (47%)
2	Psychiatrists have insufficient awareness of the referral process	4 (2%)	14 (9%)	---	72 (46%)	68 (43%)
3	The referral procedures should be clearer	5 (3%)	12 (8%)	--	71 (45%)	70 (44%)

The great majority of respondents (90%) saw the system as sufficiently flexible in existing form, disagreeing with the statement proposing greater flexibility. 89% of respondents also denied that they lacked awareness of the process. This is probably because those dealing with patient referral were more aware of the sources of referral .Also, their views might relate to their experiences of the patient problems and of managing mental health hospitals. Consistent with responses to the first two statements, the great majority of respondents (89%) of psychiatrists saw no need for the referral system to be made clearer. Thus, overall, psychiatrists were satisfied with the referral process.

Psychiatrists with different levels of experience had different views on their awareness of the referral process (F= 2.86, p = .039) as shown in Table 7.16

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Table 7.16 One-way Analysis of Variance to compare level of experiences with the psychiatrist's view on awareness of referral process

Level of experiences	N	M	SD	F	P
From 5-8	59	2.01	1.19	2.86	.039
From 9-15	51	1.52	.61		

This table reveals that more experienced people perceived psychiatrists as more aware of the referral system, while those with between 5-8 years experiences indicated less awareness.

7.8.7 Question7:

Psychiatrist's personal development

Table 7.17 The Evaluation related to Psychiatrists Personal Development of the Mental Health Services

No	Statements	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Psychiatrists should have very high qualification	85 (54%)	63 (40%)	---	7 (4%)	3 (2%)
2	Psychiatrists should have more training and education on mental health services	102 (65%)	34 (21%)	---	15 (10%)	7 (4%)
3	There has been a steady decline in psychiatrists' development in the last ten years	9 (6%)	15 (9%)	3 (2%)	72 (46%)	59 (37%)

From Table 7.17 there was almost complete (94%) agreement that psychiatrist should have very high qualifications (meaning. for example, a higher diploma or master degree), while only 6% disagreed with it.

86% of the sample saw need for psychiatrists to have more training and education on mental health provision. Just under a fifth (14%) not favoured more training and educational programmes on mental health services. 83% of the samples were disagreed with the statement "there has been a steady decline in psychiatrists' development in the last ten years" , only 15% accepted the proportion.

Psychiatrists in Riyadh M.H.H scored significantly higher than those in Tai'f M.H.H(mean = 2,34 and 1.74 respectively) on the proportion that psychiatrists need more

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training on the mental health services meaning that Riyadh psychiatrists were more in favour of this suggestion.

Table 7.18 One-way Analysis of Variance to compare two cities with the psychiatrist's view of second statement of the personal development

City	M	SD	F	P
Riyadh	2.34	1.09	3.27	.023
Ta'f	1.74	.90		

Table 7.18 Shows that the difference is statically significant (F = 3.27 and p=.023). In Riyadh hospital, 26% of psychiatrists were agreed with the second statement, while, in Tai'f hospital only 6% of the psychiatrists favoured training and educational courses in mental health services.

Respondents from Riyadh and Jeddah M.H.H had the highest mean scores (mean= 1.70 and 1.72 respectively), while Dammam had the lowest mean (mean= 1.65). However, the difference was not statistically significant

Moreover differences were recognised as being significant when using one-way variance of analysis test between the psychiatrists experience, it was found a significant difference between psychiatrists level of experiences. Table 7.19 help to recognise the differences between levels of experience among psychiatrists.

Table 7.19One-way Analysis of Variance to compare level of experiences with the psychiatrist's view of second statement of personal development

Level of experiences	N	M	SD	F	P
From 5-8	59	1.94	1.00	3.74	.012
More than 15 years	28	2.60	1.19		

Table 7.19 presents a summary of the analysis of variance. the F value of 3.74 and probability value of p =.012 indicate a significant difference among psychiatrists of different experiences, psychiatrists who had 5-8 years experience were less inclined

have more training in their work than psychiatrists with more than 15 years who perhaps more aware of their own personal development needs.

7.8.8 Synopsis

- Psychiatrists have a very strong awareness and knowledge of their aims and objectives.

- Psychiatrists in four mental health hospitals saw their roles and responsibility as not being clear.

- Almost all psychiatrists have insufficient awareness of the mental health provision and they support the idea of greater communication with other practitioners.

- Psychiatrists have a very high level of satisfaction with their treatments outcomes. Almost complete agreement between psychiatrists that would like to have more than one session per a week with their patients.

- Psychiatrists felt their referral system were flexible and clear, with high level of their awareness of the current referral system.

- The majority sample supporting the idea of having more training and qualifications for mental health professionals.

Part Three Counsellor's Questionnaire

7.9 Introduction

Recent years have witnessed the birth and tumultuous adolescence of a new concept in the field of mental health services in Saudi Arabia known as mental health social services.

Over roughly the same time period, the counselling profession, rooted in the education setting, has ventured into the field of mental health (Al-yahia, 2001). Counsellor's practice is by no means limited to the provision of mental health services. Nevertheless, Al-Sibai (1988), observed that *"professional counsellors have perceived their major function to be psychological or mental health counselling"* (p.78). And, El-Gaaly (1998) points out that mental health services in Saudi Arabia *"was born of the lack of a professional organisation for mental health counsellors"* (p.362). These statement leave little question that the emphasis of the counselling movement is in the area of mental health services, with this emphasis here has emerged the mental health counsellor.

As a mental health care provider, the psychiatry hospital based mental health services is a potentially major source of counsellor's employment. However, the primary interest of this part was the viability of the match between the mental health counsellors attitude and views of the services and current situation of the services, especially in view of recent developments in mental health care policy.

7.9.1 Analysis

This part of the study sought to examine seven major questions,

1) What were the characteristics of Counsellors in mental health hospitals?

2) Where there any significant different between aims and objectives among Counsellors?

3) Was there any difference in the roles and responsibility among Counsellors?

4) Was there a difference in services awareness, as an outcome of the Counsellors view in the services?

5) Where there any significant difference between Counsellors in their view of effectiveness of the services?

6) Where there any significant different between Counsellors in their views of referral system in mental health provision?

7) Was there any significant difference between Counsellors in their evaluation of personal development in mental health provision?

7.9.1 Question One

Many of the 185 Counsellors returned questionnaire were not usable, twenty questionnaires were returned blank, another twenty seven questionnaires respondents returned uncompleted questionnaire.

The final sample consisted of 100 mental health counsellors, representing 54% of all returned counsellor questionnaires (n= 185). A demographic description of the counsellors is provided in the Pie-chart below,

Chart 7.3 Counsellors distribution
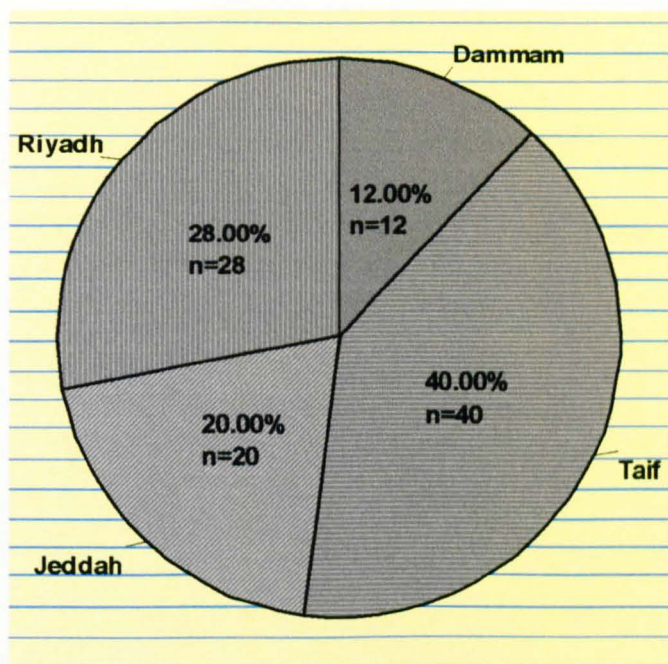
This figure shows that the bulk of responses came from Tai'f M.H.H, Which returned the greatest proportion, while Dammam M.H.H returned the lowest proportion. Riyadh and Jaddah M.H.H similarly returned the most questionnaires. The greatest response rate come from male counsellors (76%), while (24%) from female. All counsellors were from Saudi Arabia (42%) of the sample had experiences between 5 to 8 years, with the vast majority holding a graduate degree, while, (29%) of respond hold postgraduate degrees.

Table 7.20 the Evaluation Related to Aims and Objectives

No	Statements	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	**Aims and objective of mental health Provision are not clear.**	31 (31%)	47 (47%)	2 (2%)	19 (19%)	1 (!%)
2	**It is difficult for Counsellors to achieve their aims and objectives in mental health hospitals.**	25 (25%)	48 (48%)	----	10 (10%)	17 (17%)
3	**Counsellors have insufficient knowledge of mental health aims and objectives.**	36 (36%)	45 (45%)	3 (3%)	11 (11%)	5 (5%)

As Table 7.20 shows, over three quarters of counsellors (79%), considered that the aims and objectives of mental health provision are not clear. Typically, those in favour of current services saw the need for a change of aims and objectives to be clearer; and to develop and promote services offered through the mental health provision. However, a large majority of counsellors (73%), agreed that they are facing difficulties in achieve their aims and objectives. Clearly if the aims and objectives are not clear there will be difficulty achieving them.

81% of counsellors have littel knowledge of their aims and objectives related to mental health provision. Indeed, counsellor's evaluation of this aspect of the service was not favourable. t-tests and one way ANOVA were used to investigate the differences between counsellors in different cities, and with different personal characterises such as experiences, gender, nationality, and qualification. No statically significant differences were found in relation to any of these variables.

Table 7.21. The Evaluation Related to Roles and Responsibility

No	Statements	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	**Mental Health counsellors should have specific roles and responsibilities.**	22 (22%)	47 (47%)	2 (2%)	22 (22%)	7 (7%)
2	**Roles and responsibilities in mental health provision are less than they should be.**	51 (51%)	36 (36%)	2 (2%)	6 (6%)	5 (5%)

The majority (69%) of counsellors saw that their present role and responsibilities do not reflect the needs of their practice. The majority of respondents thought that their roles and responsibility should be greater then at present. Thus, there were very strong supports for the idea of establishing new roles for counsellors.

In relation to the first statement **(Mental Health counsellors should have specific roles and responsibilities),** one-way analysis of variance followed by a Tukey, showed a significant difference between the counsellor's in four cities M.H.H, the former having a higher mean score, i.e. showing greater disagreement with the item.

Table 7.22 Difference between responses in the four cities in evaluation towards the roles and responsibility

city	M	SD	F	P
Riyadh	2.07	.89	45.26	0.00
Jeddah	4.55	.51		
Tai'f	3.90	.90		
Dammam	4.16	.71		

Table 7.22 Shown a summary of the analysis of variance. It can be seen that there is a high statically significant difference among counsellors view of roles and responsibility in the four hospitals. The means presented in Table 7.22 show that the counsellors from Jeddah M.H.H were more supportive of having specific role and responsibility in their own professional practice in hospital, when those in Riyadh M.H.H had a little support

for the idea of establishing new roles for counsellors in mental health provision. In general, counsellors' evaluation of the service was not favourable and there was a strong agreement among respondents to establish new an increased role for their profession.

7.9.4 Question 4

Table 7.23 The Evaluation Related to Awareness of the mental health services

No	Statements	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Counsellors have insufficient awareness of the mental health services.	35 (35%)	31 (31%)	1 (1%)	14 (14%)	19 (19%)
2	Counsellors should have good communication with other professionals.	41 (41%)	33 (33%)	--	11 (11%)	15 (15%)
3	Overall, patients receive the best possible services from Counsellors.	39 (39%)	36 (36%)	7 (7%)	9 (9%)	9 (9%)

As Table 7.23 shows that almost three quarter of respondents (66%) confirmed that they have insufficient awareness of mental health services provision. When tested on their knowledge of the communication with other professionals (74%) recognized the need for good communication with other professionals.

The general view, with almost (75%) of respondents was that the patients receive the best counselling service. When responses were looked at by age, gender, nationality, qualifications, and experience, no statistically significant differences were found related to any of the items ($p = > .05$).

Table 7.24 The Evaluation Related to effectiveness of the mental health services

No	Statements	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Counsellors should see the patient more than once a weekly.	30 (30%)	50 (50%)	--	12 (12%)	8 (8%)
2	Counsellor's should have regular feedback from the hospital on their performance	34 (34%)	27 (27%)	3 (3%)	17 (17%)	19 (19%)
3	Counselling services have a very low effectiveness in mental health patients.	14 (14%)	19 (19%)	1 (1%)	22 (22%)	44 (44%)

The vast majority of respondents (80%) would to see patients more than once a week..

There was also a general view (65%) of the need for feedback from the hospital in order to evaluate their interventions.

More than half of the respondents (66%) asserted that the counselling services were effective. However, there was a significant difference between counsellor's view of their effectiveness of treatment, in Riyadh (mean=2.78) and Jeddah (mean=4.15), in evaluation of the effectiveness of mental health services (p= .011).

Table 7.25 Analysis of Variance to compare two cities with the counsellor's view of the of effectiveness

City	M	SD	F	P
Riyadh	2.78	1.66	3.94	.011
Jeddah	4.15	.67		

Counsellors in Riyadh had the lowest mean (2.78), while in Jeddah M.H.H counsellors had the highest mean (4.15).Tukey-HSD tests showed that counsellors in Riyadh saw their work and services as less effective than those in Jeddah M.H.H (F = 3.94 and p=.011).

7.9.6Question 6

Table 7.26The Evaluation Related to referral system of the mental health services

No	Statements	St-agree	Agree	Don't know	Disagree	St-disagree
1	counselling referral system needs more flexibility	28 (28%)	43 (43%)	2 (2%)	23 (23%)	4 (4%)
2	Counsellors have insufficient awareness of the referral process	26 (26%)	45 (45%)	4 (4%)	19 (19%)	6 (6%)
3	The referral procedures should be clearer	29 (29%)	41 (41%)	2 (2%)	24 (24%)	4 (4%)

Around 71% of counsellors though the referral system need to be more flexible. There were no significant different among counsellors gender, nationality, qualifications, and experiences in evaluation towered the first referral statement. It is apparent that the great majority of respondents (71%) regarded the counselling referral process as insufficient. no significant differences were found in relation to different cities, gender, age, nationality, and qualification (p= >.05).

There was almost complete agreement among counsellor's that the present referral procedures are not clear. Differences among counsellors age, nationality gender, qualification and the levels of experience were not statically significant (p= >.05).

Table 7.27 The Evaluation Related to Counsellors personal development of the mental health services

No	Statements	St-agree	Agree	Don't know	Disagree	St-disagree
1	Counsellors should have very high qualification	43 (43%)	41 (41%)	1 (1%)	9 (9%)	6 (6%)
2	Counsellors should have more training and education on mental health services	38 (38%)	37 (37%)	3 (3%)	6 (6%)	16 (16%)
3	There has been a steady decline in counsellors development in the last ten years	31 (31%)	36 (36%)	2 (2%)	13 (13%)	18 (18%)

Table 7.27 show that (84%) of respondent were agreed that counsellors should have very high qualifications (such as, a higher diploma in counselling or master degree). A smaller proportion, although still representing the majority of the sample saw the need for counsellors to have more training and education on mental health services.

Three quarters of counsellors agreed that have had been a steady decline in counsellors development. A one way ANOVA and t-tests were used to investigate the differences between counsellor's in four mental health hospitals, and with different personal characterises such as nationality, gender, qualification, and experiences. No significant differences were found in relations to any of these variables related to this aspect of services.

7.9.8 Synopsis
- Counsellors have insufficient knowledge of their aim and objective, with correspondingly reduced possibility of achieving their goals.

- The Majority of counsellors saw in increased significant their role in the hospitals.

- Counsellors were largely unawareness of the current model of mental health provision.

- Most counsellors were satisfied with their level of effectiveness.

- The vast majority of counsellors would like than one session per a week with their patients.

- Counsellors had little awareness of the working of the referral system.

- General agreement among counsellors in of the need for training courses to improve their personal development.

Part Four Administrative Staff Members Questionnaire

7.10 Introduction

This part presents some of the views of administrative staff members about the current issues in working in that services. It aims to compliment earlier parts focus on quantitativeable analyses. Little research exists concerning the subjective experiences of administrative staff members working in mental health hospitals in Saudi Arabia. (Al-Subaie & Alhamed (1999).

This part of the study sought to examine seven major questions,

1) **What were the characteristics of administrative staff members?**

2) **Where there any significant different between aims and objectives among administrative staff members?**

3) **Where there any difference in the roles and responsibility amongst administrative staff members?**

4) **Where there differences service awareness, amongst administrative staff?**

5) **Where there differences in staff members view of the effectiveness of the services?**

6) **Where there differences between administrative staff members in their views of the referral system?**

7) **Where there differences between administrative staff members in their evaluation of personal development provision?**

7.10.1 Administrative staff members Results

The results of administrative staff members are presented in six sub-sections. in the first three items are analysed to identify the aims and objectives of services; in the second two items are analysed to identify roles and responsibility; in the third three items are

analysed to identify awareness; in the fourth three items are analysed to identify effectiveness; in the fifth, three items are analysed to identify referral, and the last section focuses on three items to evaluate personal development for administrative staff members in mental health hospitals in Saudi Arabia.

7.10.1 Question One: (characteristics of Ad. Staff members)

The four mental health hospitals in Saudi Arabia were randomly selected; there are no any major differences in the administrative arrangements in the four hospitals. 262 questionnaires were returned and 204 questionnaires were completely valid (55%). The Pie-chart. Illustrates the Administrative staff sample.

Chart 7.4 Administrative staff distribution
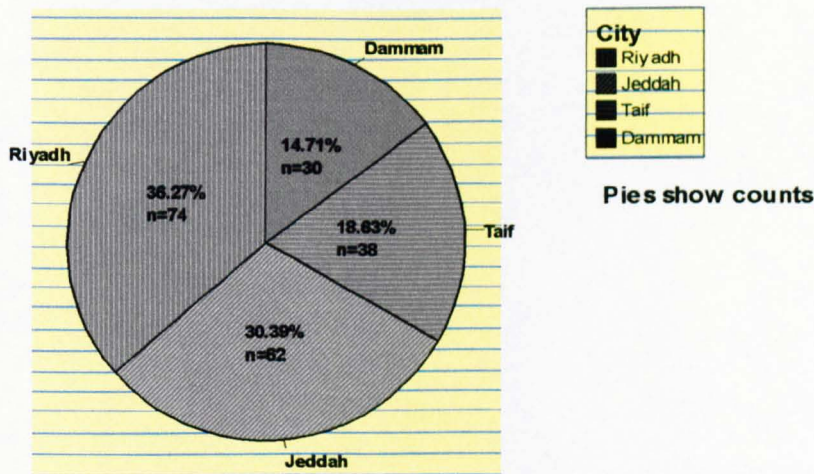
The chart shows that the administrative sample from Riyadh and Jeddah hospitals had around double the size of that of Dammam and Tai'f hospitals. More than half respondents were male (52%). The vast majority of respondents were Saudi (88%). In term of experiences of working in mental health hospital (42%) had experiences between 5-8 years, while only (7%) of respondents had more than 15 years of experiences. (67%) reported having already completed a graduate degree, (33%) had secondary school certificate.

Table 7.28 the Evaluation Related to Aims and Objectives

No	Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	.Aims and objective of mental health provision are not clear.	23 (11%)	48 (24%)	2 (1%)	65 (32%)	66 (32%)
2	Psychiatrists have insufficient knowledge of mental health aims and objectives..	17 (8%)	31 (15%)	3 (2%)	73 (36%)	80 (39%)
3	Counsellors have insufficient knowledge of mental health aims and objectives.	48 (24%)	107 (53%)	13 (6%)	29 (14%)	7 (3%)

The majority of the sample (64%) thought the aims and objectives of mental health provision are clear. There was also a general view (75%) that psychiatrists have sufficient knowledge of mental health aims and objectives, while a large majority (77%) of respondents saw counsellors having insufficient knowledge of mental health aims and objectives.

A one way ANOVA and t-test was used to investigate the differences between administrative as one group of different cities, gender, nationality, qualification and experiences. No differences were not found statically significant different in relation to any of these variables across the four mental health hospitals ($p > .05$).

7.10.3 Question 3

Table 7.29 The Evaluation Related to Roles and Responsibility

No	Statement	St-agree	Agree	Don't know	Disagree	St-disagree
1	Psychiatrists should have specific roles and responsibilities.	94 (46%)	73 (36%)	4 (2%)	20 (10%)	13 (6%)
2	Counsellors should have specific roles and responsibilities.	91 (45%)	68 (33%)	5 (2%)	34 (17%)	6 (3)

It is apparent from the table 7.29 that around (82%) of respondents would like to see a clearer specification of roles and responsibilities for psychiatrists, while (16%) denied that the psychiatrists should have specific roles and responsibilities. A similar proportion, the great majority almost (78%) of the respondents were generally very positive about counsellors should having a clearer specification of roles and responsibilities.

The results achieved through this analysis are striking between the administrative staff members in term of gender, age, nationality, qualifications, and experiences in their views of their roles and responsibility failure to find significant different, (p>0.05).

7.10.4 Question 4

Table 7.30 The Evaluation Related to Awareness of the mental health services

No	Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Ad. staff members should have good communication with other professionals	36 (18%)	91 (45%)	---	56 (27%)	21 (10%)
2	Psychiatrists have insufficient awareness of the mental health services.	58 (28%)	77 (38%)	---	52 (26%)	17 (8%)
3	Counsellors have insufficient awareness of the mental health services.	59 (29%)	83 (41%)	2 (1%)	48 (23%)	12 (6%)

The majority (63%) of respondents agreed for the need communication with other professionals.

More then (66%) of the respondents agreed that the psychiatrists have insufficient awareness of the mental health services where a larger proportion (70%) of respondents agreed that the counsellors have insufficient awareness of the mental health service. Interestingly, the evaluation of this aspect of the service by administrative staff was similar to psychiatrists and counsellors views.

7.10.5 Question 5

Table 7.31 the Evaluation related to effectiveness in mental health services

No	Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Ad. Staff members should have regular feedback from the hospital on their performance	82 (40%)	63 (31%)	4 (2%)	42 (21%)	13 (6%)
2	Psychiatrists services have a very low effectiveness in mental health patients	84 (41%)	78 (38%)	----	24 (12%)	18 (9%)
3	Counselling services have a very low effectiveness in mental health patients	37 (18%)	70 (34%)	---	49 (24%)	48 (23%)

Table 7.31 reveals that the majority of respondents (71%) supporting the idea of regular feedback from their hospital. More than (79%) of respondents asserted that the psychiatric services are very ineffective. In addition, more than half of respondent (52%) saw counselling treatment as ineffective.

Table 7.32 the Evaluation related to referral in mental health services

No	Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	The mental health referral system needs more clearer and flexibility	85 (42%)	90 (44%)	---	17 (8%)	12 (6%)
2	Psychiatrists have insufficient awareness of the referral process	93 (46%)	89 (43%)	---	14 (7%)	8 (4%)
3	Counsellors have insufficient awareness of the referral process.	132 (65%)	53 (26%)	---	12 (6%)	7 (3%)

The great majority of respondents (82%) saw the referral system as insufficiently flexible. They also admitted that the psychiatrists have a lacked awareness of the referral process (89%).

(91%) of respondents saw counsellors having less awareness of referral system in their hospitals. This is probably because administrative staffs who are dealing with patient referral were more aware of the sources of referral.

Overall, Administrative staff members were not satisfied with the referral process, and they saw other practitioners have insufficient awareness of referral system in their hospitals. However, no significant differences were found between despondences in relation to different hospitals (p= >.05).

Table 7.33 the Evaluation related to personal development in mental health services

No	Statement	Strongly agree	Agree	Don't know	Disagree	Strongly disagree
1	Mental Health practitioners should have very high qualification	119 (58%)	79 (39%)	---	4 (2%)	2 (1%)
2	Practitioners should have more training and education on mental health services	89 (44%)	112 (55%)	---	3 (1%)	---
3	There has been a steady decline in practitioners development in the last ten years	90 (44%)	100 (49%)	---	10 (5%)	4 (2%)

There was almost complete agreement (97%) amongst administrative staff that practitioner should have very high qualification (meaning. for example, a higher diploma or master degree). Similar by the majority of the sample (99%) saw need for practitioners to have more training and education courses. There was then almost complete agreement that mental health practitioners should have more training.

The great majority of respondents (93%) saw a weakness in practitioner's development in the last ten years. No statistical significant differences were found between administrative staff members in their views of practitioners personal development in mental health provision, (p=>0.5).

7.10.8 Synopsis

- Administrative staff believes that aims and objectives of mental health provision are clearer.

- Staff members saw the roles and responsibility for practitioners in four hospitals as not being specific and clearer.

- Staff members report the need for a greater communications with other practitioners, with almost agreement amongst among administrative staff that psychiatrists and counsellors have insufficient awareness of the mental health provision

- Administrative staff would like to have feedback from their hospitals, With Almost complete agreement between Administrative staff that the practitioners have a very ineffective their treatments out-comes.

- Administrative staff felt the referral system were insufficiently flexible, with a lacked of practitioners awareness of the referral process.

- All administrative staff supporting the idea of having a very high qualification, with more training courses for mental health professionals.

Part Five General Summary of Finding (Similarity and differences between practitioners)

7.11 Final though

Tables will summarises the data presented in this part, regarding to the practitioners view and evaluation of the dimensions of their questionnaire; aims and objectives, role and responsibility, awareness, effectiveness, referral, and personal development.

7.11.1 Aim and objectives

Table 7.34 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the items, aims and objectives

Questions		Psychiatrists			Counsellors			Ad- staff members			P
		N	M	SD	N	M	SD	N	M	SD	
Aims and objectives	1		1.84	1.02		3.60	1.18		3.79	1.07	
	2	158	2.00	1.07	100	3.60	1.18	204	2.79	1.07	.000
	3		1.65	.75		3.54	1.19		3.78	1.06	

As the table 7.34 shows, in aims and objectives, the difference in mean scores between practitioners are quite noticeable, in the three items. To test the differences between each per of group, Mann-Whitney U test (M-W) was used to investigate the differences between practitioners, the differences were significant at the level of .05 (p=.000). This indicated that there is a significant difference between three groups of practitioners in their views of the services. Psychiatrists show generally thought that the aims and objectives of mental health provision are clearer. While, counsellors and Ad staff member did not. This might be because a large proportion of psychiatrists control hospitals and use the values of the medical model in their practice.

7.11.2 Roles and Responsibility

Table 7.35 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the roles and responsibility

Questions		Psychiatrists			Counsellors			Ad- staff menbers			P
		N	M	SD	N	M	SD	N	M	SD	
Roles and Responsibilities	1	158	4.01	1.06	100	3.55	1.25	204	4.05	1.20	.000
	2		3.81	1.36		3.55	1.25		4.00	1.18	

As the table 7.35 shows, there were significant differences in means scores between practitioners in four Mental Health Hospitals, Using the M-W test to examine the differences between pairs of groups showed that the difference did not reach the level of significance between counsellors in four hospitals. The differences were significant between all three practitioners (M-W test, p= 0.00).

7.11.3 Awareness

Table 7.36 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the awareness

Questions		Psychiatrists			Counsellors			Ad- staff menbers			P
		N	M	SD	N	M	SD	N	M	SD	
Practitioners Awareness	1	158	3.96	.99	100	2.12	1.35	204	3.03	1.39	.000
	2		3.98	1.10		2.17	1.35		3.04	1.39	
	3		3.59	1.21		2.19	1.39		3.02	1.38	

Table 7.36 shown, there was a significant different between practitioners in their awareness of the services. There was agreement among practitioners, as the differences between each pair of practitioners are significant (M-W, p=.000)

7.11.4 Effectiveness

Table 7.37 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the Effectiveness

Questions		Psychiatrists			Counsellors			Ad- staff menbers			P
		N	M	SD	N	M	SD	N	M	SD	
Effectiveness	1		4.25	.87		2.78	1.53		2.30	1.34	
	2	158	4.03	1.04	100	2.78	1.53	204	2.31	1.35	.000
	3		1.77	.82		3.67	1.23		2.30	1.34	

As it is apparent from Table 7.37 that the mean scores between administrative staff and counsellors were close, but that for psychiatrists was higher. However the lowest position of these questions is statistically supported by all the samples as the differences are not significant inside each group. ($P >.05$). However, The differences are highly significant in this respect among the practitioners (M-W, $P=$ .000).

7.11.5 Referral

Table 7.38 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the referral system

Questions		Psychiatrists			Counsellors			Ad- staff menbers			P
		N	M	SD	N	M	SD	N	M	SD	
Referral	1		1.75	.99		3.68	1.22		1.72	.90	
	2	158	1.82	.99	100	3.66	1.22	204	1.95	1.15	.000
	3		1.80	.99		3.67	1.23		1.72	.90	

It is generally apparent from table that the great majority of the research samples strongly supported these questions (referral). However, there is general agreement among the practitioners' samples of the need to changing the current referral system. The differences were found to be significant between practitioners in their evaluation of referral system (M-W, $P.000$).

7.11.6 Personal Development

Table 7.39 view of the variable of the practitioners (Psychiatrists, Counsellors, and Ad staff member), for the personal development

Questions		Psychiatrists			Counsellors			Ad- staff menbers			P
		N	M	SD	N	M	SD	N	M	SD	
Personal Development	1	158	4.39	.85	100	1.92	1.44	204	3.97	1.24	.000
	2		4.32	1.15		3.05	1.70		3.84	1.38	
	3		2.00	1.13		3.49	1.49		3.95	1.26	

As the table 7.39 shows, the great majority of the research samples strongly supported the ideas of personal development. The agreements were found amongst practitioners of their needs for more training and higher qualifications. Difference between practitioners was absolutely significant (M-W, $P= .000$).

7.12 Analysis

This part of the study sought to examine six major issues.

    I. To determine the characteristics of Patients in mental health hospitals?

    II. To address issues relating to quality of the services.

    III. To address issues relating to patients knowledge and awareness of mental health services.

    IV. To address issues relating to effectiveness of the services for the patients perspective.

    V. To address issues relating to the patients views of referral system.

    VI. To address issues relating to patients needs.

7.12.1 Question 1: (Patients Characteristics)

This question is investigation characteristics of Patients in mental health provision, two findings may be worth noting:

Gender:
Figure 7.5 Gender of patients
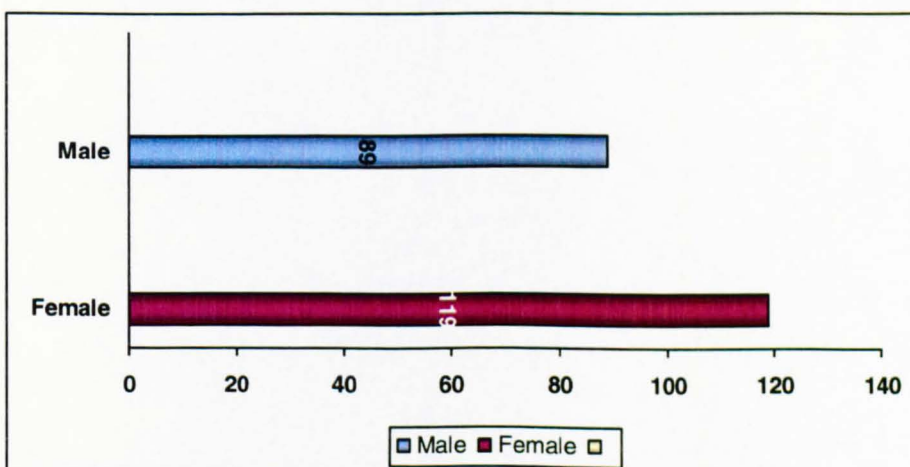
Females patients (N=119, 57.2%) outnumbered males patients 89 (42.8%). The finding

regarding this issue in the literature is very small, Al-Subaie and Alhamad (2000; 2002;

2003); and Al-majed (2003), all reported that male patients tend to seek help from

psychiatric hospitals more than females. They added that the male patients are more

likely to get psychiatric treatments than female patients.

This finding is surprising, given the nature of the Saudi culture and traditions. The

culture of Saudi society dictates that women are not allowed or expected to be out of the

house for long period of time, and families usually exhibit more tolerance to the illness

of females than they do for males patients.

Place of Residence
Figure 7.6 place of Residence of patient
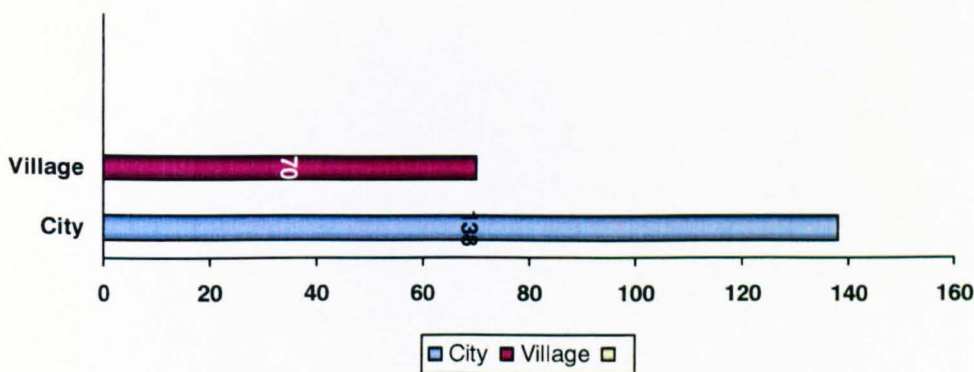
The majority of the patients (66.3%) were resident in cities. This finding has a

relationship with other variables such as level of education (Table 7.6) and hospital

location. For instance, if a patient lives in the village, the likelihood is that he/she would

be staying with immediate family or parents as the Saudi culture is such that most

villages lead their life with families and they will refuse the treatments from psychiatric

hospital as part of their culture. Also, if a patient is living in the city, the likelihood is

that he/she would be get treatment from the psychiatric hospital because public

transport and communication is easily available. in villages public transport is scarce.

In relation to the place of residence, one-way analysis of variance followed by a Tukey showed a not significant difference among patients in the four mental health hospitals, ($p > .05$).

7.12.2 Question 2: (quality of services)

Table 7.40 quality of the services

Statements	City	St-agree	agree	D-know	disagree	St-disagree
1. Mental Health services are less than it should be.	Riyadh	29 (44.6%)	29 (44.6%)	--	7 (10.8%)	---
	Jaddeh	16 (47%)	13 (38%)	2 (6%)	3 (9%)	---
	Tai'f	54 (64%)	23 (27%)	---	5 (6%)	3 (3%)
	Dammam	16 (67%)	6 (25%)	---	2 (8%)	----

89% of the patients have a general agreement that the quality of mental health provision are less than it should be. Nearly all patients rated were not thought to give any particular support to the current model of mental health provision.

Table 7.41 One-way Analysis of Variance to compare patients in four hospitals with their view of the quality of services

Hospital	M	SD	F	P
Riyadh	4.23	.91	.803	.494
Jeddah	4.23	.92		
Tai'f	4.41	1.01		
Dammam	4.50	.88		

One-way ANOVA showed no any significant different between patients view of the quality of services in four hospitals.

7.12.3 Question 3: (knowledge of the services)

Table 7.42patients knowledge of the services

Statements	City	St-agree	agree	D-know	disagree	St-disagree
2.Patients have less knowledge of mental health services	Riyadh	33 (51%)	30 (46%)	---	2 (3%)	---
	Jaddeh	13 (38%)	20 (59%)	1 (3%)	---	---
	Tai'f	44 (52%)	39 (46%)	1 (1%)	1 (1%)	---
	Dammam	10 (42%)	14 (58%)	---	---	---

98% of patients were had less knowledge of specific information about their hospitalisation and about the various aspects of treatments

Table 7.43 One-way Analysis of Variance to compare patient's knowledge in four hospitals

Hospital	M	SD	F	P
Riyadh	4.44	.66		
Jeddah	4.35	.54		
Tai'f	4.48	.58	.693	.756
Dammam	4.41	.50		

Table 7.43 presents a summary of the analysis of variance. It can be seen that the F value is .693 and the probability value (p=.756) indicating there is no significant difference among patient by hospital.

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Table 7.44 patient's treatment effectiveness

Statements	City	St-agree	agree	D-know	disagree	St-disagree
3. Psychiatrists have a very low effectiveness in their treatments	Riyadh	1 (2%)	4 (6%)	2 (3%)	28 (43%)	30 (46%)
	Jaddeh	2 (6%)	8 (24%)	---	10 (29%)	14 (41%)
	Tai'f	3 (4%)	4 (5%)	1 (1%)	25 (29%)	52 (61%)
	Dammam	---	1 (4%)	---	6 (25%)	17 (71%)
4. Counselling services have a very low effectiveness in their treatments.	Riyadh	---	6 (9%)	---	37 (57%)	22 (34%)
	Jaddeh	1 (3%)	5 (15%)	---	15 (44%)	13 (38%)
	Tai'f	1 (1%)	3 (4%)	---	34 (40%)	47 (55%)
	Dammam	---	2 (8%)	---	11 (46%)	11 (46%)
5. The frequency of Psychiatrists with patient should be more than once weekly.	Riyadh	27 (41%)	35 (54%)	---	3 (5%)	---
	Jaddeh	13 (38%)	20 (59%)	---	1 (3%)	---
	Tai'f	41 (48%)	30 (35%)	---	10 (12%)	4 (5%)
	Dammam	3 (13%)	17 (70%)	---	3 (13%)	1 (4%)
6. The frequency of Counsellors with patient should be more than once a week.	Riyadh	49 (75%)	15 (23%)	---	---	1 (2%)
	Jaddeh	21 (62%)	11 (32%)	---	---	2 (6%)
	Tai'f	65 (77%)	17 (20%)	1 (1%)	2 (2%)	---
	Dammam	11 (46%)	10 (42%)	1 (4%)	2 (8%)	---

All four questions were related to the integration of different treatments from both practitioners (psychiatric and counselling). More than (87%) of patients agreed with the effectiveness of the psychiatrist's treatment. The same proportions (89%) support the current model of counselling and its effectiveness. The response to those questions strongly supported the conclusions drawn from the psychiatrists and counsellor's questionnaire which highlights the strong support for their treatments.

89% of respondents were support the idea of seeing the psychiatrists more than once a week. And 95% of patients in four hospitals were preferred to have sessions with their counsellors more than once a week.

Figure 7.7patients preferred treatment
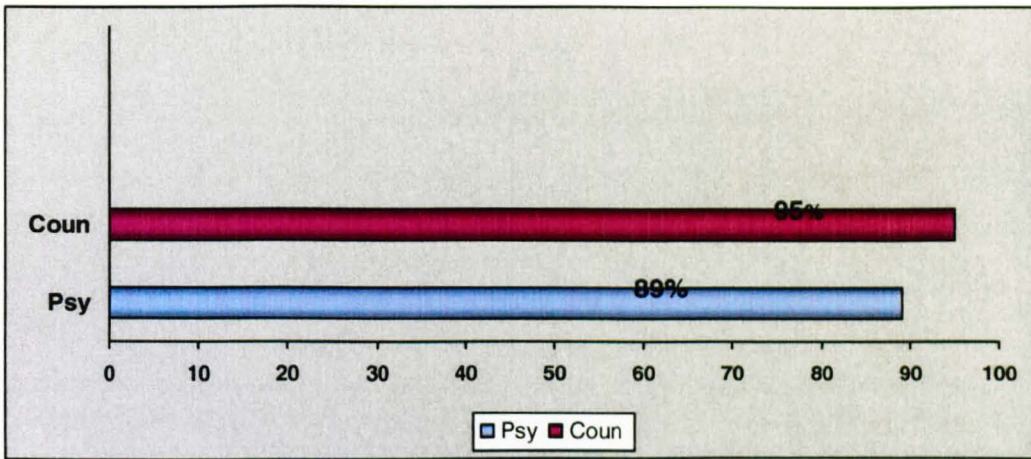
It can be seen from Figure 7.5 in both approach of treatments the majority of patients

agreed to the need to have more than one session per a week, (89% for psychiatrists and

95% for counselling).

Putting all the above questions measures into a one- way ANOVA, showed no overall

significant difference between the patients view in four mental health hospitals ($p > .5$).

7.12.5 Question 5: (patients view of referral system)

Table 7.45 Referral system

Statements	City	St-agree	agree	D-know	disagree	St-disagree
7. Patients have less awareness of referral process.	Riyadh	49 (75%)	15 (23%)	---	---	1 (2%)
	Jaddeh	18 (53%)	11 (32%)	1 (3%)	2 (6%)	2 (6%)
	Tai'f	65 (77%)	16 (19%)	1 (1%)	2 (2%)	1 (1%)
	Dammam	11 (46%)	10 (42%)	1 (4%)	2 (8%)	---
8. Patients referral system need more flexibility	Riyadh	49 (75%)	15 (23%)	---	---	1 (2%)
	Jaddeh	23 (68%)	8 (23%)	---	2 (6%)	1 (3%)
	Tai'f	65 (77%)	18 (21%)	1 (1%)	1 (1%)	---
	Dammam	16 (67%)	8 (33%)	---	---	---
9. Referral between departments in hospital should have more clear information and process	Riyadh	40 (61%)	24 (37%)	---	1 (2%)	---
	Jaddeh	24 (71%)	7 (20%)	---	2 (6%)	1 (3%)
	Tai'f	53 (62%)	28 (33%)	---	4 (5%)	---
	Dammam	8 (33%)	13 (54%)	---	3 (13%)	---

From Table 7.45 it can be seen, (93%) of patients in the four hospitals, did not know about their referral system and the range of referral procedures. As might be expected, a large majority (97%) of patients saw the current referral system as inflexible, those in each hospital held the view that the referral systems are rigid. This view may reflect a general belief abuts the patient's ability to understand their referrer. Another cause might be lack of awareness of the patients of the current referral system.

The lack of awareness may be confirmed by the critical view given to the next question related to patient's referral inside their hospitals. (94%) of patients saw themselves as not having information about referral procedures between hospital departments. The problem inferred in relation to the previous questions regarding the lack of awareness of patients to the referral system may also contribute to understanding the root of such problems

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7.12.6 Question 6: (Patients Need)

Table 7.46 Patients Needs

Statements	City	St-agree	agree	D-know	disagree	St-disagree
10. There are weaknesses in counsellor's abilities to understand patient's needs.	Riyadh	42 (65%)	23 (35%)	---	---	---
	Jaddeh	18 (53%)	16 (47%)	---	---	---
	Tai'f	62 (73%)	21 (25%)	1 (1%)	1 (1%)	---
	Dammam	3 (13%)	18 (75%)	1 (4%)	1 (4%)	1 (4%)
11. There are a weaknesses in psychiatrists abilities to understand patients needs	Riyadh	48 (74%)	14 (21%)	3 (5%)	---	---
	Jaddeh	23 (68%)	11 (32%)	---	---	---
	Tai'f	42 (49%)	42 (49%)	---	1 (1%)	---
	Dammam	8 (33%)	15 (63%)	---	1 (4%)	---

The majority of the respondents (97%) clearly saw their counsellors as having little ability to understand their needs. However this question might be given lower priority, partly because of the patient's experiences, so that the patients did not want to show support for counselling which might add more attention on their needs. Only (1%) thought that their psychiatrists had understood their needs.

7.12.7 Synopsis

- **Almost all patients rated the quality of services as unsatisfactory.**

- **All patients point out they did have little knowledge and information of a treatments strategies.**

- **Almost all patients felt that the treatment they received from psychiatrists and counsellors was effective, and reported the need for more sessions with their practitioners.**

- **Patients felt their referral system inflexible and not clearer.**

- There was general agreement amongst patients that they did not have self-awareness of the referral system.

- The vast majority of patients felt that the psychiatrists and counsellors fail to understand their needs.

Chapter Eight

Chapter Eight Exploratory Interviews

Introduction

Analysis

Sample Characteristics

Psychiatrists Interview

Counsellors Interview

Patients Interview

Administrative Staff interview

Chapter Eight Exploratory Interviews

I want to understand the world from your point of view. I want to know what you know in the way you know it. I want to understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them, will you become my teacher and help me understand? (Spradley, 1979, p.34).

Introduction

This chapter reports an exploratory field study to examine the work of mental health service practitioners in Saudi Arabia.

As this study was exploratory in nature, the researcher did not follow a particular agenda or develop particular ideas, but rather examined the mental health field through the views of the interviewees'. Result are presented in five sections: (1) Sample Characteristics, to give some details about this study's sample, (2) the psychiatrists interview (3) counsellors interviews, (4) administrative staff member interviews, (5) patients interviews.

8.1 Analysis

A qualitative research methodology was use to elicit data from twenty eight mental health workers and twelve patients informants. The focus of the analysis was to discover psychiatrists, counselors, patients, and administrative staff perspectives. The data analysis involved identification of patterns to identify of credible, confirmable, and meaningful themes.

The process of data analysis as described by Huberman & Miles (1994) was followed. It began with the lower level of analysis of raw data (i.e. words and sentences) and descriptors, followed by the identification of recurrent patterns, and when appropriate the generation of most comprehensive and abstract themes. The raw data derived from

the transcripts of the interviews with the interviewee, were read and reviewed carefully to identify ideas reflective of their practice.

However, findings were not derived a *priori*, but obtained from informants in their natural environment practices. In the next stage, all statements and field notes related to the practices as well as to conditions that influenced services and practice were manually coded. The descriptive categories or abstraction of themes, which constituted the last stage of content analysis, involved identifying all the practitioners' activities that emerged. That is, all of each response was used to identify a theme or a descriptive category. In this way no data were excluded. The analysis considered the research questions as well as the larger gestalt of services features.

8.2 Sample Characteristics

The main scope of this study was to interview people most involved with the mental health services in Saudi Arabia. It was not feasible to study the whole population of the mental health map, because of the cost and the time efforts that would be involved. Therefore, it was decided to undertake interviews to obtain data from the following sources.

I. Psychiatrists in four mental health hospitals (Riyadh, Jaddah, Ta'f, and Damman);

II. Counsellors; whose practice as a mental health counselors in these hospitals;

III. Administrative staff members, including those responsible for the out-patient unit in the four hospitals;

IV. Patients, whose received treatment from hospitals in both in and out-patients departments.

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8.1 The breakdown of the sample into the four categories

Categories	N	Percent
Psychiatrists	8	20%
Counsellors	6	15%
Patients	12	30%
Administrative Staff	14	35%
Total	40	100%

The sample chosen were from different backgrounds in their experience, and most involved with the mental health hospitals and they are more likely to be aware of the services. The sample included three non-Saudis, one of whom was a psychiatrist and two were administrative staff members.

The time spent on the interviews is shown in chart 8.1

Chart 8.1 time spent on the interviews with all participants
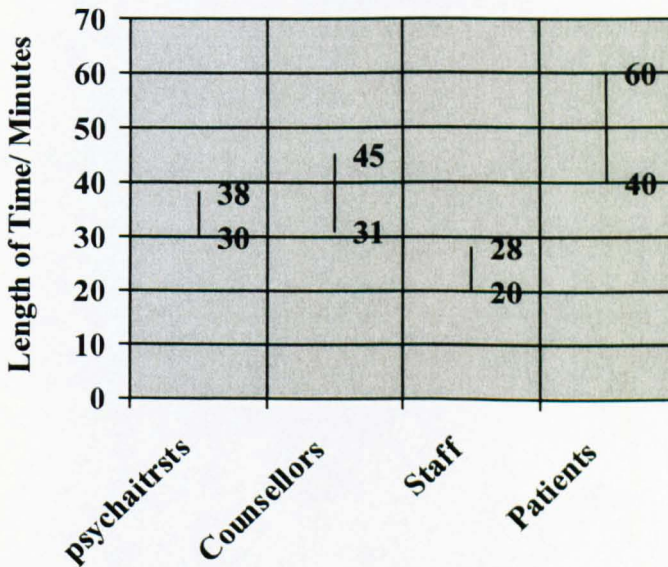
Chart 8.1depicts the length of time for respondents are different, for instance, psychiatrists interview started from 30 to 38 minutes, counsellors interview were started from 31 to 45 minutes, staff interview started from 20 to 28 minutes, and patient interview started from 40 to 60 minutes. The interviews were typically conducted in the four mental health hospitals **(each hospital proved a place for interviews and the interviews took place in a relaxed atmosphere and the respondents talked freely without appearing nervous).**

8.3 Psychiatrist's Interview

Table 8.2 Responses to semi-structured interview for psychiatrists,

ITEM	Yes.	No.
Understanding the Aim and objectives	7	1
There is evident weakness in awareness of the patients needs	8	0
the current referral procedures not clear	0	8
Roles and responsibilities are Involve with patient treatments.	8	0
There is a clear medical diagnosis.	7	1
Specific government agencies provide a great help to patients.	8	0
Regular meeting between the psychiatrists, counsellors and ad. Staff.	1	7
availability of Psychiatrists	0	8
There is a need for specific training courses in mental health provision.	7	1
Psychiatrists are not able to achieving their goals	0	8

In Table 8.2 the voice of participants are placed into ten main categories. They are reported here as quoted in the respondents own words. The depends on the particular hospital; a benefit more important to one hospital might not be at the same level in another.

8.3.1 Classification of Patients' Problems

Psychiatrists were asked, *"How do you describe the problems that most patients present with to the unit?*

All informants' classifications in describing patients' problems consisted of shortened, descriptive medical diagnosis. Terms used were "schitzy," manic; depressed; paranoid; drug abuse and alcoholism. The term "schitzy" is a shortened version of schizophrenic, conveying that the patient is "out of contact with reality" and suffers from hallucinations and/or delusions. A patient could be described or classified as having more than one of these characteristics concurrently, or the terms used to describe the patient could change over time. The terms were not mutually exclusive.

However, one patient exhibited symptoms of hallucinations, delusions and confusion while the other was very hyperactive and difficult to control. The psychiatrists called the first patient "schitsy" and the second patient manic.

"Schitsy." Generally a patient who is termed schitsy is a patient who is experiencing hallucinations or delusions, or is confused and disoriented. Schitsy patients are the first main category that psychiatrists used in describing patients. Statements made by psychiatrists to illustrate this point are:

> **The patients that we most often identify as being out of contact with reality are those diagnosed as schizophrenic. These have two main symptoms: delusions and/or hallucinations. The two most common types of hallucinations involve sight and hearing, and these are the hallucinations that are experienced by our patients at [this] hospital. Not all patients talk about their hallucinations to us.**

The second main category that psychiatrists used was manic. They described a patient as being "manic" if the person is hyperactive, disorganized and are experiencing an

elevation of mood. These patients do not necessarily carry a medical diagnosis that indicates mania. One psychiatrist made the comment

> **At times the energy and creativity of manic patients could be used to benefit the unit.**

One of the psychiatrists had a different opinion, he add that

> **Not all patients we describe as "manic" hold the diagnosis "bipolar disorder, manic."**

Another descriptive term that was used by psychiatrists is paranoid. Patients are termed paranoid if they looked suspicious or stared at people. One psychiatrist went for more information **"I find 'paranoid' patients extremely difficult to care for".** However, the other psychiatrist confidently stated his experiences with paranoid patient:

> **U is a paranoid patient. He sits and stares at various people on the unit for long periods of time. He has a very intent, hostile stare, as if he knew what someone is thinking and does not like it. When I approached him or asked him what he was looking at, he often moved away from me. Frequently I then became the object of his stares."**

All the psychiatrists reported that Saudi patients are infrequently diagnosed as having depression as opposed to mania, and suggested several reasons to account for the low reported cases of depressive illness among the Saudi's, as the following statements illustrate:

> **We have a lot of patients who are depressed, who are unable to take care of themselves, feeling hopeless, not interested in any thing at all, isolated, sleepless name it and you'll find it...our main concern with these patients is observing them very closely.**

On the other hand, some of the psychiatrists interviewed had different views. A psychiatrist who worked as a Head of Psychiatric Department in Jaddeh M.H.H stated:

> Maybe we, indeed, suffer less depression, and that is
> because, I think. Pathogenesis conditions for depression
> such as divorce, alcoholism and drug abuse are less
> prevalent in Saudi Arabia, whereas mutual help through
> an extended family or neighbourhood alliance is more
> readily available for those under stress in Saudi society.

Psychiatrists are particularly concerned if the patient had ever attempted suicide or was expressing a desire to do so. Psychiatrists very closely observed patients who had made **"real suicide attempts"**. They see this as an indication that the person might make another attempt at any time and that the next effort might be successful. Fortunately, during the period of this study, there were no successful suicides in the psychiatric hospitals. The following statement reports additional reflections:

> **Actually, some depressed patients admitted to this unit
> had made very real suicide attempts. I mean very serious
> and potentially lethal, made at a time and place where the
> person was unlikely to be found.**

A senior psychiatrist expressed the view, that the depressed patients in Saudi society do not display **real suicide attempts,** for him this view was a reflection of Saudi culture:

> **Not all the incidents are real suicide attempts. And I
> believe a Saudis reluctance to express or discuss one's own
> feelings, especially to anyone outside of the family, may
> play a part in inhibiting the expression of depression.**

He added that:

> **We have more educated depressed women than
> uneducated. I think this could in part be related to the
> patriarchal structure of the Saudi family, the father or the
> oldest son still holds absolute power for decision-making
> causing severe conflicts to educated women**

8.3.2 Other Diagnosis

Generally, all the interviewees stated that they made little connection between diagnosis, and patients treatments about services value, **"I think I place much importance on diagnosis and patients behaviour, by that I suppose I'm doing my**

best". However, despite such statements, other statements even by the same reason suggested that diagnosis was considered significant in certain ways:

> **I think the relevance I place on diagnosis is if it's alcohol related diagnosis or substance related diagnosis, or perhaps personality disorders, I think if the diagnosis is one of a psychotic nature then I'm more likely to try and treat the patient with medication, but only if it seems feasible at that time.**

However, Psychiatrists referred to some patients as being drug abusers and/or alcoholics **"Our patients mainly abused alcohol, marijuana, hashish, heroin and prescribed drugs such as Valium".**

Essential in this classification were behavioural changes associated with regular use of substances such as impairment in social or occupational functioning as a consequence of substance abuse, inability to control use of or stop taking the substance and the development of serious withdrawal symptoms after cessation of or reduction in substance use. Psychiatrists reported that this term is the least frequent category in their settings. Selected statements illustrate this point.

> **We don't have too many substance-abuser patients and that may be because of the social and religious factors restricting drinking; you know that alcohol is forbidden by Islam and there is a strong taboo against bringing alcohol into the home in the traditional Muslim family, limiting its availability for drinkers. However, with recent social changes such as urbanization and breakdown of traditional Muslim family, we observe that drinking is also becoming associated with social and family problems such as traffic accidents and divorce.**

8.3.3 Causes of the patients problems

In relation to the question: *"How do Psychiatrists describe the causes of the presenting problems at their setting?*

All Psychiatrists described two factors:

➤ Genetic causes i.e. problems related to heredity

➤ Psychosocial causes i.e. problems related to emotional and personal life. Below

are statements of what the Psychiatrists said about these factors.

> **I believe that schizophrenics inherit a genetic vulnerability for the disease rather than the disease itself. We have many schizophrenic patients who are related, such as cousins**

Other psychiatrists had different views:

> **I believe social factors have some effects in causing depression. For example, the destruction of village life and migration to cities have deprived the Saudi individuals of social support and community living, and thus increased their insecurity and isolation. I have many depressed patients who moved to the cities to work or study. These considered distrust as the highest manifestation of wisdom. So they isolate themselves... no friends, no social activity... you know, 1 think this could partly explain their developing of depression.**

8.3.4 Aims and Objectives

All eight psychiatrists offered their evaluate opinion on the issue of aims and objectives.

"our aim and objective it's very clear, and Ministry of Health have a clear message to all psychiatrists about their aims and objectives", but one interviewee (from Dammam M.H.H) claimed that:

> **The quality of mental health services and the access of psychiatric care provides to the patients, well I think, it is how do I want to put it just the little bit I know about psychiatric care systems. First of all you have to have clear aims, in order to be part of psychiatric care system, and you are not even going to be at the door of services if you don't have a clear aims and objectives.**

This view was considered as a negative statement about issues of: **patient's needs, and psychiatric care systems.**

Four psychiatrists shared the view that the lack of awareness of patients needs is a common cause of many problems: **overstay; family communications; patients discharge; treatment and medications.** One psychiatrist (who acted as a Jeddah

M.H.H Manger) concluded that the "most problems we are facing at the moment are patient needs and how to increase our awareness of their needs".

8.3.5 Referral system

A number of comments were made to the effect that some referrer's patients know how to frame referral so that they have to be evaluating by system. Psychiatrists themselves had clear ideas about referral. For example, one psychiatrist pointed out "I think some people are clearer about how they put thing, they know the magic words". Whilst sometimes this was simply good communication skills on the part of the referral, at times they were felt to be deliberately misleading, as the junior psychiatrists explained that:

> sometimes it's obvious when you have seen a referral that it's not an appropriate one, for instance, a lot of these referrals are hyped up, you know the police, especially out of hours the police officers says definitely suicidal otherwise they know you are not going to accept the patient.

Whilst psychiatrists commented on what they perceived as distortion in referral information, there did also seem to understand the problems of the referrers, the former participant explained that: "I think we have many problem for our referral system, for example, when the police or local authorities referred any patients we have to accept the patients without any obligation".

New junior psychiatrists may be apt to refer unnecessarily, but this was due to their newness "we don't need the referral procedures because we make our own decisions about our patients". He adds, "If there are no beds you get more referrals" this statement related to the idea that psychiatrists having problems of patents admission when they were unable to access in-patient beds.

Interviewees were at times suspicious of whether referrals were appropriate to their hospital; they showed varying levels of sympathy and understanding in explaining the actions of dubious referrers:

> **Reefers generally want what is best for the patients at that time; generally I think other government agencies refer because they have stuck their hands up in the air and give up the ghost.**

8.3.6 Feeling about the admission

With all eight psychiatrists interviewed, there were ranges of feeling expressed about having to admit patients to hospital: **"I'm very loath to press for admission, it just sometimes seems, well I known it shouldn't, but we are there to keep people out of hospital"**.

A psychiatrist from Jaddeh M.H.H found the experience of being able to keep significant numbers of individuals out of hospital very positive, but when they did require admission, it was just **" part of the spectrum of care"**, not negative in itself. In addition, six of the respondents shared the view that the lack of care giver outside the hospital is a common problem precipitating referral.

Psychiatrists stated that, some referrers acted in a way the psychiatrists felt was deliberately intended to push them into having to admit to hospital, this often produces an emotional response:

> **Really hard if someone said to you (this patient has got suicidal thoughts, and we cant guarantee if he will be safe) you are left with no choice, even though you know that person probably wouldn't kill himself.**

Individual psychiatrist's feelings about patient's admission were seen as making the job of working with them, and keeping the patients out of hospital, more difficult. A psychiatrist's form Riyadh M.H.H emphatically claimed that:

> The truth is, it's very stressful to try and keep someone out of hospital who you don't like and you find it difficult to relate to, but there is other times as well, I have actually thought if we just admitted them in the first place they would be alright by now, but that does not particularly affect the decision making of admitting them, that's more an after thought of what is going on really.

In the other hand all eight psychiatrists interviewed stated that after admitted patients face **overstay as another problem** of the hospital, **"we accept patients and after a few weeks we facing overstay problems"**. That not only produces adverse effects on the patients themselves, but also has negative effects on the other patients and the treating doctors as well, **"we do have a waiting list because of the overstay problem"**.

8.3.7 Roles and Responsibilities

All interviewees, when discussing roles and responsibilities, specifically raised their roles with: the patient; the organization; other professionals; and team meetings. In addition to the formal responses, all the psychiatrists shared the view that **lack of information** about the hospital **"regulations"** is a common problem leading to misunderstanding of their roles and responsibilities **"I am a psychiatrists and my work is the most important job in this hospital, but so far I haven't found any specific information about my job regulations"**.

8.3.8 Ripple effect

It is clear from the data that monitoring patients' physical care reflected an essential function of the psychiatrist's role; it involves three types of responsibility. These are:

- *Diagnosis's, giving medications and observing side effects.*

- *Promoting the Patient's Strength*

- *Praising and Encouraging Patient's Efforts.*

8.3.8.1 Giving Medications and Observing for the Side Effects

All participants expressed a strong regard for ordering and giving medications; ensuring patients took the medications and observing their side effects. In the following descriptors, the psychiatrists indicated that their major goal was giving medication and observing its side effects. This goal was achieved by encouraging patients to take their medication and reporting any side effects. Statements from the psychiatrists pointed to the value of giving medications as a major goal.

> **Giving medications and observing their side effects is our biggest responsibility from the hospital point of view. We believe in counselling as a way of therapy, I mean, the doctors, but family and the majority of patients see medication as a main way to control the illness or behaviour. So we had to make sure that patients take their medications, and if not we should report it as soon as possible. Sometimes we give medications in syrups form to assure compliance.**

The psychiatrists also confirmed that providing medication is influenced by the patient's culture:

> **We give medications and that is not always easy. I mean, some patients do not trust anything foreign like medications, or they don't feel they need medication any more.**

8.3.8.2 Promoting the Patient's Strength

One activity that psychiatrists engage in, is promoting the patients' strength. The psychiatrists in this study described patient's strength as **"the resources of patients that have been used to cope with his illness... this could be their children, family, occupation, or religion"**. All participants' described promoting the patient's strength by acknowledging the patient's progress, **"We use our religious skills to help patients cope with life"**. However, Psychiatrists described patients as not always recognizing their own progress, for this reason, the psychiatrists emphasized the importance of

bringing changes in the patient to the patient's awareness as part of promoting the patient's strength.

> Maybe what I do is not a big thing, or you can't see it, but if you know the patient... it is a big thing! Even if you see a little change, that is a big success... even just the little thing to the patient... it is very important to recognize that little thing and show it to the patient, and say `you are doing well'... sometimes they do not recognize their own progress so you have to point it out to them.

Five of the eight participants said promoting the patient's strength is also accomplished through addressing the strength already present in or shown by the patient. It pertains to helping the patients remember what was important to them, such as the person involved determining what the patient cared about, this could be **"religious leader"** or their **"children, family, occupation or spiritual cultural beliefs"**.

8.3.8.3 Praising and Encouraging Patient's Efforts

Encouraging the patient's strength was also accomplished by the psychiatrists approving the patient's efforts, such as the patient remembering to pray or fast during holy month. **"Our patients are mainly Muslims who place great importance on performing the obligatory prayer along with their beliefs which are required according to Islamic tradition".**

All participants described encouraging patients as important in making the patients feel good about themselves, and provided the patient with verbal reassurance such as "**you just have to trust, you have to have faith, and you have to carry on**". In addition, all psychiatrists emphasized that they encouraged patients who were discouraged with their progress by utilising the culture knowledge and experience with other patients in similar situations. A most potent reflection of the culture comes from consultant psychiatrists, who act as a Riyadh M.H.H:

> I think my beigest responsibility is looking at the patient's strength and that starts from the beginning when they first come in. The patient's strength could be a family member or it could be their religion. Sometimes they have a skill or a profession that they have come from which you can get into; that you can address to help them remember the strengths they have, so the patient can get into accomplishing their activities of daily life again.

This interviewee aimed his responsibility at the patient's culture by addressing the strength that was already there by helping the patient focus on the things they did when they were well.

8.3.9 Communication among Themselves and Organization

All participants evaluated the services in terms of regular meetings; they reported that they did have a communication with others (**social workers, nurses, counsellors, and for other members of the interdisciplinary team**).

One of the ways in which the participants maintaining communication with others is by giving and receiving information, support and suggestions to social workers and nurses. This involved giving "**shift report about patients**", diagnosis for "**new patients**" and asking for advice in handling situations in a more productive manner.

> Communication with other practitioners is most important stage in our working idea for example, in shift reports; we give and receive information about the patients' conditions. They consist of stating the patient's referral, name, ward and room number, medical diagnosis, medications, test results, tests to be done and any abnormality in the patient's general condition such as eating and sleeping patterns, behavioral and emotional changes

Three participants considered lack of communication as a major cause of many patients problems, such as: "**patient's diagnosis, counsellors and social workers awareness of**

patients file". Their reasons were that, "most of the psychiatrists are not responsive when they carry out their duties to communicate" secondly, "communication with the hospitals bodies is routine work, but it is also a tedious procedures". They delay in response and lack of co-operation from the relevant bodies creates a barrier for the practitioners in fulfilling their task.

8.3.10 The Organizational Perspective

All participants said the availability of additional professional staff would increase the quality of service and so give more attention to the treatment of the patients, "The sad part is when we cannot give patients the care they need when we are so short of staff. It is frustrating when patients get the impression that we do not care". The shortage of psychiatrists seems to have had an overwhelming influence on the practice of Saudi's psychiatry. Practically all participants complained about their inability to provide their ideal of good patient care because of staff shortages. The head of psychiatric unit in Jaddeh M.H.H confirmed this issue:

> Our biggest problem is understaffing. You cannot take care of patients well if you are one psychiatrist to 21 or 30 patients. I have to prioritize my work, you feel frustrated because you do not have enough time to understand what patients really need. To really get to know the patients, you need time.

The psychiatrists unanimously expressed frustrations with the inability to provide adequate patient. Seven of the psychiatrists considered the training courses and training programmers as the most important issues in mental health provision. A Head of the psychiatric unit in Dammam M.H.H offered the following appraisals:

> If I had the power to change service delivery I would do it through education, so that if the administrators and counsellors, understand the needs of our people. And they're the ones who have the power to help them.

He has ideas about other practitioners:

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So, I think we need more academic training sites for language and specific training. I think that it would be a very good idea if we could help other practitioners get regional accreditation for their works. We're working with the King Saud University right now to help them get their accreditation by training their faculty most of whom don't have a degree in clinical psychology so that they can become regionally accredited so our students can be trained over there too and their students can be trained over here as well.

8.3.11 Synopsis

The psychiatrists interviewed, made the following suggestions to improve the service:

1) Creating clear policy with other governmental departments, so as to facilitate better co-ordination and co-operation between these departments and the psychiatric hospitals.

2) Setting up of a psychiatric clinic in each primary care center, in order to reduce the burden on the psychiatric hospital. Thus, patients would be able to seek treatment at an early stage of their illness.

3) Create specialised centres to provide professional care for the patient's e.g. Counselling Centre, Occupational Therapy Centre, Out-patient Treatment Centre.

4) A more focused role should be undertaken by the Ministry of information to create greater public awareness about mental health services, through perhaps, T.V and local newspapers.

5) Increase the number of psychiatrists, and other mental health practitioners.

6) Creating new training courses for psychiatrists and other practitioners.

7) Availability of convenient transportation for patients, especially those referred from outside cities.

8.4 Counsellors Interviews

The following results relate to the interview data reflecting the Counsellors view of their practice.

Table 8.3 Responses to semi-structured interview for Counsellors.

ITEM	Yes.	No.
Understanding the Aim and objectives	0	6
There is evident weakness in awareness of the patients needs	6	0
the current referral procedures not clear	6	0
Roles and responsibilities are Involve with patient treatments.	6	0
There is a clear medical diagnosis.	5	1
Specific government agencies provide a great help to patients.	4	2
Regular meeting between the Counsellors, psychiatrists, and ad. Staff.	0	6
availability of Counsellors	0	6
There is a need for specific training courses in mental health provision.	6	0
Counsellors are not able to achieving their goals	0	6

8.4.1 Professional identity

All the participants perceived themselves as being psychologists. Two participants defined their profession as academic, one as a religious, two as researchers and one as a scholar. All participants defined their professional identity as clinical counselling practitioners.

8.4.2 General view of the services

By way of introduction, interviewees were asked the following open question: *What do you think about counselling services in mental health?*

This was not the sort of question which asked for a ranked assessment; however, many interviewees started their replies by attempting such an appraisal. The interviewee responses were, **"Less than good and does not satisfy patients needs, it could get better"**. **"The whole service needs to have clearer idea as to how it should be; I hope it is going to be better"**. Another counsellor added **"I'm going to take a very rigid view here. Mental health counselling is just an arm of society. We reflect social beliefs. We are part of the system whether we like it or not, and yes, there is a need to change the counselling policy in mental health"**. The reasons for the services problem are complicated, **"Although the problem is too old and too big, it is solvable"**. He believed that it is not possible to point to any one reason for the current weaknesses. In addition, he argued that the important thing is **not to know the reason,** but to **alleviate the problems.**

However, another participant aimed his evaluation in terms of western countries, **"It is not good. Western countries give better value and have better services than here"**. He says that patients do not **receive an appropriate service**. A counsellor who acts as a Head of a unit in Riyadh M.H.H had a different opinion:

> **This is an old problem. There is dissatisfaction with the whole service in general. And I think, the mental health system is complicated and it is difficult to judge it. All the nations of the earth complain about their mental health services.**

He suggested that:

> **There is a need to change the whole policy.**

It can be said that all counsellors experiencesed dissatisfaction with the whole service or **"much ado about nothing"**. However, there is some optimism about the changes

being applied to the counselling services "**The management and policy of mental health is very weak, but there is some optimism regarding improvement of the services**". Whilst some of the Heads departments were more formal and diplomatic in expressing their opinions "**The service needs to be re-evaluated and the counselling service is currently less than it should be**". In addition, he felt in a weakness in his practices. As he himself said "**The effectiveness of counsellor practice is very weak**". It could also be noted that the views of Heads of the counselling unit were more optimistic than other participants.

All participants raised the same issues criticising the poor standard of counselling services in their hospitals. In addition, they all mention weaknesses of **understanding patient's needs**, but to different degrees "**there are noticeable weaknesses, in relation to patients needs, but not only in the counselling services, but in all of the mental health services**". On the other hand, some of the people interviewed had different views "**I do not like exaggeration and I want to be realistic, the current awareness of patients needs is not bad, and I think we should follow the psychiatrist's view of our patients needs**".

8.4.3 Aims and Objectives

All participants offered comments and opinions about the counsellors aims and objectives. One pointed out that "**counsellors cannot be sure that if their aims are reflective of the actual practices**", or whether they are "**biased**", or "**based**" on unclear aims and objectives. Another participant confidently stated that "**while the mental health system has been improving for a number of years, counsellors ability to understood their aims has been decreasing**".

All participants shared the view that the current aims and objective should change "**I think to solve this problem we must have a clearer aims**". In addition, five of the

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counsellors interviewed agreed in their optimism about the arrangements for changing their aims. The Head of Counselling Unit in Riyadh M.H.H mentioned that the Ministry of Health is about to conduct a new scheme of evaluation in the field of counselling, which will help counsellors to better understanding their purpose.

There was a difference in opinion in the importance of the effort that has been made. Two participants argued that the effort that has been made has been superficial rather than reaching to the core **"it's about psychiatrists and their management of mental health hospitals, because we don't have the power"**. They believed that the changes have been made in the hospital, but not in the service a whole. This change cannot be described as a counselling reform, but rather as a management's change **"I felt that my practice as a counsellor was being undervalued"**. Yet, there was a distinct feeling among the participants that changes in counselling practice have begun to take an active part in addressing patient's needs.

8.4.4 Roles and responsibilities

Some individuals had a negative view and responsibility in relation to the services **"It is complicated, it can be changed in one day"**, while some others had opposite views **"you know we have roles and its clear, but I think many counsellors do not understand their responsibilities"**.

Three participants felt that their roles are intertwined with the psychiatrist's roles, typical of the other side would be replies such as:

> **In the last ten years we started to have very specific roles in this hospital, we follow psychiatrist's lead for treating our patients.**

However, another counsellor argued:

> **Our main responsibilities are with patient's treatments and have a number of sessions with them. But the most responsibilities we have to take are to make sure that patients are in the right place and help patient's in**

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their communcation with his or her family, and
sometimes we examine patients by using psychological
tests.

All participants cited **respect** and **patience** as values they had learned early in life and

this prevailed in their roles with patients. In the following discussion, respect is

presented first followed by patience. Selected statements from counsellors illustrate the

significance of respect in their **cultural tradition** and how this value influenced their

care of patients and the relationships with patients and others. **"We were taught to**

respect people, not just talk to them but know them. Saudis society has respect

for other people." All informants used the respectful term "sister" or "Mrs." when

speaking with the researcher. Respect is therefore a generic practice, which counsellors,

integrated in their practice in a professional hospital context. In addition, all counsellors

described how their families instilled the value of respect when they were growing up.

They reported that respect must be accorded to all human beings especially older

persons such as parents, older brothers and sisters, older relatives and persons in

positions of authority.

Another description that emerged in the counsllors role and responsibility is that

psychiatrists continue to **wield power** and **influence** in hospitals which effects

counsellor practice **""In our hospital, psychiatrists are the ones who have the say,**

counsellors opinions are obtained for the record, but what they say does not

matter".

8.4.5 Managed Care Organizations

As soon as the patient has been admitted the counsellor is required to communicate with

the psychiatric clinic and arrange a proper **"number of session for the patient to**

receive his/her medical treatment, in relation to the patients source of referral,

and communicate with their supervisor". In addition, the counsellors will communicate with the general department, so as to arrange patient treatment.

All participants point out that the psychiatrists wield great influence and power in hospitals because of the Ministry of Health depend on psychiatrists. A counsellor who had worked for more than twenty years described an extremely awkward result of poor counselling power in their practice:

> **Here the medical care and the psychiatrist's diagnosis tasks are dominant. I cannot say that the session and treatments we do are not valued, but I can tell you, they are not rewarded. What is valued around here is your technical know how and how well you carry out the doctors' orders.**

Hospitals have traditionally been organized to serve the needs and requirements of psychiatrists. Counsellors were viewed as hired employees to carry out the psychiatrist's treatment plan **"counsellors are dependent on doctors. We are only the providers of treatments".** This hierarchical relationship is still the accepted structure in all hospitals **"our hospital like all mental health hospital in Saudi Arabia is controlled by psychiatrists".** All counsellors interviewed had a submissive attitude toward psychiatrists

> **There was no space for the counsellors for sessions with their patients. There was no office space so we had to put our offices in inconvenient places and sometimes it's some little places you could hardly turn. They would make space for the social workers and everybody else, so we had to serve in other offices. We had to share offices; we weren't given offices, and it was not because they didn't have space but it was not in the thinking of the authorities that counselling should get a spot in the clinics (hospital). But we fit in and we shared offices with the social workers and we got along and, after awhile, it was decided that we might as well have some space after awhile, we got spaces. When they saw the need for the service, they really expanded and gave us space**

Counsellors stated that other mental health professionals such as social workers might usurp their function of practice. All participants experienced discomfort with their **positions** in the hospital.

8.4.6 Counselling Services interface

All counsellors emphasised a systems approach in which counselling needs to be part of hospital policy.

All participants described **cognitive, person centred or (client–centred)** and **religious** approaches as their method of providing sessions to the patients, the **"client–centred approach resembles Saudi society attitudes and values"**. Ten participants stated that **person centred** can be a **safe climate conducive** to the Saudi patients needs and **safer for exploration** of their problems. One of the participants described the counselling approach as:

> **Person centred method; practices; active listening and hearing; reflection of feeling; clarification and being there for the patients are practising Western counselling theory and skills. But I believe there is a striking similarity between the person centred approach and the general attitudes in Saudi society about human life.**

All participants also believed that the **"psychiatrists and many hospital administrators"** see the function of counsellors as **"carrying out doctors' orders"**. They were sure that the counselling services not clearly known enough throughout the hospital, and indicate that they are suffering from a **"lack of awareness and knowledge"** about their service. Furthermore, one participant saw counselling in a **"dependent role to medicine"**. He believed that counselling had some **"effect"** on patients' recovery, but **"you should have confidence in the doctor"**, that its, impact was dependent on how well the patient or counsellor followed doctor's orders and was limited by, how well psychiatrists **"managed treatments"**.

In the four mental health hospitals where this study was conducted, psychiatrists held key hospital positions. Psychiatrists traditional occupied a superior position over counselling and expected counsellors to "**follow doctors' orders**". Five of the counsellors complained that psychiatrists did not have any respect for counsellors. One stated,

> **They do not read our reports. There was a case of a patient who has been complaining of respiratory distress. I reported this to the doctor and I wrote it in the patient file. Doctors do not listen to us. They still see us as their handmaidens. They do not see that we have our own counselling skills for patients.**

8.4.7 Referral system

All interviewees, when discussing the referral system, said that the hospitals did not have a specific referral system, the **"referral system to me means unequal access, unequal services, or unavailable services , and you know... whatever it is we're talking about referral system to me means unequal, or difference, or different than... and also maybe unavailable"**.

In this sense it might be worth mentioning that after reviewing four mental health policies and prior to conducting the interviews, the researcher identified around thirty five articles of code of practice that are relevant to counsellor's practice in mental health hospitals in Saudi Arabia. Generally, there was a need to gain a general understanding of the referral system of mental health hospital. The interviewees raised the same issues that had been identify in the articles'

> **The methods used to produce and present the referral system in our setting are still old and traditional. They need to change and to be made clear.**

In addition, all participants stated that the shortage of counsellors has had an overwhelming influence on practice **"The greatest challenge in here is keeping your cool**

especially when have more than 105 patients in your hospital. When you are working and you have many patients. I find that you do not have the time to really sit and have enough sessions with your patients", it's their **frustration** to understaffing and increased workload **"With the counselling shortage, it is getting harder and harder to do every thing you want to do".** The shortage of counsellors influenced patient care, and the counsellors frustration over their inability to provide what they considered adequate care is evident in their statements.

> **There are so many things to do that you wind up doing what is needed most, like contacting with patients family, transportation , social activities for patients. That disturbs me as a mental health counsellor. You know sometimes we have less than five minutes to talk to patients. I really would like to get to the personal aspects, the emotions, but you can't all the times**

8.4.8 Counsellor Personal Development

The current goals for the service include the **"continuation of the educational goals"** for the counsellors and health staff and the integration of services. All counsellors interviewed, generally, talked at length about this point. Some of them believed that there is a strong link between the training and the outcome of their treatments.

> **I think we were talking about getting into a more legislative activity and asking people for demand services, getting more people trained which is hard to do nowadays. Any type of thing that has to do with mental health delivery is very hard to do. Again, this is, may sound to you like completely out of the left field, but I think media is very powerful, and our people, everybody watches. So I think using media effectively could also be an avenue of informing and changing opinions of many people who working with counsellors.**

One said, **"I'm the president of the Saudi Counselling Society. But you know we need to have more academic training sites that train bilingual and bicultural counsellors and therapists. We need to have more attention to training because we**

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have to start somewhere and it has to happen". He believes the educational process must be seen as a whole and it is training for counsellors must be seen as an important element.

All participants emphasised the necessity for courage in making sweeping changes in counselling practice and to, **"establish new courses for practical counselling in all universities and institutions around the country"**.

8.4.9 Synopsis

The counsellors interviewed, made the following suggestions to improve the service:

1) Creating a clear policy for counselling services.

2) Availability of alternative care services e.g. day hospital, rehabilitation centres.

3) Create specialised centres to provide professional care for the patient's e.g. Counselling centre, Occupational therapy centre.

4) A more focused role should be undertaken by the Ministry of information to create greater public awareness about Counselling services, through perhaps, T.V and local news papers.

5) Increase the number of counsellors, and other mental health practitioners.

6) Creating new training courses for counsellors.

7) More attention to following up patients and to ensure that the regulations for discharge patients are rigidly adhered to the counsellor's practice.

8.5 Patient's interviews

This part documents the results in the participants' descriptions of their experiences, with the investigator's reflections. Each narrative has an introductory case history followed by the participants' comments.

8.5.1Introducing the Participants

As with the practitioners sample, the patients sample were selected randomly from four hospitals, by using a table of random numbers. They were representative of all four mental health hospitals in four cities in Saudi Arabia.

The patient's participants comprised 12 psychiatric patients, 7 were male and their aged between 27 to 54 years, only three of the male patients had completed their university education. Five were female and their aged between 24 to 40 years, all female patients had completed their university education. Six participants were married, with 8 having two or more offspring; three patients had divorced. Three interviewees were unmarried.

8.5 .2 Sample case History Narratives

All participants met the following criteria:

- All patients were defined as patients who were still in the hospital;

- They could articulate their psychiatric experiences, as well as their experiences of counselling;

- None of the participants was a direct patient of the author of this study;

- They read and understood the "letter of information" (Appendix 2), outlining the purpose of this study, the expectations from participants, the right to refuse or withdraw from participation at any time without offering an explanation. Such a refusal will bear absolutely no consequences for the participant and will be honoured by the researcher, they informed that the **names and any information**

of identifications have been changed as a part of the Confidentiality, and all data collected through any participant who subsequently withdraws will immediately be destroyed, they agreed to participate and signed the "Consent form" (Appendix 2).

Ahmad (Riyadh M.H.H)

Ahmad is 54 years old, from Riyadh. He is a father of 5 children, he is high school educated with a computer diploma, and now is retired and received a pension from the government, but occasionally ventures into selling cars. Ahmad shares living quarter in his inherited house with his oldest brother. He came for the interview casually dressed, and exactly on time. Ahmad parents were typical nomadic Bedouins who lived in small village far away from Riyadh. His childhood as reported by himself was painful and difficult, because his father treated him very harshly and considered him as a bad boy. Ahmad has a long history of hospitalisation which labelled as a chronic patient. His last hospitalisation was five years ago in Riyadh M.H.H, he was brought in by his brother in such a weak physical condition that he could not eat or drink. When the staff were asked about his admission, they answered that he had quit talking his medication, which resulted in his physical and psychological deterioration. Ahmad received only medications without any support from counselling or any kind of therapy, *"I have seen some people around and they called them selves Marsheden (counsellors) but they ignored me or even not asking me why I'm here"*. He would complain about his current physical condition or the situation he had been in, and he seemed like his favourite topic, and complains about disrespect from the psychiatrists *"they treat me like a child"*. He is physically weak, walked slowly, talked slowly and it seemed to have rigid body movement. His relatives were not supportive of his independence, and he has no friends. He spent most of his time in his room or praying in the small mosque of the psychiatric unit.

Taher is a 32 years old, divorced father of two children. He is uneducated, and for many years has been working as a driver. Taher was referred by police after his family contacted the local authority about his unacceptable behaviour, he was diagnosis of paranoid schizophrenia five years ago. He decided to stop taking his HALDOL because it made him feel heavy and too tired to get up in the morning. Within a few days of stopping the medication, he was unable to leave his house for fear of someone harming him. Although he liked his unpaid job at a bakery and knew that he had the chance to earn money in the near future, he refused to go to work for fear that he would be hit by a bus on his way there. He was eventually fired because of poor attendance. In this instance, his medication increased biological vulnerability with marked behavioural and eventually environmental consequences. He believed that his medication treatment was unbeneficial, and in this sense unsuccessful. Taher was hospitalized in the special ward (locked ward), and the doctors called him an unstable patient, he spent most of his time watching T.V and smoking cigarettes. Importantly, Taher have had Seven counselling session since he last hospitalization, he described his experiences as *"it was the richest experience I ever have in this hospital"* and that *"it has changed the way of how I see myself"* as a matter of fact, he suggested that *"I don't know why, I couldn't see my counsellor easily and regularly"*. Taher is hopeful that after his discharge he will contact a private Counsellor to see him regularly.

Kaniema (Dammam M.H.H)

Kaniema is 25 years old, a female patient, from Alhafouf (city near Dammam), she is single. She is university educated with a post graduate degree in education. She has never been admitted into mental health hospital before. She has referred by her brothers after they had agreement from the local hospital. Kaniema had a very difficult childhood, her father was alcoholic and her mother died when she was 16 years old. She does not dwell in her past, and does not ruminate over her past injurious life. She was diagnosed as a schizophrenic patient suffering from auditory hallucinations, stated that she was the kings daughter. She was extremely suspicious. From her facial expressions and sometimes her verbalizations, she seemed to be seeing or hearing someone threatening her, she never confided in anyone. Although these hallucinations were upsetting to Kaniema, the psychiatrist who responsible for her treatment said *"we do not find her as difficult to care with either command or threatening hallucinations"*. She is having a medication as well as one session every week with her female counselor. During her interview Kaniema had showed respect to the interviewer and talk candidly about her experiences in mental hospital *"you don't know what kind of live we have here"*, she has not happy about her hospitalization and the treatment she has received.

Zamil (Jaddeh M.H.H)

Zamil is a 28 years old, he married two years ago, he is from Jaddeh city, and working as a sergeant in the Army. Zamile had not previously been admitted to any psychiatric hospital. His relationship with his family is good. His wife visited him regularly. Zamil had a bad experience, during he childhood, two guys kidnap him and had sex with him. Since that time he felt shameful to talk about his experience in the Saudi culture. He was brought to the hospital by police because he had been going into other people's houses and urinating on their floors. He claimed he owned the houses and had a right to be in them. He said that he had been brought to the hospital unjustly and that we are plotting to keep him here. He claimed to have a number of serious medical conditions, none of which could be validated by various diagnostic tests or physical examination. Zamil was violent during his hospital stay. The violence occurred when he was given medication against his will, which was given intramuscularly. When admitted, he ripped one nurse's ear and scratched another nurse's face. Since he thought the medication was poison, he was literally fighting for his life. Zamil complained about his hospitalization and his psychiatric treatment *"I don't like this situation, my behaviour, my feelings nor myself"*. Zamil had so far Ten Counselling session and he described his counsellor as *"close friend, and very helpful person, but he couldn't speak with the doctors"*. He gives an indication that his counselling is useful because as he described himself *"after each counselling session I feel somehow stable physically and I feel I'm still alive"*.

Ebtisam (Dammam M.H.H)

Ebtisam is a 35year old, female patient, from a small village near to Dammam, she is a divorced mother of two children, she is university educated, and for many years she has been working as a teacher in a public school. She had experience of a "relationship" with her private psychiatrists, and when her brother discovered her relationship brought her in this hospital. Ebtisam had been raped by her family driver when she was 14 years old and her first and second marriages were unsuccessful. The doctors called her *"schizophrenic patient, much disorganization and hyperactivity lady"*. Ebtisam is enamored with a young medical resident on the unit and begins to undress whenever she sees him, which make the doctors think that her behaviour is becoming troublesome and may require long time of hospitalization. She is a very sociable person but often her attempts at being friendly with others are bizarre. She approaches someone, stares at the person and smiles. Often her sentences or greetings to others make no sense either the sentences are a jumble 'word salad,' or she uses words that have meaning only to her: "neologisms." Ebtisam like reading and writing Arabic poems, she is not happy to be in the hospital, and some time refused her medication. She feels her Counselling treatment is helpful and she keep asking her counselor *"how can I find a Marshed (Counsellor) outside this hospital"*.

Ali is a 29 years old, single male from Tai'f, he has never been admitted into a psychiatric care before. He is well built, tall and has a pleasant appearance in spite of the long scar on the left said of his face. Ali has had some education, he dropped out of secondary school when he was fifteen, and then he joined his father business shop. At the age of eighteen he became eligible to enroll in government services. Ali is one of eight children; his mother was divorced when he was about seven years old. Ali seems to appreciate music; he constantly wears a walkman tape player and listens to Western music. Ali has had several crises that probably contributed to the unexplained recent crises that brought him to the hospital. When he was eight years old his mother was divorced and he felt as if it were his fault, also as a result of the divorce he was partially separated from his mother. As a teenager he was in love with a girl whose family would not let them marry, he tried to get engaged to her but was told that he would be refused. he continued to love her until she got married to a rich man, a year prior to the loss of his love he had a car accident on his way to work, his close friend , who was riding with him at the time, was killed. He came out of this accident with some broken bones and some terrible wounds, including the large scar on his face. Ali hospitalization came two months after he lost all hope of marrying the love of his live. He was referred from the local hospital and the ambulance brought him to the hospital emergency room because he had collapsed on the floor while having a conversation with his sister. At the time he was brought into the psychiatric hospital he was agitated and very angry, he was placed in the isolation room in the locked ward to calm him down. During the following three days he exhibited psychiatric symptom and accused his nurse of beating him. He was placed under close observation and restricted to his room for the first three days because he chased every woman who entered the unit. At that time Ali began talking with other patients in the ward and enjoys reading news papers. Ali was received drug medication and his psychiatrists after several days label him as *"depressed patient"*. Ali has so much anger and unpleasant feeling because the treatment he received in the hospital *"I swear not to come here again"* he said. In Ali's opinion counselling was very helpful, it changed his relationship with others, and with himself *"my relationships are much more honest, I'm not in pursuit of everybody liking me, I feel more me .. I'm more confident in myself"*. He had a opinion about religious counsellors *"I don't know why, they did not have in this hospital a religious counselor"*. Ali spends most of his time sitting quietly in his room, occasionally watching T.V, and praying in the mosque.

Naif (Riyadh M.H.H)

Naïf is a married 42 years old, male from a small village near Riyadh, he is university educated, with twenty years working for the government agencies. Naif's mother had died giving birth to him. He has brothers and sisters from his fathers two new wives, he has been trying to divorce his wife for the last three years but his father has a court order restricting all of Naif action, and believes that Naif is in no position to make such a decision as divorcing his wife. This had been created major problems that may have contributed to Naif level of frustration. He has been hospitalised three times in the last three years. Naif was brought to the hospital by the police because he stabbed his wife with a seven inch knife; he thought that she was having a sexual relationship with his father and their chauffeur. This is not the first time such an incident occurred; most of his hospitalization in the last three years involves aggressive behavior toward his wife. He was diagnosed as a paranoid schizophrenic three years prior to this hospitalization, and his doctor described him as *"paranoid, violence and mistrust patient"*. Naif usually complains of too many medications, and complains his room is untidy and unclean. Naif had so far eight Counselling sessions *"I like that the way my Morshed (Counsellor) treating me, it's nice and respectful"*. Naif spend most of his time smoking in the smoking area, watching T.V, and most of the time Naif asked to be the *(Imam)* when patient are praying.

Fatimah (Tai'f M.H.H)

Fatimah is a 40year old, female patient, from Tai'f, married, and has no children, she is university educated, but she is never been worked. She has a close relationship with her husband and her extended family. Her husband is addicted to alcohol and she learned to drink by watching her husband and she recognized alcohol as a remedy for psychic and physical pain. She has never been admitted into a psychiatric hospital before, Fatimah has been arrested by religious police because she was drunk, and she referred to mental hospital three weeks ago. She is dually diagnosed due to addiction to alcohol and having bipolar disorder, manic. She avoided eye contact, appeared embarrassed and apologized for *"getting into this mess again."* she said, *"I really don't need to be here. I can handle this problem"*. One day she did was rearranging some of the furniture; her rearrangement was a much more functional use of several of the decorative tables in the living room. Fatimah doctor said *"she needs much redirection"*. Fatimah usually complains that there are too many restrictions in this hospital. She has had one counselling session so far, and she asked her counsellor to have another counselling session. Fatimah spends most of her time sitting quietly in her room, and infrequently reads a magazine and books.

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8.5.3 Patients Experiencing Hospitalisation

Some patients having experiences hospitalisation and have had their progress followed by the clinic after their discharge. A number of them (4 patients) alternated between being hospitalised and being an outpatients for many years. For these people, the mental hospital became an **unwelcome** but significant part of life.

For whatever reason, all participants pointed out that their hospitalisation was a **traumatic experiences**; one became defined as a mental patient 24 hours a day. Patients must lead a life together in the enclosed setting of the hospital, where activities such as eating, sleeping, playing, and praying all take place in the same setting. Such an experience in on institution would require endurance even for an ordinary individual.

For someone who is emotionally unstable **"It invariably led to anxiety and frustration"**. However, the intensity experienced during hospitalisation varied from patient to patient. But it was a **painful experience** for all participants particularly when the hospitalisation was involuntary. Ebtisam was 24 years old when she was forced to go the hospital. Before being hospitalised, she had been seen by private **Egyptian psychiatrist**, at the private clinic in Riyadh city. However, on the day of hospitalisation Ebitsam was again violent at home, she recollected the day:

Three people, psychiatrist male, and two female nurses, came to my home to take me to the hospital. I was violent and overturned the dining table. It was about 3 in the afternoon, I was tired and was lying down on the couch in the kitchen when the psychiatrist came in and said "let's go and have you hospitalised", and there was no discussion with me of hospitalisation before this incident. I said "No" and resisted physically. My mother telephoned the hospital, after the team arrived; they and my family had a talk upstairs. I resisted but was pulled by the hand by the psychiatrist and nurse; I was taken out of the house without having a chance to put on my shoes. My older brother followed us, and said to me, speaking for my mother "follow what the

doctor says", when he came down to see me off at the car. My mother was crying inside the house and didn't come out, she was distressed perhaps. I said repeatedly, "No", "No" but didn't fight back, because the doctor "that psychiatrist" not other people, said that I should get hospitalised because my family complained about my behaviour. I thought if I resist with violence they will give me an injection by force. While being taken out of my home. I said I would call my father, but the doctor said "he is agreed as well" , while I was being dragged along by the doctor and the nurse, my brother said from behind " follow what has been said Ebitsam", my mother was not there, my brother came out so see me off at the doorway. Oh emm,{silent},I was wearing pyjama and an old T- shirt; I covered my head and my body by a black cloak. I had watched T.V for a while after being violent and then rested in the kitchen.

I cried until the car arrived at the hospital, the nurse said to me "dinner will by ready at 4 p.m. let's eat there" so I said bluntly, "who the hell are you". That was about all the conversation I had in the car. I kept crying, I took about 2 hours to arrive at the hospital. when we arrived at the hospital I put on slippers at the entrance and want up to the second floor " you know the locked ward" supported by both arms by the nurse. One of the nurses introduced me to two other room mates. The room was for three people, I crouched and cried at the entrance of the room without going in, because the room at first sight looked like a prison, and I didn't know what kind of people were in this room. Anyway, I was frightened, Uh emm   the nurses and the doctor had all disappeared. One old lady a patient actually, came and spoke to m, being asked my name, I replied, and then she stared singing a tune sung by an actor whose name was the same as mine. I said to myself "I can not stand such a crazy hospital as this", I was very frightened and resented the psychiatrist.

On the same day I met the psychiatrist for 20 minutes in his office, I was sobbing, bending my head down. He said "Ebtisam, your family want you here", I said how

come you brought me into such place? I added, people here are all crazy, the doctor said in a harsh tone, "You too are crazy, aren't you? I will quit being in charge of you as of today, tomorrow your new doctor comes, and you should talk to him" I simply listened to what he said, but with a sense of being betrayed. I wondered whether he really had deceived me. I came back to my room from his office, because I wanted to get out, I poked my finger down my throat and vomited two times. I thought that if I became ill, they would discharge me. I tried to get into the nurses station, they opened the door and let me in. "let me call my family, I want to get back home" I told the nurse repeatedly. The nurse took my blood pressure and found some abnormality so that I was given an injection, then I returned to my room.

The staff thought I might vomit again and didn't give me dinner. I want back to the room without being able to call my family; the nurses looked like a group of cruel people. When I requested a telephone call, they didn't let me use it, saying "you cannot use the telephone unless you have a doctor's permission". When I vomited, I was simply left alone at the treatment corner in the nurse's station, I firmly realised that my appeal would not be heard by the staff and gave up all hope. I returned to my room and cried.

That night a girl patient in the same room took good care of me. It was in August and the weather was extremely hot, she wiped my back with a towel and washed my clothes. After the light was out, I started to talk to her, she seemed like a normal person, I said "you look normal, why are you hospitalised?" I have my own reason to be hospitalised" she replied. I told her I was forced to be taken to this hospital; we talked for about a three hours, lying down on our beds. With this girl I felt relieved for the first time since I stared that long day.

Ebtisam clearly recollected the day of her hospitalisation, her account was sometimes redundant and out of sequence; her telling of the story itself seemed to evoke in her the

bitterness and anguished feeling she experienced throughout this trauma. Once she was hospitalised, she could no longer assume ordinary privileges taken for granted in outside society, such as **telephone call** or **going out**. Through her story, she felt terribly hurt and betrayed when the psychiatrist told her that he was going to hand her over to **another psychiatrist**, since she trusted the psychiatrist and followed his advice. To the extent she felt such bitterness; her encounter with the girl in the room was moving and significant.

Another male patient,

Ali was also taken to the hospital involuntarily; he had become violent at home and his work, He was involved with new political movement (against the monarchy). He was watching T.V when several men came into his house, one of the men said "we are from the public authority, and we will give you an injection because you aren't emotionally stable". He was tranquilised, when he woke up he found himself in a large hospital room.

However, many patients were hospitalised with their consent. Yet they recognised the need for professional help from psychiatrists. In such cases, the patient usually visited the out patient clinic together with spouse or other family members. But even if the patient consented to the admission, they would frequently develop a **fear**, particularly during the first admission, that they might not be able to get out again and that they might have to stay in the hospital for the rest of their life **"I know they might keep me for ever here, yah emm yes, yes I remember doctors told me that"**. However, many patients during their interview described a **terrible feeling** when the steel door of the **closed ward** was locked behind them for the first time, indicating a breaking off from society **"it's worst feeling I ever had, all my family out and I'm here alone"**.

8.5.4 Patients patterns of closed ward

Confinement and gravity of illness characterized life in the closed or locked, ward. The following of statements give some sense of the pace of life in the ward. Observation was the main method for this part of patient life. Only in one hospital (Tai'f M.H.H) was the allowed researcher for full observation in the closed word, other hospitals **rejected the observation**. Observation was made from the corner of the nurse's station.

All patients in the closed word have a **very serious condition**, for almost all patients, an ordinary conversation was **difficult**, they were usually **heavily drugged** and their freedom and **privacy were limited**. The closed ward had a more intense atmosphere compared to that to the open ward, where many of the patients looked unmotivated.

Life in the locked ward presented **inconvenience, hopelessness** and a **degrading** experience. The closed ward is a group detainment and all patients had difficulty **finding privacy**. Moreover, the routine schedules for going out to the field, having meals, talking and different activities were **fixed** for the purpose of group living, not for individual preference. For all patients to gain privacy or distance from the group was not easy unless one fell a **sleep or resorted to delusionary reaction**. Emotionally, all patients had to cope with many confliction phenomena, such as,

I.   **Fear (almost all patients in the locked ward most immediate concerns for them were perhaps that of being attacked).**

II. **Suppressing emotions (for all patients in the locked ward expressions of emotion were rare, some patients might smile subtly or laugh in a shallow way, Life in the locked ward robbed a patients of situations in which their could honestly express such emotions as happiness, sadness, affection, and anger).**

III. **Escape (under the pressure of group living and with the restriction on expressiveness, all patients longed for a form of escape, the most common way of escape were observed in the locked ward was to fall a sleep, writing, smoking, and others into watching T.V. Depression and withdrawal were**

other forms of escape for patients. when the light went out, crawling into bed was often a pleasurable escape).

8.5.5 The inner-world of the hospitalisation

All patients spoke initially about their experiences in mental health hospitals in a generalised manner such as their referral producers and their life in hospital. In addition, three patients fused insight with their experiences of the seclusion room or as they name it the **green room**. A patient for example claimed:

> **I think there are here five green rooms, I spent many times in one of them, and the size of the room was a rectangle of about 2m by 3m, you know the confinement created a hopeless feeling, it's an isolated room no, body can listen to your voice.**

All three patients complained about their communication with their nurses and doctors when they were in seclusion room; the nurse's response was sometimes **quick** and sometimes **delayed**. In addition, painted on the walls of the seclusion room were various statements scribbled by the patients, *"I am the greatest man in this world"*, *"I can even stop the rotation of the earth"*, *"nobody knows how mighty and ruthless I am"* etc. The walls were filled with such statements, and they seemed overwhelming.

Another patient wrote:

I am completely normal
I only came in hospitalized by my own will to rest and think about my future
Why am I treated so badly here?
I will escape, I must escape
Using all my wisdom
But if possible, I want to be discharged without trouble

8.5.6 Cognitively Impaired (Patients Diagnosis)

The most common diagnosis of all patients interviewed was that of Schizophrenia, followed by Mood disorders and Disorders of personality and behaviour.

Seven patients in this group were diagnosed with Schizophrenia, three patients were diagnosed with Bipolar Mood disorders; and two patients were diagnosed with Personality disorders. All patients stated that they were dissatisfied with their course of medications regime **"nobody told me what kind of medications I'm taking, why I'm taking them, nobody would listen to me that this medication made me feel heavy and too tired to get up in the morning"**.

There were senses amongst these patients that they unaware of the side effects of their treatment and the timetabling for their medications **"always my doctor is telling me next week we will stop your medications"**. In addition, all patients stated that they complained after they received their medications, their dislike of medications are **underpinned** by the side effects, including **dry mouth, breathing problems, speech, sleeplessness, blurred vision, tiredness, and abnormal movements of the hands(hands trembled), legs, face, neck, and for many patients could not control their rolling eyeballs.** Seven patients stated that medication have impaired their quality of life, or have solved, as well as created many problems, **"you know now I feel better now, since doctors give me this medication I feel really happy, and you know if I didn't have this medication for a single day I would die"**. He felt that it was **effective** in short term in reducing painful, but he was becoming **addicted** to the medications.

8.5.7 Traditional Healer

All participants identified the first source of help they sought to be a traditional healers. Nine interviewees decided to go by themselves, and for three patients it was a family decision. All 12 participants had sough help from local traditional healers (who is normally a religious male from the local area), before coming to the psychiatric hospital, **"at first I want to see *shikah*, and he advised me to see him once a week, he told me that I might have a female jinni, yah he is right I still remember that night**

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when I was in my village I saw many people dancing in the dark". He defended the healer and stated that "shikah was not a charlatan as most of the doctors think, you know why? Because he did not charge patients", the healer give him water to drink. He explained that this water was a **curative** because the healer "read some verses of the holy Quran". In addition, all patients remarked that they had experienced many types of traditional treatments, such **branding** *(cautery on the part of patient body in which he/she had a pain))* and **Zar**. The alarming finding in these contexts was that some doctors seemed have ambiguity and powerlessness in understating their patient culture:

> My first doctor was an Egyptian doctor, he even misunderstood the *Kaay* and he seemed to laugh at me when he saw my stomach with big mark of *Kaay*, he asked me to ignore the pain, how can I ignore the pain when I can feel it inside me, I cannot ignore that I have a sickness.

However, failure to receive immediate relief influenced patients decisions to seek help from a physician or private psychiatrists where they referred to a psychiatric hospitals, " **I traveled around this country with my brother, we seek all shikah's, with thousands of money, but I couldn't find anyone help me and take this voices away from me".** Seven participants in their interview said that **if they did not benefit from their current treatment, they would turn again to traditional healing.** A patient from Dammam M.H.H he stated that **"if I do not get better, my family told me that we will seek *shikah Alamri* you know him don't you? He is a very good traditional healer".** (This traditional healer who was a popular phenomenon in Saudi Arabia at the time the research was conducted).

To explore the phenomenon from traditional healer perspective, an interviewed was conducted with the traditional healer who lived in the capital, Riyadh.

> *He is a 46 year old male, lives in a villa with two floors, after he took the research to the reception room in his house, he sat in the corner of the room with a shelf of books behind him, and there was also frankincense and a small desk that he used to write. In that room he has hundreds of boxes of water and oil " Every day I do reading of some verses of the holy Quran over these bottles", and he said "I do not charge people, if they did not have money, I never asked them" , he started his conversation saying" **you people do not believe in the effectiveness of our treatment**". His vision is that psychiatrists and counsellors cannot treat everything; psychological doctors do not think there are illnesses that occur because of jinn, they think they are a product of our imagination" he crticised treatment that was prescribed by psychiatrists "**medication takes over peoples minds**", he stated that some patients sought help from him based on psychiatrists recommendations, he said many cases were **referred** to him because a physician could not find a medical explanation for them. Two diagnostic categories   that the Shikah used in his cases into were: magic spells and Jinn*

Religion was seen to be the most significant factor contributing to understanding why patients who experiences mental and psychological problems did not avail themselves of psychiatric and counselling services. All participants identified their well being as rooted to religious values, **"God is always with me and protected me from evil, and I'm a good prayer"**, In addition, all interviewees stated that two religious values help them to cope with their illness.

The first value is the belief that the hardship and illness they undergo is **from God (e.g., I should strengthen my self power by adhering to the religious methods).** One interviewee felt that his problem and illness is a test from God **"when I have any problem I review my behaviours and see if I have conducted something against my religious value"**, she continued,

> **when I feel pain inside myself, I pray and read the Quran,**
> **I constantly remind myself that this life is God's test, yah**
> **you know here our doctors very religious and they give me**
> **many books, they helped me a lot.**

All patients stated that during their staying in hospitals they often embraced some traditions of Prophet Mohammed (*pbuh*) and verses of the holy Quran when they discussing their problems with their practitioners. One patient from Tai'f M.H.H said

that "you know in this hospital I met many people they told me; you believe in God and I should believe that even our suffering has rewards make us feel better, and when you thank you God in any situation, problem will disappears".

The second religious value for patients coping with their crisis and illness is the belief in predestination. Ten interviewees when they talked about their experiences and their illness, tying these problems to being inevitable of God's will, they acknowledged the pain, nonetheless, they soothed themselves by their doctors, social workers, and counsellors, stating that "it was God's will". One patient thought that "my doctor and the social worker told me it is my destiny, oh I should tell you, you know they asked me to thank God with prayed, I really don't know if God known my problem why I'm here! Why is my doctor not suffering like me".

8.5.8 Aspects of referral

Only two patients reported having gone to their referrer with clear idea of wanting either psychiatric or counselling help. Most did not know much about the range of counselling treatments available.

All patients stated in their interviews that they were dissatisfied with their referral procedures. They believed that they spend more than half day for the decision about their hospital admission "I remember when I came here, they told me I have to wait in the waiting area at least seven hours, I don't know why they do that to me?" In addition, all interviewees stated that the hospitals did not accept them in the first place "for two day I was in waiting list to be here". Another patient stated that "I found myself in the psychiatric hospital", he explained that it was not a planned decision to seek help from the psychiatrists, and the decision was made on the spur of the moment, when he reached the highest point of emotional pain, but he did not get treatment because "they asked me to bring a referral letter from my GPs".

Four patients were referred by **local hospitals, GPs**, or **Accident and Emergency**. Five participants were referred by **governmental departments (police, social services, and local authorities)**. Three patients were referred by themselves or their family. Ten participants viewed the timetabling for the first appointment with their psychiatrists as unacceptable. **"Seven months I have been waiting to see a psychiatrist in the local hospital, but I paid for the private doctor em..{Silent} you know him the consultant who referred me here"**. In addition, seven patients' stated that they had no knowledge of their referral producers that left them feeling dissatisfaction **(embarrassed)** with having to mingle with addiction patients. They pointed out that becoming **normal people** as they identified themselves with these they were stigmatised and seen as **drug abusers** when mixing with addiction patients. There was no designated place for addiction patients to wait. The waiting area was used by all patients when they came for their first hospital visit. One patient commented **"I have no idea a bout this hospital referral system, when I came here I saw many addicted patients in the waiting room, you know located outside this building. They keep looking at me, but since that day I haven't seen them"**.

8.5.9 Nurses Role

All patients stated in their interviews that their nurses were very helpful to them during their hospitalisation, and they mentioned many positive aspects to their interaction, **"the nurses provide self-care for us, supervise our eating, given a medication, they are very helpful, but some of them cannot speak Arabic"**.

All 12 participants agreed on in three activities where the nurses were very helpful to them, being available and responsive to their concerns of daily living; **sharing food and drink** with patients as an indication of **hospitality** and **trust, showing respect** and **patience.**

8.5.10 Home support

All twelve participants spoke about their relationship support, specifically from their parents, wives, children, and other relatives. Family members provided most of the patients' physical care which is consistent with the cultural values of the central role of Saudi's family in taking care of the sick. In addition, four patient were interviewed stated that they received a regularly visited by their family at least once a week or every two weeks **"I have a many visitors every week"**.

Five patients stated that they **felt isolated** with no **supports** from their families, and they do had not received any visitors for long time, **" I have made a good friend here, but you know I feel a bit up set when I see people here having a visitors"**. In addition, some families may find visiting their patients difficult because they may be living far away from the hospital, **"my family live far away, and I don't have any relatives here"**. However, some patients families becomes very anxious and embarrassed because mental illness is **stigmatised** in their culture, and at the same time they don't know how to help, **" my brother told me he felt embarrassed because of my diagnosis, so he told me that he can not visit me even after I get discharged"**.

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8.5.11 Patient's Needs

All participants described their **needs** in a general manner, emphasizing that they wanted to be **discharged** from hospital and wanted their **normality** back, , **"I only want to be discharged and want my normal life back, I was working and have a family, but you here look around you it's a prison it's not hospital"**. Eight patients spoke about wanting **to stop their medications** at that moment and many simply wanted to **talk with their psychiatrists** about their health issues.

8.5.12 Common concerns were

8.5.12.1 Symptom relief: Almost All patients were clear that their wanted are **symptom release** and get back to normality, **"I need to get better and have a normal life".**

8.5.12.2More information at an earlier stage:

Patients wanted more information, particularly at an early stage in the process, such as in their first referral, about such matters as:

- o Different departments in mental health hospital, their nature and relationship
- o Different options for treatments.
- o What kind of problems are appropriate for different kind of help.

8.5.12.3 Access:

Seven patients stated that they saw difficulty in actually getting treatments **"I had to fight hard to get in"**, in addition, five patients complained about getting access to the services from their regions **"it is very long way to get here".**

8.5.11.4 Waiting lists:

Ten patients spontaneously commented that the major problem was the wait for treatment, and all patients stated that the psychiatrists normally have delays in giving appointments.

8.5.12.5 Setting:

Twelve patients stated that they wished that the department was not on a specific psychiatric hospital site.

8.5.12.6 Direction:

Five patients stated that they have difficulty finding a counselling unit in their hospital **"I still have difficulty to find my way".** In addition, seven patients commented on the difficulty of finding their psychiatrists clinic.

8.5.12.7 Help and support

Four patients stated that they want more support after their discharge. **"an appropriate place to live after discharge"** and **"an adequate income and finical support".**

8.5.12.8 A varied of activities in their hospitals

Eleven participants expressed the need to have more activities in their hospital **"I'm wasting my time here by sleeping and doing silly things, I asked my doctors if I could using the internet here, but they said its not allowed".** In addition, four patients mentioned that they liked being given a degree of choice of activities

8.5.12.9 Communication

Five patients stated that they wanted more freedom to **communicate** with their family, **"to feel that they not forgotten by their relatives".** This need for communication was almost as potently important as a family visit. Many patients want the sanctity of a visit, **"patient here are treated as social outcasts".** In addition, seven patients stated that they the hospital is in a tatty building **"the Head of this hospital told us, that we might get new building, but so far nothing".**

8.5.12.10 Choice of Time

Ten participants expressed the need to have more time with their psychiatrists; a female patient stammered that, **"I only see my doctor once a week, only ten minutes not enough I think; sometime I feel that I want to tell him more about my feeling and my health is getting worse".** In addition, seven patients emphasised the need for more

volume, such as **quality of food** they did received, and the quality of **nutrition, hygiene, and work activities.** Related to treatments, over half of participants spoke generally about wanting to have more respect from people around them in hospital and more , **"doctors, nurses, counsellors, social workers, every one chided me for not talking medications".** Another patient stated that he first watches the people face-such as doctors and nurses waiting to **see therein their respect.** Two patients interviewed judge their psychiatric intervention as **an appropriate, effective and efficient,** one patient spoke of his treatment, **"I have a better sense of my treatment, and I'm also more aware that I have a say in how my depression and anxiety goes, and that I have a good intervention from doctors".**

8.5.13 Counselling Consequences

All patients agreed that counselling was very helpful and **comfortable, "counselling expanded my understanding of what I wanted".** In addition, all patients stated that they **get out of counselling** much more than they originally hoped, *(on a scale from 0 to 10, where the 0 represents nothing and the 10 everything, how would you evaluate what you have got out of counselling as compared with what you wanted to get when you started with your counsellors),* all patients between 6 to 9 in their evaluation of counselling treatment. Importantly, almost all patients counselling experiences were of individual sessions, with the exception of **1-2 initial** sessions per a week **"every week I have to see my counsellor for 35 minutes per a session, I feel more relaxed and happier with her".** In addition, all patients stated their expectations about counselling, and the **need to understand their pain,** respect, confidentiality, advice, information, friendliness, managing their life after discharge, helping them to communicate with their family, and non-medications treatments, another patient claimed that he want his counselling intervention as:

> **I want to hear advice and to be guided to the right path,**
> **you know I want someone to follow my health issue, care**

> about me and put himself in my situation to understand me.

Nine patients had decided to keep contact with counsellors after discharge from their hospitals, **"I felt that I need to contact with the counsellor after my discharge"**, **"I would recommend the counselling services to all patients here"**. In addition, seven of them they decided to **seek traditional healers.** Almost all participants emphasised that they wanted to **hear stories from their counsellors** that were similar to their problem in which people overcame their plights **" it is nice and more effective if a counsellor or social worker tell me stories and experiences that are related to my problem, the counsellor does not need to tell my who they are"**.

Two patients expressed discomfort with counselling **"counselling is for students in school, psychiatrists treatment is deeper, I remember last session with the counsellor it was a total waste of time and just a matter of talking"**,

8.5.14 Synopsis

The patients interviewed, made the following suggestions to improve the service:

1) Creating awareness of the patients values, because religion is an extremely important cultural factor that influences the decision to seek a specific sources of help in Saudi society

2) Creating clear regulations and policy from the Ministry of Health for patient treatments in psychiatric hospitals.

3) Setting up of a psychiatric unit with counselling centers in each primary care center, which would be able to the patients to seek at an early stage of their illness.

4) More focused referral procedures.

5) A more focused role to be undertaken by the Ministry of information to create

greater public awareness about mental health services, through perhaps, T.V and local news papers.

6) Increase the number of practitioners such as counsellor, psychiatrists, and increase the time for each patient in each session.

7) Creating new activities for patients in the hospital, while solving their finical problems.

8) Availability of convenient transportation for patients, especially those referred from outside the city.

8.6 Administrative Staff Member's Interview

Introduction

The Evaluation of mental health provision from the perception of administrative staff is examined under three headings;

a) The administrative system.

b) The quality of the services

c) The employee's perception of the hospital and the support it provides for them.

Data derived from the semi-structured interviews, in the four mental health hospitals across Saudi Arabia.

Table 8.4 Responses to semi-structured interview for administrative staff members.

ITEM	Yes.	No.
Understanding the Aim and objectives	0	14
There is evident weakness in awareness of the patients needs	12	2
the current referral procedures not clear	0	14
Roles and responsibilities are Involve with patient treatments.	14	0
There is a clear feedback from patients	14	0
Specific government agencies provide a great help to patients.	2	12
Regular meeting between the psychiatrists, counsellors and ad. Staff.	0	14
availability of professional staff	3	11
There is a need for specific training courses in mental health provision.	14	0
Ad. staff are not able to achieving their goals	13	1

8.6.1 Aims and objectives

From table 8.4 it can be seen that none of the 14 administrative staff understood their aims and objectives in the mental health hospitals, and reported the negative influence of the awareness of the patients needs. In addition to the formal response, all the administrative staff considered the referral system to be a major problem. These interviews sometimes offered further calcifications of their points. One participant, a member of Tailf M.H.H said:

> **Quite often we have difficulty in understanding the patient's referral system, because only the doctors can make decision about the appropriateness of referrals.**

Another staff from Riyadh M.H.H expressed the view that:

> **The current methods of patients referral, is worthless. It is a Ministry of Health responsibility**

8.6.2 Administrative staff roles and responsibilities

In terms of their roles and responsibilities, all administrative staff referred to their roles in the medical treatments of patients. Several also pointed to the influential psychiatric presence in the hospital, a Head of patents department in Riyadh M.H.H offered the following appraisals

> **We do not have any role or policy, we just following the hospital manger, who's normally a psychiatrist.**

8.6.3 Keeping an Eye on the Patient

All administrative staff members described keeping an eye on the patient as one of the ways to keep the patient safe from self and others. Crises were often averted by the watchful eyes of the administrative staff. When a patient looked tense or anxious, or began to act in a strange manner, a member of the administrative staff usually intervened. At times, a patient was taken out of the day room to avoid a confrontation

with another patient. Another time an administrator would talk to the patient, attempting to find out what was bothering him or her. In the following example, one participant spoke of their roles within the hospital:

> **Acknowledge that people are here and give them some time. (Paused for about 30 seconds, quite thoughtful.) That, I guess, is my biggest role - to give them my time. I don't even know if this is my job really, but it's how I see my purpose for being here. So in a sense, that supercedes everything else-- the tasks that are given to me, the duties that are assigned to me. At times it just looks like I'm sitting out in the lounge, reading a magazine, but in actuality I'm watching what is going on, and you know, listening. I might notice that someone is upset or angry about a telephone call. So I keep an eye on him to prevent any harm he might cause to him or others. I also watch for the right time to talk to his about it.**

This pre-thinking of administrator relates more to certain aspects of treatment, for instance, **"I'm watching what is going on"**. There is ample evidence from the interviews that the administrative staffs are involved with particular treatments. One interviewee stated categorically that he believed that most Administrative Staff were involved with patients' treatments as part of their roles and responsibilities. **"We do have roles with our patients."** However, despite such statements, other statements even by the same people suggested that Ad. Staff role and responsibilities considered as a part of the treatments in certain way:

> **We observe the patient more closely after a violent episode and at times we keep a greater distance, but we do not show any anger. For example, one male patient with a black belt in karate, who had injured an aid nurse on a previous hospitalization, was kept under very close observation during this admission. Whenever he began to get agitated or did karate chops into the air, I intervened. This intervention was done in a kind and gentle manner. I usually intervened by walking in front of him, placing myself in the patient's line of vision. Then I began talking to him. Usually I called him by his name, and invited him to participate in another activity. This intervention was successful, and the patient injured no one during this hospitalization.**

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8.6.4 The surrounding referral system

Although all the administrative staff reported the existence of a hospital policy for patient referral, and all expressed essential feedback from patient as clear, only two respondents reported that the help provided by the various government agencies was of any great value. In addition, these two administrative staff quoted the following agencies, which they would contact, over a difficult referral: **the Ministry of Health; the principality (the local governor who has more authority to convince or obligate the hospital to accept patients; and the Police (who call the hospital in co-operation with the local authority).**

Twelve participants further reported other issues that contributed to the services problems, including: **lack of co-operation from government agencies, lack of specialized institutions (for example, institutions for the younger patients, institution for mental retarded, etc.); lack of awareness of the hospital policy; delay on official routine to transfer patients from hospital to another; lack of accesses to the patients files; and lack of transportation.**

8.6.5 The organizational perspective

All participants evaluated the services in terms of regular meetings; they reported that there is no policy for regular staff meetings. They said the hospital did not have a clear policy for communication with other practitioners such as psychiatrists; counsellors; social workers and nursing staff. An administrative officer captured the collective view:

> **Meting with others practitioners, surely, would improve the process of services, and I believe the strategic reasons for have a regular meting is to established new model of services, in order to solve some other organizing problem such as lack of professional staff and lack of awareness of the hospital policy.**

In addition, twelve of the administrative staff members reported the availability of additional professional staff might increase the quality of services and so give more attention to the concerns of the patients. All participants interviewed suggested the importance of **establishing training courses** for administrative staff. One stated that:

> **Establishing new courses for training would be very helpful to the quality of services in general and the administrative staff members in particular.**

Another administrative officer made a serious point regarding the training and personal development for the administrative staff emphatically claimed that:

> **Personal development and training courses are a special issues for the services purposes should be given a high priority by the Ministry of health. This should be a target. However, the Ministry could start to short courses four or three hours a day through any general hospital, then this could be developed to be specific in mental health hospitals.**

8.6.6 Synopsis

The administrative staff interviewed, made the following suggestions to improve the service:

1) Creating clear policy with other government departments, so as to facilitate better co-ordination and co-operation between these departments and psychiatric hospitals.

2) Creating a clear aims and objectives for administrative staff.

3) A more focused role should be undertaken by the Ministry of Health to create greater administrative awareness about the services,

4) Creating specialized centres to provide professional care for the patients e.g. counselling centres, and occupational therapy centres.

5) Increase the number of professionals such as psychiatrists, nurses, administrative staff, and social workers.

6) Co-operation between the other governmental organizations such as: Police, Local Authority and Ministry of Health.

7) Creating and maintaining strong relationship between all professionals in the hospitals.

8) Create new training courses for the administrative staff members.

Chapter Nine

Discussions Conclusions and Recommendations

The Organisation perspective

Practitioners' perspective

Referral system

Treatment information

Treatment effectiveness

Traditional treatments

Treatment Decision

The Patient perspective: a discussion

Patient choice of treatments

Patient Needs

Summary of the Study

Possible Action

Limitation of the study

Recommendation

Chapter Nine Discussions, Conclusions and Recommendations

OVERVIEW

To end this study, it would be appropriate first, to discusses the finding from the questionnaires and interviews with participants. This will be followed, in the second section, by an overall summary and conclusions. A third section will note the limitations of the study and, then, the final section will present recommendations resulting from the study, including suggestions for further research.

9.1 Organisation perspective

The problem of developing the mental health services in Saudi Arabia has a long history, as indicated earlier in this study. Minor changes have occurred almost every five years. In the last few years, many and dramatic changes have occurred in the mental health interventions in the hospitals in particular. Those changes, generally, took the form of new aims and objectives. This led psychiatrists, who are more involved with those processes, to be more supportive to a medical model rather than small and isolated changes. This might be because the medical model is applied in hospital administration, 22% of the administrative staff members samples were involved with hospital psychiatric units and a large proportion of psychiatrists were from control hospitals and used the medical model in their practice more than others.

With reference to the distribution of hospitals manpower, all the hospitals seem to be rather inefficient in their management of human resources. In almost every category of professional staff covered in this study, all hospitals had far more staff than required attending to their in-patients. This was especially obvious in the practitioners sector where there were more professional staff than needed to run the hospital operations. For

example, regarding psychiatrists, the M.O.H plan proposed one psychiatrist for twenty beds, but all the hospitals had one psychiatrist to between four to ten beds instead. Regarding staff members, again most of the hospitals had more than was required and proposed. On the other hand, in the counsellors units, there should ideally be one counsellor to fifty patients, but all the hospitals had one counsellor working with more than a hundred patients. This seems to signify a shortage of counsellors in the mental health hospitals in Saudi Arabia.

In general, it seems that all the hospitals were handling their human resources distribution in a rather inefficient manner. Yet despite the presence of excessive practitioners, patients feel that there are never enough practitioners around to serve them.

Thus, a few considerations emerge from the hospital findings. Firstly, the recommendation given by the M.O.H was in the early 70s and the strategy relates to operations in the mental health provision at that point in time. This recommendation may no longer be appropriate to the present era. Secondly, interviews conducted with professionals revealed that quite a number of the **practitioners hold more than one position** of role and responsibility. For instance, a number of psychiatrists in all hospitals were not performing only duties relating to their profession, but had additional workload and responsibilities, such as being a Head of the hospital, or a Chief of the Health Education department. Thirdly, the findings showed that practitioners from Riyadh M.H.H were more satisfied with the number of professionals than those in the rest of the hospitals. This may be due to that fact the M.O.H is based in Riyadh (the capital city of Saudi Arabia), and there may therefore be more communication and liaison between Riyadh M.H.H and the M.O.H. The M.O.H needs to update or renew its strategies regarding practitioners in mental health provision, or perhaps, push for stronger regulations with regard to patient treatment.

9.2 The practitioners sub-inquiry: a discussion

Regarding the distribution of practitioners in mental health provision in Saudi Arabia, it was found that Tai'f hospital was operating with many more mental health professional staff workers than the rest of the hospitals. This can be explained by the fact that Tai'f psychiatric hospital was the first to be established; it is the headquarters of the other hospitals and it covers the Southern region of the Kingdom. Riyadh psychiatric hospital which cover the central region; Jaddeh psychiatric hospital covers the Western region; and Dammam psychiatric hospital covers the Eastern region. Not surprisingly, the numbers of manpower in the four hospitals are different, because each region has a different size of population, taken into account in the Saudi five year plan strategies and the Ministry of Health policy. However, all the hospitals are suffering from a shortage of counsellors and psychiatrists. This finding is agrees with Al-Subaie and Alhamed (2000)in their study, where it was found that psychiatrists in Saudi Arabia face shortages number of psychiatrists in Saudi Arabia. On the other hand, the number of mental health counsellores in mental health hospitals in Saudi Arabia has increased rapidly in the last ten years.

In terms of psychiatrists' and counsellors' experience, it can be concluded that although psychiatrists had more experience than counsellors, administrative staff members had more experience than both groups. Two reasons underlie the lack of experience for counsellors. One is that they may have been newly appointed because of the large number of mental health hospitals being established, as explained in Chapter 3. The other is the rapid increase in the number of newly graduated mental health counsellors from Saudi universities which contributes to the 'Saudi Counsellors'. However, administrative members were involved with hospital management, which allowed them to acquire more experience in the services than other professional workers. The three sample group (psychiatrists, counsellors, and administrative staff) showed no gender

differences in their view of mental health services, even though for women to work in hospitals in Saudi Arabia is still not acceptable to Saudi society, and there are few work opportunities for women in mental health hospitals. The practitioners findings overall provided no strong evidence of any significant difference among practitioners of different age, gender, nationality, or qualifications in their evaluation of current mental health provision in Saudi Arabia.

A marked difference was found among the opinions of practitioners regarding service aims and objectives. A majority of psychiatrists thought that aims and objectives in mental health provision are clear, while counsellors found them unclear. This might be because a large proportion of psychiatrists were in control the current services and the Ministry of health used their power of practice more than other. On the other hand, the problem of developing the counselling in mental health services in Saudi Arabia has a short history as indicated in chapter five. In the last few years some universities in Saudi Arabia established new counselling courses for mental health counsellors which led dramatic changes have been conducted in the mental health interventions in the hospitals in particular. Those changes, generally, relied on adding new aims and objectives for counsellors. This led psychiatrists, who are more involved with those processes to be more supportive to their aims and objectives rather than small and isolated changes.

A complete review of the mental health services has not occurred for the last 20 years. In fact, the whole policy was produced in the early 70's and is still largely unchanged to the present day. Similarly, psychiatrists gave an account of the roles and responsibilities and had a strongest view of roles and responsibility then other practitioners, which means psychiatrists disagree with establishing specific roles and responsibilities in mental health provision. One possible explanation of this finding is that psychiatrists' knowledge of roles and responsibility of the services was poorer.

Many researchers, as mentioned in Chapter 4, have suggested a complete review of the mental health services which was supported, theoretically, by the Minister of Health (Al-Nafa, 2002) *"For the health services to be at this level of importance will encourage decision makers to award it a higher degree of attention in order to develop the mental health provision".*

Al-Subaie and Alhamed (2000) is an example from the literature on psychiatry that highlighted the significance and importance of personal development for psychiatrists in the professional fields of mental health, including self-awareness and self-discovery of the culture and patients' values. However, from the findings, awareness about services was lacking among the majority of practitioners.

Personal development in mental health hospitals in Saudi Arabia normally allows individuals in general, especially new practitioners, to recognise the ways in which gender, class, race and ethnicity have conditioned their experiences and their behaviour patterns. the importance of in-service personal development of practitioners is well known and the Ministry of Health in Saudi Arabia is fully aware of this fact, as it was stated in a 1999 report (The Ministry of Health, 1999) that *"practitioners training comes first in any service development programme in the Kingdom of Saudi Arabia"(*
p.127). From the review of the literature the researcher established the importance of the need for a strong linking between academic rigor and personal development in mental health practise. Sadly, this was found to be lacking in this evaluation. Thus, there is some doubt about the content of the programmes. It might be seen in the light of this study finding that there was a lack of connection between the training programmes provided to the practitioners, and their actual needs.

9.3 Referral system

The data available from this study do not enable us to say with any real certainty whether patients referred to the four hospitals are different or not. There was also some suggestive but inconclusive evidence that patients might more often have initiated the referral themselves, a maximum of 5% of the patient sample was actually referred from local hospitals, and more often the referral was by governmental agencies. Also it seems that at least some of them had slightly different goals of referral, in the sense of being more concerned about understanding their problems, rather than resolving them. Two clearer findings were that psychiatric treatment took on average nearly twice as much time as counselling and entailed a significantly longer wait for the patient after referral. Certainly the actual rate of referral in the study was tiny and unclear. Whilst it is possible that this lack of referral was due to almost perfect choice by referrers of the best place to refer in the first place, other data such as that on how referrers chose, and that on patients' preferences, suggest that this was not the case. Putting together all these data, these results suggest that at least 90-95% of referrals did not have any true access to a range of different treatments.

However, there is a distinct lack of sophisticated evaluation of the clinical model and other sources which affect the patient system of referral to acute mental health services, compared to the western countries (Al-Issa, 2000). It should be indicated that in many cases, especially with mental health services such as psychiatry, the referral system is imposed on psychiatrists without their knowing how it was developed, or how to help to develop it. Perhaps even more telling is the implication from these results that even when patients do get referred to the hospitals, they are quite unlikely to have any real chance of choosing amongst, or even being considered for, a range of different treatment options. Based on the results of this study, a number of processes seem to

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combine to lock in most patients at a very early stage to one treatment or the other. First, at referral, few patients have any clear idea of the range of treatment options available, so they are dependent on practitioners to make them aware of the choices. Nevertheless, administrative staff only considered the psychiatric unit as a possible destination in a minority of cases. The journey to treatment for most patients thus begins with little real idea of what they are entering into, and less about what else they might have chosen.

The processes by which referrers reported making their decisions about allocating patients may also play a part in this problem, with possible confirmation biases tending to make psychiatrists see features which are consistent with their own model of treatment, or their first thoughts about which treatment is most appropriate for patients. However, psychiatrists considered alternative treatment in around a third of cases, and only discussed the other treatments as a possibility with the patient in a third of the cases where it was considered. Psychiatrists generally seemed to be asking themselves whether they thought the patient would benefit from their own form of treatment and only considering the other possibilities, if at all, when the answer to this question was "No". Furthermore, most of the psychiatrists felt there were systemic blocks to effectiveness, even if they did get as far as considering another form of treatment: both practical problems such as the patient's having to restart at the bottom of a new waiting list, and cultural blockages such as the feeling that refer patient elsewhere was to admit failure.

This study suggests that were considerable problems for patients in getting access to a reasonable range of treatments. For instance, patients often felt that it was quite difficult to get any form of counselling treatment before doctors (psychiatrists) saw them, either because of a lack of awareness at psychiatric care level or, more often, because of the difficulties of long waits for treatment **"Seven months I have been**

waiting to see a psychiatrist in the local hospital, but I paid for the private doctor". Such long waiting times are an unfortunate fact of life in most counselling treatment services across Saudi Arabia, and various suggestions have been made to deal with their attendant problems (Almoshawah, 2004). Whilst it is not likely that there is any quick fix for such problems, it may be salutary to be reminded that they do cause real problems.

9.4 Treatment Information

Perhaps the strongest theme running through the results is the need for wider availability of relevant information. The demand for more information came through particularly loudly from patients themselves in their interviews, but was also voiced by practitioners. Counsellors want better information about what treatments are on offer and where they might refer different kinds of patient, and the patients want information about these questions and about what to expect from treatment; and administrative staff need information about the other departments and about how to select patients.

Of particular concern was the dearth of information given to patients, even when they had consented to treatment, in the sense that they had been placed on the waiting list for one treatment or the other. On average patients received somewhere between "None" and "A little" information on the various aspects of information previously identified as necessary for informed consent, with typically almost all patients and around a third of practitioners saying there had been no discussion at all of at least one of these matters. Psychiatrists in their interview generally rated discussion as more substantial than patients did, which might be due to patients forgetting what they were told, but which also might be due to psychiatrists exaggerating what they were aware they ought to have discussed. However, even if we accept practitioners' views, we are still left with the conclusion that between a quarter and a half of practitioners were not in a position to

give real informed treatment and medication after discharge order. These data are similar to the uninformed proportions suggested by Chaleby (1986; 1996) and Al-Issa (2000).

9.5 Treatment effectiveness

Adding to the concern about effectiveness are some of the findings from the patients' treatments. This suggested that when patients were given strong medications, it might have beneficial effect in their condition, but majority of them were not aware of possible side effects. If this finding is an accurate representation of patient views, it again suggests that significant numbers of patients taking medication without a real understanding of their treatment.

It was notable that despite this finding, none of the patients in the study took up the offer to discuss any worries with their practitioners or even with their hospitals administrative staff. Of course it may be that their concerns, while real, were not sufficiently strong for them to take what might seem like the intimidating step of contacting their practitioners. It is planned to undertake a follow-up of some of these patients when they have all begun treatment, to see whether the apparent medication had any obvious effects on treatment.

It should also be noted that when asked to compare the effectiveness of psychiatrists and counsellors, a majority of patients chose counselling treatment to some degree. Even on the assumption that there actually was a significant difference in effectiveness; a significant minority said they would prefer not to have any medications. To my knowledge this is the first time patients have actually been asked for their own views on this topic, and the results suggest that practitioners who argue that considerations of effectiveness 'trump' informed consent may face an ethical problem. Even if there were

evidence for the supposed deleterious effects of their treatments, these data suggest that to place effectiveness first would be to act against most patients' wishes.

The main effect of the treatments was to shift the majority of both psychiatrists and counsellor patients towards a preference for treatment. What might explain this finding? Unfortunately, the two types of practitioners are exclusively in isolation from each other and there was a difference between them in their aims, roles, and awareness of the services and even their attitudes towered mental health patients. In the absence of any other evidence, this finding means that we cannot rule out the possibility that counselling services were preferred simply because patients understood their counsellors better. On the other hand, other arguments might suggest that the differences are not purely artefact.

The next step would be to allow patients more say in choosing treatments. The differences amongst patients in their knowledge and confidence mean that any such move must be flexible and tailored to the individual, although we would also need to ensure that it was not so flexible as to allow practitioners too easily to slip back into their habitual procedures of not involving patients very much. Written information would be helpful, as might other procedures such as the use of patient advocates, although the latter might demand a high level of resources if most patients used them. There were differing views on when or where it would be best to have such information available, so the best option seems to be to try to deliver it at both main stages in the allocation process. It could be available in GP's, local hospitals, private psychiatric clinics, so that patients would have a chance to obtain it and discuss it before referral. It could also be sent out from the hospitals to patients' families after referral. This procedure would improve the chances that patients were at least aware of more than one treatment option.

9.6 Traditional Treatments

The majority of patients in this study believed in the power of the evil eye. Patients pointed out that their belief was supported by traditional healers. **"At first I want to see shikah, and he advised me to see him once a week, he told me that I might have a female jinni".** Belief in the power of the Jinni, in the active interference of spirits in the human world, and the notion of vulnerable persons and periods of life, continues to play an important role in determining therapeutic modalities in cases of mental illness. Anyone experiencing symptoms of illness or distress will usually categorise the cause of his illness in a general way and then seek out the treatment he regards as most appropriate. To the extent he is able, he will seek help from those practitioners he believes are most skilled in dealing with his particular kind of problem. Consequently, a patient who believes he/ she suffers because of spirit possession will most likely first turn to traditional healers specialised in dealing with spirits. If his treatment is "unsuccessful", that is, the person begins to doubt the efficacy of treatment because his symptoms are unrelieved, he will turn to alternative therapies or to other healers of the same type.

In many instances, popular healers address the problems which the modern medical system does not or cannot. In a sense, traditional healers complement the formal medical system since they deal directly with problems which medical professionals are not trained to handle. The stress generated by social disruption, changing male/female relations, and urbanisation in other words, personal conflicts perhaps aggravated or caused by forces of modernisation may cause symptoms of illness which the medical profession, as presently constituted in Saudi Arabia, is unable to meet.

Practitioners in this study failed to appreciate the extent to which Saudis resort to popular healers depends as much on the availability of healers as it does on the availability of modern medical services. Access to the vast majority of traditional

healers depends on the relative extent of government suppression of healers, popular demand, the continued transmission of skills from one healer to another and the continuity of specific cultural beliefs among society. As various causes, both natural and supernatural, may be ascribed to the same illness, the mentally disturbed individual may resort to popular healers and/or modern health care services either successively or simultaneously. The relative strength of certain cultural values and cosmological conceptions among different classes and individuals determines in large part variation in strategies of treatment.

Specific therapeutic strategies are necessarily bound up with cultural explanations for the efficacy of popular forms of treatment. Popular therapies which treat patients suffering from disorders which physicians diagnose as mental, psychological, behavioural or social do not assume such distinctions. Ideal modern medical practice assigns a specialist to deal with each aspect or set of symptoms consigned to a "mental" disorder, a psychiatrist or physician for the physiological, a psychologist for the psychological, and a social worker for the social aspects. While these functions may in practice be performed by the counsellor, the structural distinction underlying treatment remains. Specific forms of treatment, psychotherapy, counselling, drugs, etc, are directed to different aspects of the disorder.

Popular healers in Saudi Arabia are not directed to the physiological, psychological or behavioural symptoms of an underlying disease process. Instead, such treatments strive to eliminate the perceived causes of the disorder experienced as such by the afflicted person. Whenever a particular form of therapy proves to be effective, the underlying aetiological assumptions as to the cause and nature of the illness are validated. Since causes of mental disorder as popularly conceived in Saudi society are general and multiple, different remedies from various specialists are sought. The continued

acceptance of various popular treatments varies depending on the perceived "success" of the treatment in alleviating symptoms.

In general, the sequence of popular healers sought for mental disorders thought to be caused by spirit possession or the evil eye usually includes a visit to a sheikh for initial help. The sheikh diagnoses the disorder (i.e., determines its precise cause, the evil eye, possession by a particular spirit.) The aid of things possessing spirit of religion lends strength to the victim of such forces to resist the power directed against him. Sometimes attempts are made to exorcise the spirit. The sheikh writes out amulets, and recites Quranic verses to help shield the victim from evil forces.

Usually possession is suspected when other treatments fail to relieve symptoms. In this case, efforts are usually made to communicate directly with the possessing spirit. A relationship between the patient and spirit can be established whereby the desires of the spirit can be made known. The possessed person will try (by means, for example, of attending Zar) to avoid having the spirit make onerous demands upon him. To avoid experiencing the spirit's wrath or vengeance (evident by more troubles) for failure to comply, the victim tries to appease the spirit and keep him contented. Thus, possessed persons attend Zar as a prophylactic measure against future mental and life disturbances.

Those who go to Zar vary in their degree of involvement in the Zar and in the degree to which they are aware, in daily life, of being possessed.

However, results from this study indicate that the relative acceptance of practitioner's treatment on the part of the patient depended on the direction, and intensity of the patient's fears and doubts. The more dubious the patient was concerning the efficacy or validity of popular treatments; the more likely he/she was to accept treatment from the practitioners. The surrender was not unconditional, however. If professional assistance was found ineffective, patients reverted to traditional healers. As many patients in this

study illustrated **"If I do not get better, my family told me that we will seek a** *shikah*". Belief in the existence and power of spirits and envy continue to inform many of the therapeutic strategies pursued to alleviate psychological and somatic stress. As long as such forces exist in the social world, Zars, visitation of saint shrines, exorcisms, and other forms of popular healing by Quranic means will be considered the necessary means of containing social and psychological disorder and stress.

9.7 Treatment Decision

The results of the study also give a reason to be concerned about the ways in which patients are allocated to treatments. The current picture may be described well by a remark made by one of the patients interviewed: **"I found myself in the psychiatric hospital"**. Empirical evidence was mentioned as a factor affecting treatment choice by most of practitioners. Both psychiatrists and counsellors reports suggested that what influenced their choices were more often non-specific factors, such as the patient's perceived inclination towards 'here and now' work, or the perceived need for exploratory work.

Not only is there little evidence that most such factors do predict success in treatment, but the results from the questionnaire suggested that there is little consensus about the implications of these features, either amongst psychiatrists, or between counsellors and administrative staff. For most of them, what one professional thought clearly indicated one treatment, another thought had no implications, or even the opposite implication. Several psychiatrists also commented spontaneously that even though referral and treatments suitability was one of the prime goals for their work, they felt they had little idea about how to do it: **"but so far I haven't found any specific information."** The picture that emerged was one of professionals trying to do their best in a highly complex task for which they felt ill-equipped.

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9.8 The patient perspective: a discussion

The findings in chapters 6 and 7 have highlighted differences in the characteristics of patients in the four hospitals. This section will analyse certain characteristics of patients in each hospital. Inferences will then be drawn to seek any possible reason behind the characteristics noted.

Regarding patients' gender, the culture in Saudi Arabia is such that a clear line is drawn between males and females, and usually the females are referred to as the weakest link in the family, who play a negligible role in the working environment. Most Saudi women play an important role in the family by creating a homely atmosphere for the upbringing of children. Even if they do paid work, their choice of working environment is very limited. Thus, it is men who stand high the society and have authority.

In this study, it was found that female's patients (57.2%) outnumbered male (42.8%). Evidence regarding this issue in the literature is spares. Al-Subaie and Alhamad (2000; 2002; 2003); and Al-majed (2003) all reported that male patients tend to seek help from psychiatric hospitals more than females. They added that the male patients in Saudi society are more expected to get psychiatric treatments than female patients. However, the finding of this study supported that female patients have a slightly greater tendency to seek treatment than males. With this finding it seems that the female patients in Saudi Arabia may be facing tremendous stress from both the demanding work environment and their family life. The lack of a strong sense of belonging their family, with stressful working environment and married/ divorced or widowed life may be among the reason that contribute to female patients' admittance in psychiatric hospitals. This finding is surprising, given the nature of the Saudi culture and traditions. The culture of Saudi society dictates that women are not allowed or expected to be out of the house for long period of time, and families usually exhibit more tolerance to the illness of females than they do for male patients. It is be noted that, among these females in the four hospitals,

there was a greater proportion making frequent visits either once a week or every two weeks, than among the male patients.

Many studies in Saudi Arabia generally (Al-Fahed, 1998); (Alhomidi, 1999); (Ministry of Health 1998); (Al-subih et al, 2002) emphasised the role of patient's family and that the family should be close to their patient. Chaleby(1987) reported that patients' families play an important role in the treatment of the patients. In this study, the interviews showed evidence of patients who are socially isolated with few contacts: " **I have made a good friend here, but you know I feel a bit up set when I see people here having visitors"**. Those with poor resources and no support from close relatives had shwed less improvement in their condition and a greater tendency to stay longer in the hospital than those who were not socially isolated and who had considerable social ties.

Most of the studies in the literature regarding categories of diagnosis generally put the emphasis on schizophrenic patients and pay very little attention to the diagnosis in particular. This study has revealed that majority of the patients surveyed were diagnosed with schizophrenia and only a small minority were diagnosed with mood disorders and disorders of personality.

There is some evidence that Riyadh Mental health hospital patients may be more symptomatic on some measures (e.g. more depressed), and some evidence that they may have a different range of problems, with more schizophrenic , more relationship problems and more personality disorders. However, the lack of a validated method of diagnostic labelling in the study makes it impossible to know whether these differences are real or due to different labelling biases. This finding coincides with Chaleby's (1986) study which revealed that there were many more schizophrenic patients in Saudi society than other diagnoses. On the other hand, many studies such as Mann and Sproule (1972); El-Gaaly (1984); Fan et al (1987); El-Rufaie (1988);Chaleby (1992);

Mai et al(1993); Alhamed (2004) all reported that patients who are diagnosed with schizophrenia are more likely to get hospitalisation.

Among the four hospitals, it was found that, the majority of patients from Jaddeh and Dammam had not previously been admitted to the hospitals, while in Riyadh and Tai'f hospitals, most of the patients had been previously admitted at least once. One explanation for this finding is related to the hospitals' admission rules and their bed capacity. However, it is an interesting to note that these recurring patients from Riyadh were the ones who received the strongest support from their family and relatives. On the other hand, patients from Jeddah felt that their relationship with family was far from being strong. This may provide some evidence of their deteriorating condition and their sense of a loss of belonging despite the fact of receiving strong support from their family.

9.8.1 Patient's Choice of Treatment

Findings relevant to patient choice in treatment can be considered in many ways. First, it has already been seen that in the patients' interviews, most reported having had no opportunity to exercise any real choice about what kind of treatment to have. Though most saw the referral decision as having been a joint one between psychiatrists and administrative staff, this decision was usually only about the basic question of whether to refer, and only occasionally included an explicit consideration of the treatment model available. Most patients had little idea of what counselling treatments were available and no particular preferences for one treatment over another at that stage, though there were some suggestions that counselling patients might more often have a clear preference for treatment in mind. However, when asked, the majority of patients themselves said that they did not want to have a greater role in choosing treatment,

although they did indicate that they wanted the decision about treatment to be a joint one between themselves and their doctors.

The reluctance to take greater responsibility for treatment decisions appeared to stem mainly from patients' feeling that psychiatrists were the experts and that patients were not qualified to make such a decision; they also had concerns about their ability to take in or understand information about different treatments, and fears of what would happen if the treatment did not go well. However, it was emphasised to patients in the interview that this was a research question and that their choice would have no real impact. It is possible that their ratings in this situation set were different than if they had actually been choosing their own treatment.

It is also important not to get into too black and white a view in this area. We do not have to, and should not, take either of the polarised views that either patients make the decision or practitioners do. In reality what is most likely to be needed is a flexible approach which might range anywhere along a continuum of control. At one end, some allocation decisions might be very patient-controlled, for the patients who know exactly what they want, and where there are no other indications to strongly guide the choice. In the middle range of joint decision making and negotiation, the practitioner could offer any relevant technical knowledge and his or her advice, whilst also eliciting the patient's preferences, if any. At the other end would be a very practitioner controlled group, either because the patient did not wish to play a part, or because the practitioners considered that the likely benefits or risks, meant that there were strong reasons to recommend or refuse one treatment or another. It would be hard to deny that there is scope for at least such a limited extension of patient choice, and it is possible that a move in this direction might offer concrete benefits in the form of increased patient satisfaction, lower drop out or even improved outcome.

9.8.2 Patient's Needs

Finally, the researcher would summarise the other quality issues raised in the patient interviews. The general questions put to patients about likes, dislikes and desirable changes suggested that the following variables were important to them; most of the patients described their needs in a general manner, for instance, they wanted to be discharged from hospital and wanted their normality back. **"I only want to be discharged and want my normal life back".**

It also found almost all patients' have common concerns such as, a relaxed atmosphere in their sessions with psychiatrists and counsellors and more time for each session; courtesy; some guidance as to the expectations for what would happen and what they were supposed to talk about in the treatment; help and support after discharge, being listened to (but also not being silent); direction; a varied of activities in their hospitals more information particularly at an earlier stage; being validated as having a real but not insuperable problem; gaining understanding of, or reassurance about, their problems; and the psychiatrists being clear and open about matters such as the time available or the likely waiting time for treatment. Such a narrow focus might be less important if there were substantial opportunities for wider consideration at the stage of treatment. However, the few patient characteristics which did attract widespread agreement about their treatment implication all concerned the number of their sessions with their psychiatrists and counsellors. Most of the practitioners agreed, with a high degree of consensus, that the time being with patients should be increased.

Thus, these results suggest that counsellors and psychiatrists were failed in some way to understand their patient's needs. For instance, the number of sessions and being available for patients when they feel need them.

9.9 Summary of the Study

Many studies in the literature have based their research on mental health services in the psychiatric hospitals and their findings have identified several factors which influence a patients' treatment and practitioner's value. In the study the result are consistent with many of the academic studies in the Saudi Arabian society and also show some interesting new findings, with regard to psychiatrists', counsellors', patients' and administrative staff views of the services.

This study is of great importance, particularly to Saudi Arabia, which the research was based upon; it enables the researcher to formally examine and evaluate the current mental health provision. In doing so, a greater sense of awareness of the services was created among the psychiatric authorities, personnel working in the field of counselling and patients. Moreover, to the researcher knowledge, this thesis is the first study which emphasises specifically on the issues of the examination of mental health provision with particular references to counselling. Thus, it is hoped that the originality of this research topic will not only yield considerable useful contribution to Saudi Arabia, but also to all other mental health fields at large

The great importance given to the mental health provision is reflected in the weight gives to the practitioners. However, this emphasis is not reflected in the achievement of the mental health practitioners and the general situation of services. Many writers have criticised the current services, which has remained undeveloped for a long time.

However, highlighted below is some of what seem to be most interesting and/ or important finding from this study.

9.9.1 Psychiatrists

- Psychiatrists have a very strong awareness and knowledge of their aims and objectives.

- Psychiatrists in four mental health hospitals saw their roles and responsibility as not being clear.

- Almost all psychiatrists have insufficient awareness of the mental health provision and they support the idea of greater communication with other practitioners.

- Psychiatrists have a very high level of satisfaction with their treatment outcomes. There is almost complete agreement between psychiatrists that would like to have more than one session per a week with their patients.

- Psychiatrists felt their referral system were flexible and clear, with high level of their awareness of the current referral system.

- The majority of psychiatrists supporting the idea of having more training and qualifications for mental health professionals

9.9.2 Counsellors

- All counsellors experienced dissatisfaction with the whole service and all participants raised the same issues criticising the poor standard of counselling services in their hospitals.

- Counsellors have insufficient knowledge of their aim and objectives, with correspondingly reduced possibility of achieving their goals.

- The majority of counsellors saw increased significance in their role in the hospitals. And they saw their roles and responsibilities as intertwined with the psychiatrist's roles, although they continue to wield power and influence in hospitals, which affects counsellor practice.

- Most counsellors were satisfied with their level of effectiveness. However, they mentioned weaknesses in understanding patient's needs.

- The vast majority of counsellors would like more than one session per a week with their patients.

- Counsellors had little awareness of the working of the referral system.

- There was general agreement amongst counsellors in of the need for training courses to improve their personal development.

9.9.3 Patients

- Almost all patients rated the quality of services as unsatisfactory.

- All patients identified the first source of help they sought to be a traditional healer.

- The most common diagnosis of all patients was that of Schizophrenia, followed by Mood disorders and Disorders of personality and behaviour.

- All patients pointed out they hade little knowledge and information of treatment strategies.

- Almost all patients felt that the treatment they received from psychiatrists and counsellors was effective, and reported the need for more sessions with their practitioners.

- Patients felt the referral system was inflexible and not clearer, and they stated in their interviews that they were dissatisfied with their current referral procedures.

- Most patients were referred by local hospitals, GPs, or Accident and Emergency, governmental departments (police, social services, and local authorities), and by their family.

- The vast majority of patients felt that the psychiatrists and counsellors failed to understand their needs.

- Patients' needs: Symptom relief, information at an earlier stage, Access to their treatments, shorter waiting lists for the treatments, a more pleasant environment, clearer signposting of departments, help and support, a variety of activities in their hospitals, more freedom, communication with their families, and more time with their psychiatrists and counsellors for their sessions..

9.9.4 Administrative staff

- Administrative staff believed that aims and objectives of mental health provision are clear.

- Staff members saw their roles and responsibility for practitioners in four hospitals as not being specific and clearer.

- Staff members reported the need for better communication with other practitioners, with almost complete agreement amongst among administrative

staff that psychiatrists and counsellors have insufficient awareness of the mental health provision

- Administrative staff would like to have feedback from their hospitals. There was almost complete agreement between Administrative staff that the practitioners have a very ineffective their treatment out-comes.

- Administrative staff felt the referral system was insufficiently flexible, with a lacked of practitioner awareness of the referral process.

- All administrative staff supported the idea of having a very high qualification, with more training courses for mental health professionals.

- Administrative staff favored creating specialised centres to provide professional care for the patients.

- Administrative staff perceived a need to increase the number of professionals such as psychiatrists, nurses, counsellors, and social workers.

- They called for co-operation between the other governmental organizations such as: Police, Local Authority and Ministry of Health.

9.10 Possible Action

Finally, the findings of this study might imply possible action to improve the quality of the psychological treatment assessment service. One obvious fact which stands behind this study (and one which is probably familiar to all practitioners) is the current degree of separation between the psychiatrists, counsellors, and administrative staff. Should the practitioners be looking towards a greater degree of integration, either simply at the level of more integrated roles and responsibilities, or in a broader organisational sense? This seems an obvious proposal; it appeals to common sense and is consistent with the Joint Statement (Ministry of Health, 2001). But would it actually solve any of the problems identified here? It would certainly seem likely to contribute towards a reduction in some of the difficulties, particularly some of the barriers to aims and objectives, awareness and referral system which were found. A more integrated treatment service would presumably help to improve communications between practitioners from different models, increase their knowledge of each other, and make it

easier to organise joint waiting lists which did not cause problems to patients transferring from other agencies. However, many problems would remain, most obviously, how an integrated service might allocate patients to treatments any better than the current mental health provision in Saudi Arabia.

One also should not underestimate the difficulty of bringing these practitioners closer together. There is quite a long local history over the last few years of attempts to do just this, and they have so far made little impact. Perhaps most important is the fact that these are not just different groups of people who happen to offer different treatments, they differ in many other ways. Amongst the important differences one might speculate about are their largely different professions of origin, with a long history of rivalry between psychiatry and other psychological treatments, focused on what psychologists see as psychiatrists' attempts to establish hegemony over other professions; a view which psychiatrists see as demonstrating psychologists' over-sensitivity, their different approaches to many problems, which often seem to reflect their therapeutic approaches, counsellors often appearing more reflective about their patients' problems, psychiatrists more "let's get on and do something"; and their different priorities in many areas of work. These differences both make it hard to bring the practitioners together and also mean that if one did manage that feat, the need to convince two very different cultures might make some changes to the service harder rather than easier, changes which one group of practitioners likes, the other may dislike.

Perhaps the best way forward would be to find small and specific areas where they could co-operate, so as to begin building up a greater degree of trust and awareness. One suggestion was that hospitals teams, where there is perhaps a greater tradition of multi-disciplinary working, might be a better place to explore more integrated practitioners in mental health hospitals in Saudi Arabia. However, integration of the roles and responsibilities of practitioners might help in some

ways, but certainly would not solve all the problems identified here. As one example, the findings suggest that there is currently considerable confusion, uncertainty and disagreement about which form of therapy and treatments would be the best for most of the patient characteristics which were considered. How might this situation be improved? Integration by itself does not solve these problems.

From the finding, it seems likely that any substantial improvement over the current provision would be very much more time consuming than that. Would the benefits be worth the cost? This is a judgement that needs to involve psychiatrists, counsellors, managers and, ideally, patients and government agencies as well. There are several possibilities for improving the current provision.

- It would be possible at least to set up and disseminate local guidelines concerning the patient features which were widely agreed to have clear implications for treatment. It would also be useful to let administrative staff know about the psychiatrists' and counsellors' views on features which were widely used by administrative staff but widely disagreed with by the practitioners themselves. However, this is complicated by the finding that even when the administrative were united in opposing practitioners' views, they often still disagreed about what was the right place to refer such cases. Many administrative staff also pointed out in their interviews needs for more information about what services are available, and about how to access them.

- A forthcoming and reputedly wide ranging review of the evidence concerning psychiatric treatment in mental health, sponsored by the Department of Psychiatry in the Ministry of Health (Al-Subaie & Alhamad, in press), may be useful in providing a manageable and up to date survey of the field which could assist such an evidence based treatment..

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- The final possibility for improving allocation might be to put more resources into local audit and service evaluation research. For instance, if some joint outcome measures could be agreed, then rather than relying only on published pure research studies, the practitioners might also build up some knowledge about local services.

9.11 Limitation of the study

Before consideration of the implications of the results, note should be taken of several general limitations to any conclusion based on this study.

A) It is noted that the study's central methodology might be open to criticism in at least two ways.

- First, in assessing several important areas of quality such as effectiveness of psychiatrists and counselling treatment, or what factors affect practitioners' decisions about patient referred, the study depends on patients and practitioners to remember accurately what happened in an interview an average of three months earlier. It is clearly possible that such recollection is unreliable, and that some of the results found were due to such memory effects, rather than to true differences of act, behaviours being in mind, the well known finding that patients have forgotten a significant part of what they were told in a medical interview within hours (Rogers and Pilgrim, 2001).

- The second methodological problem is that even if we accept that respondents can report accurately what they think happened, their reports may still not describe reliably the actual processes operating. This objection perhaps applies most clearly to the practitioners' description of what led to their view of the services. Some of the literature might give a reason to be cautious about expert judgement in general and suggested that people are not always aware of the true

factors affecting their judgment, and thus may not accurately report them to someone else(Rogers & Pilgrim,2001). This is a pertinent objection, but also one which if taken too seriously would make any survey of this kind impossible. Despite these concerns, practitioners often can give some useful idea about their experiences, and it seems worth exploring their views, even if we must be careful about assuming that each account of a process gives the whole truth.

B) It may be worth making the point that generalisation from this study to other services should be made with caution. The researcher is aware of nothing which would suggest that there is anything particularly unusual about the service, but every service will have some unique features and this was a service evaluation rather than pure research, there may be lessons here for other services as well, but the true focus is the particular services under examination.

9.12 Recommendation

This current study has looked at and gained an understanding of the current mental health provision in Saudi Arabia, with particular reference to counselling. However, based on the examination of the mental health system, this part could offer many suggestions for moving the current model of services forward.

1) **Improve regulation:** The findings from the questionnaires and interviews of practitioners in four hospitals indicated that the regulations of the mental health provision are not clear. All practitioners who were interviewed considered the existing hospitals regulation are not effective enough. Moreover, the full consensus from psychiatrists and counsellors that current aims and objectives affected their work negatively shows that there is a great need for radical changes to the regulations of mental health provisions. The current regulations were formulated by the Ministry of Health in 1980 are still provisional. Evidence from finding here suggests that many of these regulation are insufficiently clear, and structured do not apply in practice. This is especially true for the procedures of treatments, admission and discharges, aims and objectives of practitioners, the roles and responsibilities of all practitioners in these issues, the regulations regarding referral system, the roles of the government agencies in referring patients, and assessed effectiveness of practitioners' treatments. Thus, the philosophy and regulation of mental health care should be more systematic, structured and applicable, and should be regularly assessed and revised. Improved regulation and procedures in the areas of concern will be necessitating that mental health services are evaluated regularly.

2) **Enhance practitioner's awareness and knowledge.** The economic policy of mental health services should be revised. This study has revealed that the changing policy towered provision greatly influences patients' numbers to hospitalisation. The fact that mental health services in Saudi Arabia are free of charge actually increases the

likelihood of number of patients hospitalised in psychiatric hospitals. Moreover, because there is no financial burden on the families, there is a temptation for them to choose the easy solution of leaving the patients in hospitals even after they are stable, rather than making some efforts to help them adapt in the community and develop their skills of living. It is may be suggested and recommended that the Ministry of Health should decrease the number of psychiatric hospitals and establish alternative care centres such as one-day treatment centres.

3) **Care programmes**. There is a need for improved availability of alternative care programmes, for example, day-hospitals, rehabilitation centres, counselling centres, psychotherapeutic centres, and specialised centres for geriatric patients etc. This recommendation is supported by most of the practitioners interviewed with though that a greater availability of programmes will not only benefit the current hospitals by reducing the number of patients, but also be beneficial to the patients themselves to participate in the appropriate programmes. These services could provide access to very high skilled practitioners and specialised treatment facilities for the patients living in the community. Their availability would decrease the waiting list for treatments and burden on the family and provide the needed support for both patients and their families. It is expected that availability of alternative care programmes would guarantee more co-operation in meeting patients' needs from the hospitals and practitioners. Furthermore, active participation by patients in the relevant programmes will decrease finical cost and burden on the mental health hospitals and their practitioners, and at the same time, patients will have a better chance of developing their skills to function independently of institutional support if they are treated in the least restrictive setting which supports their safety and well being.

4) **Patient information**. In this research the twin issues of more patient information and greater patient involvement in decisions about treatment have already been briefly considers these issues arc linked, in the sense that more decision making would only be possible if patients had more information on which to base their decisions. They also seem to be desirable whether or not the services and treatment by practitioners are more integrated. A minimum goal, and perhaps a necessary first step, would be to ensure that all patients have at least enough information to give reasonably informed consent. A Written information package similar to that used in ordinary hospitals (suitably modified) would probably be necessary but not sufficient to meet this goal: for instance it is hard for any leaflet of reasonable length to cover every available possibility for treatment. Patients may also need time to discuss and reflect on written information. There are numerous suggestions in the literature previously reviewed about how informed consent procedures can be implemented.

5) **Information institutions**. The Ministry of Information could play a significant role in changing the society's attitude towards mentally ill people. It has been found in this study that a majority of patients had sought help from local traditional healers, and they had experienced many types of traditional treatments, such as **branding** and **Zar**. There is a possibility that their families may support them. Therefore, it is desirable to have mental health education programmes which highlight the nature, causes, treatment methods and the negative sides of neglecting the treatment of psychiatric problem, with emphasis on the role of family and environment. These educational programmes will properly educate the public on the facts of mental illness and dispel any myths borne by some traditional folk. Most importantly, the aim of such education is to encourage patients to come forward to seek treatment as soon as possible and also to encourage the family of the mentally-ill person to persuade the former to seeking treatment. Such a

move to educate the public will assist in treating some of the cases that will occur in the future. Participation in such programmes is expected from psychiatrists and counsellors.

6) **Communications.** It would be helpful to develop more informal co-ordination between the hospital practitioners themselves and patients. The findings of this study revealed inefficient referral procedures such as lack of firm actions taken by administrative personal in ensuring compliance with referral procedures, delay in psychiatrists writing reports of patients hospitalised, delay of counsellors in handling the referral procedures etc. Thus, before a patient is referred to the hospital, some arrangements and co-ordination should be made between the practitioners, not just as a routine; it should also be written and documented. The main purpose is to provide and, effective communication system between practitioners to increase their awareness of referral system.

7) **Patients review committee**: To further facilitate effective planning, it would be desirable to establish a Patient Review Committee, within each hospital, to monitor their practice with patients and try to solve their problems. This committee should consist of the medical director, head of the counselling unit; and head of the admission office. This committee should meet once a week to discuss the circumstances faced by particular patients. It would also be beneficial if all hospitals establish a case review from each hospital would meet up annually to discuss and share their ideas on coping with the new patient and discuss the issue of over stay by some patients'.

8) **Patients' financial problems**. The majority of patients in this study were unemployed and most of them were females from a low-income bracket. If the patient does not have adequate income to meet his/her daily requirements the administrative

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staff could try to arrange with the Ministry of Labour and Ministry of Social Affaire to find a job or pay a monthly allowance for patients. Also, the Civil Cabinet could create jobs for discharge of patients, so they need not be dependent on the hospital environment. This might diminish patients' worries about not having a proper job or not having adequate income upon discharge.

9) **Patients – family support.** The result of this study revealed that patients generally had lower family and relative support. A majority of patients report in their interview a poor relation with their family and most of them received few visits from family during their hospitalisation. Rejection by family and the negative attitudes of society towards these psychologically-ill patients will only further deteriorate their conditions when they are discharged into the community. Thus, if there were greater acceptance by the society of these patients, it would greatly help to boost their self-confidence. It is recommended that **half way houses** should be established under governmental supervision. These houses would provide social support and follow up services for patients who are capable of leading an independent life in the community. A greater degree of co-ordination is also recommended between the mental health hospitals and social welfare institutions and the vocational training centres of the Ministry of Labour and Ministry of Social Affairs for achievement of such integrated services. Such social health services would make the patients and their families feel more secure when the patients are to be discharged into the community. Availability of such an integrated support system would provide an alternative solution that is more positive than leaving the patients in hospitals for an indefinite time after their condition is stable and they are capable of leading a more independent life outside the hospital environment.

10) **Mental Health Act**: Although Saudi Arabia has had a mental health Shari'a (Islamic jurisprudence) to organise the relationship between mentally-ill people and their doctors since 1970, the Ministry of Health does not have such an Act. There is a need for mental health legislation to define the responsibilities and extent of authority of professionals and institutions and to prevent the abuse of mentally ill patients by families, society and professionals. The act should define the minimum responsibilities of the government, the privileges, responsibilities and liabilities of professionals, clarify the roles and limitations of caregivers, and establish criteria and awareness for the rights of the patients and ways to protect them. The scope of legislation should involve the patient's right to treatment, patient's individual human rights, rights and obligations of the family, the community and the legal basis for service development.

Finally, it is hoped that this study will be of practical use for those involved in making decisions and those who are involved in mental health provision in Saudi Arabia. It is hoped that it will stimulate a review of the services and a reform of the mental health policy in Saudi Arabia or at least raise particular questions about the current situation and how to develop it.

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Appendices

Appendix 1- Letter to Hospitals

Directors of Mental health hospitals

Dear Sir,

May I request your permission to conduct a research study in the Riyadh, Jaddeh, Tai'f, and Dammam Mental Health hospital

I am a mental health counsellor currently registered on the Ph.D. program in the Department of Psychology at the University of Hull, England. My study is a requirement for the degree of Ph.D. in Psychology. In support of this may I refer you to the attached official study information sheet and the official study consent form for details related to what is proposed, plus the expectations of the mental health staff under your directorship should you agree to give permission.
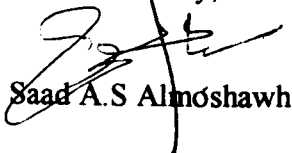
The purpose of my study is to explore the nature and scope of mental health practice in Saudi Arabia in order to gain an understanding of how mental health counsellors become involved in therapy. It is hoped this study will contribute to the development of Mental Health provision in Saudi Arabia.

I write to request your assistance in providing an opportunity for me to join Psychiatric/Counselling meetings to explain my study to the members, and ask if they would agree to participate in my research.

Enclosed is a copy of the aims and objectives that detail the main questions of my research. I can make myself available to attend a meeting with you should you wish me to do so.

Thank you for giving of your time to consider and hopefully assist in my request

Yours sincerely,

Saad A.S Almoshawh

February 1st, 2004

Dear Head of the Counselling Unit

I am a Ph.D student at the University of Hull, Department of Psychology, who conducting a study of the mental health services in Saudi Arabia with particular reference to Counselling, as a Counsellor you are being asked to participant in this study which will contribute to a better understanding of Mental Health services in Saudi Arabia.

You are being asked to participant in this study because of your status as a counsellor who is currently conducting counselling in your hospital. You are eligible to participant in this study if you: 1) provide counselling or therapy to the patients, 2) working in mental health hospital. If you qualify based on these criteria, please take a few minutes to participant in this study. Your participation is purely voluntary. You will not receive any immediate or direct benefits from this research.

Please complete the attached questionnaire, which should take you approximately 10 minutes, and return it in the envelope provided. Unless you have received these materials from researcher. Your response is anonymous. The questionnaire and interview have identification much information. This information is confidential and will be known only by the researcher.

The result of this research will constitute the researcher theses and may be published in journals, presented at professional conferences, and made available to officials at the National Guard in Saudi Arabia, and other interested individuals. You may receive a copy of the result by writing "copy of results requested" on the back of the return envelope, and printing your name and address below it.

I would be most happy to answer any question you might have. Feel free to call me on my or ends me a letter at my address, my telephone number 0501407100, E-mail: S.A. S.A.Almoshawah@hull.psy.ac.uk, P.O Box 100466Riyadh: 11365, Saudi Arabia

Thank you for your assistance.

Sincerely,

Saad Almoshawah

بسم الله الرحمن الرحيم

KINGDOM OF SAUDI ARABIA

NATIONAL GUARD

KING KHALID MILITARY ACADEMY

المملكة العربية السعودية

كلية الملك خالد العسكرية

التاريخ ١٤٢٤/١٠/١٨ هـ

مدير عام المستشفيات بوزارة الصحة   حفظه الله

السلام عليكم ورحمة الله وبركاته   وبعد،،،

نفيد سعادتكم بأن الأستاذ / سعد بن عبدالله المشوح أحد منسوبي قسم العلوم الإنسانية
والمبتعث في المملكة المتحدة (University of Hull) تخصـص علـم الـنفس تحـت
موضوع الصحة النفسية في المملكة العربية السعودية والمملكة المتحدة ، ويقوم الآن برحلة
علمية في موضوعه ،

نأمل مساعدته لإتمام مهمته في بحثه العلمي .

شاكرين حسن تعاونكم ،،،،

١٤٢٤/١٠/١٢

دكتور /

عبدالله بن محمد النغيمشي
رئيس قسم العلوم الإنسانية

المملكة العربية السعودية

الحرس الوطني

كلية الملك خالد العسكرية

<u>قسم العلوم الإنسانية.</u>

الموضوع .... التاريخ .... الرقم .... الرقم

رئيس قسم الطب النفسي بمستشفى الملك خالد الجامعي   حفظه الله

السلام عليكم ورحمة الله وبركاته   وبعد،،،

نفيد سعادتكم بأن الأستاذ/ سعد بن عبدالله المشوح أحد منسوبي قسم العلوم الإنسانية المبتعث في المملكة المتحدة (University of Hull) تخصص علم النفس تحت موضوع الصحة النفسية في المملكة العربية السعودية والمملكة المتحدة ويقوم الآن برحلة علمية في موضوعه ، نأمل مساعدته لإتمام مهمته في بحثه العلمي.

شاكرين حسن تعاونكم،،،،

دكتور/

علي بن سالم النصيف

رئيس قسم العلوم الإنسانية

بسم الله الرحمن الرحيم

المملكة العربية السعودية

كلية الملك خالد العسكرية

الرقم ٨٧٧ التاريخ ١٨/١٢ الموضوع

مدير عام الشئون الصحية بمنطقة الرياض   حفظه الله

السلام عليكم ورحمة الله وبركاته   وبعد،،،

نفيد سعادتكم بأن الأستاذ / سعد بن عبدالله المشوح أحد منسوبي قسم العلوم الإنسانية والمبتعث في المملكة المتحدة (University of Hull) تخصص علم النفس تحت موضوع الصحة النفسية في المملكة العربية السعودية والمملكة المتحدة ، ويقوم الآن برحلة علمية في موضوعه ،

نأمل مساعدته لإتمام مهمته في بحثه العلمي .

شاكرين حسن تعاونكم ،،،،

١٨/١٢/١٤٤٩

دكتور/

عبدالله بن محمد النغيمشي

رئيس قسم العلوم الإنسانية

Appendix 2- Consent Form

Consent Form

Consent to participate in research on the <u>Mental Health services in Saudi Arabia with reference to counselling provision.</u>

<u>Purpose of the study:</u>

To examine and describe mental health services and practice in Saudi Arabia, with particular reference to counselling services. This research is towards a Ph.D in Counselling psychology.

<u>Procedures:</u>

Participants will ask to complete the attached questionnaire, which should take them approximately 10 minutes, and return it in the envelope provided. Unless they have received these materials from researcher.

After a screening a questionnaire the participants will have an option to permit the researcher to conduct an interview with their experience in mental health (approximately 30 minutes videotaped interview), questions asked in this interview will be authorised by the participant beforehand. Any questions a participant may have regarding the purpose and procedures involved in this study will be gladly answered by the researcher, at any stage of the participant's involvement in the study.

<u>Confidentiality:</u>

The Ministry of Health Code Of Practice related to confidentiality in research will be fully adhered too. <u>All names will be changed, and all non-essential identifying features will be changed or disguised through coding that will be only known to the researcher</u> These changes will be discussed and reviewed with participants, and their wishes will be respected. The data will be kept under lock and key by the researcher. Upon completion of this research project, all taped recording of interviews will be erased, and all written materials such as transcripts and notes will be shredded.

<u>Right to refusal:</u>

All participants have the right to refuse or withdraw from participation in this study at

any time without offering an explanation. Such a refusal will bear absolutely no consequences for the participant and will be honoured by the researcher All data collected through any participant who subsequently withdraws will immediately be destroyed.

Result

The result of this research will constitute the researcher theses and may be published in journals, presented at professional conferences, and made available to officials at the National Guard in Saudi Arabia, and other interested individuals. You may receive a copy of the result by writing " copy of results requested" on the back of the return envelope, and printing your name and address below it.

Consent: The signature below acknowledges consent to participate in this study It also acknowledges the participant has received a copy of this consent form.

Participant *"Signature"* ·	Date

Appendix 3- Questionnaire English Copy

Psychiatric questionnaire

Section A:

Most of the questions in this section merely require you to select one of the listed options and indicate this by placing a tick (√) in the box provided.

Please answer all questions.

1. Gender:

A	Male	
B	Female	

2. Your Age:

A		Under 25		D		45 - 56
B		26 –35				
C		36 - 45				

3. Nationality

A	Saudi	
B	Non Saudi	

4. What is the highest level of formal education you have completed?

A	University		C	Other (Please specify)	
B	Postgraduate Masters				

5. What is your position in your Mental Health hospital?

A	Counsellor		D	Other (Please specify)	
B	Psychiatrists				
C	Administration Staff				

6. Could you tell your level of experiences working with mental health services:

A		Under 5 years		D	More than 15 years	
B		5 - 8				
C		9 - 15				

This section contains statement about the counselloing services. For each statement, please indicate how far you agree or disagree, by placing a tick (√) in the column which best reflects your opinion.

Statements	Strongly agree	Agree	Don't Know	Disagree	Strongly Disagree
1. Aims and objectives of mental health provisions are not clear.					
2. It is difficult for psychiatrists to achieve their aims and objectives in mental health hospital.					
3. Psychiatrists have insufficient knowledge of mental health aims and objectives.					
4. Psychiatrists should have specific roles and responsibilities.					
5. Roles and responsibilities in Mental Health provisions are less than it should be.					
6. Psychiatrists should have good communication with other professionals.					
7. Psychiatrists have insufficient awareness of the mental health services.					
8. Overall, patients receive the best possible services from Psychiatrists.					
9. Psychiatrists should see the patients more than once weekly					
10. Psychiatrists should have regular feedback from the hospital on their performance					
11. Psychiatry services have a very low effectiveness in mental health patients.					
12. The Psychiatry referral system needs more flexibility					
13. Psychiatrists have insufficient awareness of referral process.					
14. The referral procedure should to be clear.					
15. Psychiatrists should have a high qualification					
16. Psychiatrists should have more training and education in Mental Health services.					
17. There has been a steady decline in mental health Psychiatrists' development in the last ten years.					

Counsellor Questionnaire

Section A:

Most of the questions in this section merely require you to select one of the listed options and indicate this by placing a tick (√) in the box provided.

Please answer all questions.

1. Gender:

A	Male	
B	Female	

2. Your Age:

A	Under 25		D	45 - 56	
B	26 –35				
C	36 - 45				

3. Nationality

A	Saudi	
B	Non Saudi	

4. What is the highest level of formal education you have completed?

A	University		C	Other (Please specify)	
B	Postgraduate Masters				

5. What is your position in your Mental Health hospital?

A	Counsellor		D	Other (Please specify)	
B	Psychiatrists				
C	Administration Staff				

6. Could you tell your level of experiences working with mental health services:

A	Under 5 years		D	More than 15 years	
B	5 - 8				
C	9 - 15				

Section B:

This section contains statement about the counselloing services. For each statement, please indicate how far you agree or disagree, by placing a tick (√) in the column which best reflects your opinion.

Statements	Strongly agree	Agree	Don't Know	Disagree	Strongly Disagree
1. Aims and objectives of mental health provisions are not clear.					
2. It is difficult for counsellors to achieve their aims and objectives in mental health hospital.					
3. Counsellors have insufficient knowledge of mental health aims and objectives.					
4. Mental Health Counsellors should have specific roles and responsibilities.					
5. Roles and responsibilities in Mental Health provisions are less than it should be.					
6. Counsellor should have good communication with other professionals.					
7. Counsellors have insufficient awareness of the mental health services.					
8. Overall, patients receive the best possible services from counsellors.					
9. The frequency of counselling with patients should be more than once weekly					
10. Counsellors should have regular feedback from the hospital on their performance					
11. Counselling services have a very low effectiveness in mental health patients.					
12. The Counselling referral system needs more flexibility					
13. Counsellors have insufficient awareness of referral process.					
14. The referral procedure should to be clearer.					
15. Counsellors should have very high qualification					
16. Counsellors should have more training and education in Mental Health services.					
17. There has been a steady decline in mental health Counsellor's development in the last ten years.					

Administrative Staff Questionnaire

Section A:

Most of the questions in this section merely require you to select one of the listed options and indicate this by placing a tick (√) in the box provided.

Please answer all questions.

1. Gender:

A	Male	
B	Female	

2. Your Age:

A	Under 25		D		45 - 56
B	26 –35				
C	36 - 45				

3. Nationality

A	Saudi	
B	Non Saudi	

4. What is the highest level of formal education you have completed?

A	University		C	Other (Please specify)	
B	Postgraduate Masters				

5. What is your position in your Mental Health hospital?

A	Counsellor		D	Other (Please specify)	
B	Psychiatrists				
C	Administration Staff				

6. Could you tell your level of experiences working with mental health services:

A	Under 5 years		D	More than 15 years	
B	5 - 8				
C	9 - 15				

Section B:

This section contains statement about the administrative staff member. For each statement, please indicate how far you agree or disagree, by placing a tick (√) in the column which best reflects your opinion

Statements	Strongly agree	agree	Don't Know	Disagree	Strongly Disagree
1. Aims and objectives of mental health provisions are not clear.					
2. Psychiatrists have insufficient knowledge of mental health aims and objectives					
3. Counsellors have insufficient knowledge of mental health aims and objectives					
4. Psychiatric should have specific roles and responsibility					
5. Counsellors should have specific roles and responsibility					
6. Administrative staff should have good communication with other professionals.					
7. Psychiatrists have insufficient awareness of mental health services.					
8. Counsellors have insufficient awareness of mental health services.					
9. Administrative Staff should have regular feedback from the hospital in their performance					
10. Psychiatric services have a very low effectiveness in mental health patients.					
11. Counselling services have a very low effectiveness in mental health patients.					
12. Mental health referral system need more clearer flexibility					
13. Psychiatrists have insufficient awareness of referral process.					
14. Counsellors have insufficient awareness of referral process					
15. Mental Health practitioners should have very high qualifications.					
16. Practitioners should have more training and educational courses in Mental Health services.					
17. There has been a steady decline in mental health practitioner's development in last ten years.					

Patients Questionnaire

Section A:

Most of the questions in this section merely require you to select one of the listed options and indicate this by placing a tick (√) in the box provided.

Please answer all questions.

1. Gender:

A	Male	
B	Female	

2. Your Age:

A	Under 25		D	45 - 56	
B	26 –35				
C	36 – 45				

3. Nationality

A	Saudi	
B	Non Saudi	

3. What is your level of education:

A	Intermediate		B	University	
C	Secondary		D	Postgraduate	

4. Place of Residence:

A	City		C	Other	
B	Village				

5. Referral by:

A	Other hospital		D	Governmental establishment	
B	Police		E	Others	
C	Family				

This section contains statement about the Patients. For each statement, please indicate how far you agree or disagree, by placing a tick (√) in the column which best reflects your opinion

	Strongly agree	agree	Don't Know	Disagree	Strongly Disagree
1. Mental Health services are less than it should be					
2. Patients have less knowledge of mental health services					
3. Psychiatrists have a very low effectiveness in their treatments					
4. Counselling services have a very low effectiveness in mental health patients.					
5. The frequency of Psychiatrists with patient should be more than once weekly.					
6. The frequency of Counsellors with patient should be more than once a week.					
7. Patients have less awareness of referral process.					
8. Patients referral system need more flexibility					
9. Referral between departments in hospital should have more clear information and process.					
10. There are a weaknesses in counsellors abilities to understand patients needs					
11. There are weaknesses in psychiatrist's abilities to understand patient's needs.					

Appendix 4- Questionnaires Arabic Copy

بسم الله الرحمن الرحيم

السلام عليكم ورحمة الله وبركاته :

أمل تعبئة البيانات التالية وما يتناسب مع اعتقادك بوضع علامة (صح) أمام العبارة
المناسبة :

1. الجنس :

أ – ذكر (   )   ب - أنثى (   )

2 . العمر :

أ – أقل من 25 سنه (   )   ب – 26 – 35 (   )
ج – 36 – 45 سنه (   )   د – 46 فما فوق (   )

3. الجنسية :

أ – سعودي (   )   ب – غير سعودي (   )

4. المستوى التعليمي :

أ – متوسط (   )   ب – ثانوي (   )   ج – جامعي   د – غير ذلك (   )

5. وظيفتك في مستشفى الصحة النفسية :

أ – طبيب نفسي (   )   ب- مرشد نفسي (   )   ج-
علاقات مرضى (   )   د – أخرى (   )

6. الخبرة :

أ- أقل من 5 سنوات (   )   ب- 5 - 8 (   )   ج – 9–15 (   )
د – أكثر من 15 سنه (   )

النموذج الخاص بالأطباء النفسيين

غير موافق بشدة	غير موافق	لا ادري	موافق	موافق بشدة	العبارة
					أهداف الصحة النفسية غير واضحة
					الأطباء النفسيين يواجهون صعوبات في تحقيق أهدافهم
					ليس لدى الاطباء النفسيين مستوى عالي من المعلومات عن خدمات الصحة النفسيه
					يجب ان يكون لدى الاطباء دور محدد في مجال الصحة النفسيه
					الادوار في الصحة النفسيه اقل مما ينبغي
					الاطباء لديهم مستوى منخفض من الوعي عن مستوى الخدمات النفسيه
					يجب ان يكون هناك متسوى من الاتصال بين الاطباء والعاملين بالمستشفي
					بشكل عام المرضى يتلقون مستوى عالي من الخدمات النفسيه
					عدد زيارات المرضى للطبيب النفسي يجب أن تكون اكثر من مرة في الأسبوع
					يجب ان يكون للطبيب النفسي تقييم داخلي من المستشفى
					ليس للطب النفسي اثر ايجابي مع المرضى النفسيين
					تحويل المرضى يحتاج الى مزيد من المرونه
					ليس لدى الاطباء معلومات كافيه عن عملية تحويل المريض
					يجب ان تكون عملية تحويل المريض واضحة المعالم
					في سنوات الاخيره لوحظ تطور الطب النفسي والخدمات النفسيه
					يجب على الطبيب النفسي أن يكون حاصل على درجة علمية عالية
					يجب أن يكون هناك برامج تدريبية في مجال الصحة النفسية للأطباء النفسيين

بسم الله الرحمن الرحيم

السلام عليكم ورحمة الله وبركاته :

آمل تعبئة البيانات التالية وما يتناسب مع اعتقادك بوضع علامة (صح) أمام العبارة المناسبة :

1. الجنس :

أ – ذكر (   )   ب - أنثى (   )

2 . العمر :

أ – اقل من 25 سنه (   )   ب – 26 – 35 (   )
ج – 36 – 45 سنه (   )   د – 46 فما فوق (   )

3. الجنسية :

ا – سعودي (   )   ب – غير سعودي (   )

4.المستوى التعليمي :

أ – متوسط (   )   ب –ثانوي (   )   ج –جامعي (   )   د – غير ذلك (   )

5.وظيفتك في مستشفى الصحة النفسية :

أ – طبيب نفسي (   )   ب- مرشد نفسي (   )   ج-
علاقات مرضى (   )   د – أخرى (   )

6. الخبرة :

أ- اقل من 5 سنوات (   )   ب- 5 - 8 (   )   ج – 9–15 (   )
د – اكثر من 15 سنه (   )

البيان	موافق بشدة	موافق	لا أوافق	غير موافق	غير موافق بشدة

بسم الله الرحمن الرحيم

السلام عليكم ورحمة الله وبركاته :

آمل تعبئة البيانات التالية وما يتناسب مع اعتقادك بوضع علامة (صح) أمام العبارة المناسبة :

1. الجنس :

ا – ذكر (   )   ب – أنثى (   )

2 . العمر :

ا – اقل من 25 سنه (   )   ب – 26 – 35 (   )
ج – 36 – 45 سنه (   )   د – 46 فما فوق (   )

3. الجنسية :

ا – سعودي (   )   ب – غير سعودي (   )

4. المستوى التعليمي :

ا – متوسط (   )   ب – ثانوي (   )   ج – جامعي   د – غير ذلك (   )

5. وظيفتك في مستشفى الصحة النفسية :

ا – طبيب نفسي (   )   ب- مرشد نفسي (   )   ج-
علاقات مرضى (   )   د – أخرى (   )

6. الخبرة :

ا- اقل من 5 سنوات (   )   ب- 5 - 8 (   )   ج – 9–15 (   )
د – اكثر من 15 سنه (   )

المشرف على النشاط الرياضي

البند	موافق بشدة	موافق	لا أدري	غير موافق	غير موافق بشدة

بسم الله الرحمن الرحيم

عزيزي العميل :

السلام عليكم ورحمة الله وبركاته :

أمل تعبئة البيانات التالية وما يتناسب مع اعتقادك بوضع علامة (صح) امام العبارة المناسبة :

1. الجنس :

أ – ذكر (   )   ب - أنثى (   )

2. العمر :

أ – اقل من 25 سنه (   )   ب – 26 – 35 (   )
ج – 36 – 45 سنه (   )   د – 46 فما فوق (   )

3. الجنسية :

ا – سعودي (   )   ب – غير سعودي (   )

4. المستوى التعليمي :

أ – متوسط (   )   ب – ثانوي (   )   ج – جامعي   د – غير ذلك (   )

5. مكان الإقامة :

أ – قرية (   )   ب- مدينة (   )   ج- أخرى (   )

6. التحويل تم عن طريق :

أ- مستشفى (   )   ب- الشرطة (   )   ج – الأسرة (   )

د – مؤسسات حكومية (   )   هـ - أخرى (   )

النموذج الخاص بالمرضى

غير موافق بشدة	غير موافق	لا ادري	موافق	موافق بشدة	العبارة
					خدمات الصحة النفسيه اقل مما ينبغي
					مستوى معلومات المريض عن الخدمات النفسيه متدنيه
					الاطباء النفسيين لديهم مستوى متدني من الفاعليه العلاجيه
					المعالجين النفسين غير مجدين في العملية العلاجيه
					عدد جلسات الطبيب مع المريض يجب ان تكون اكثر من مره اسبوعيا
					عدد جلسات الاخصائي النفسي مع المريض يجب ان تكون اكثر من مره كل اسبوع
					مستوى وعي المرضى بعملية التحويل متدني جدا
					عملية التحويل الى المستشفى يجب ان تمتاز بالمرونه
					التحويل بين اقسام المستشفى غير واضح المعالم
					هناك ضعف واضح لدى الاخصائيين النفسيين في فهم حاجات المرضى
					هناك ضعف واضح لدى الاطباء النفسيين في فهم حاجات المرضى الاساسيه

Appendix 5- Interview English Copy

Interview Guide Questions for Psychiatrists

Background

Question 1 will be asked so as to establish a relax atmosphere to proceeding with the specific research questions:

1. What official qualifications do you hold?

2. Is your position as psychiatrists your only job in the hospital? If not please Detail what other jobs you are required to do?

Aims and Objectives

1. What were your initial expectations?

2. What are your aims, objectives and goals related to your role and practice?

3. How far have these goals been met?

4. Can you tell me what you believe the Mental Health Hospital expects you to achieve?

Roles and Psychiatric Services details

1. Please tell me about the roles and regulations related to Psychiatric hospital.

2. Are there other roles you feel should be undertaken by psychiatrists? If yes, please give details.

3. in your hospital?

      a.   How many regions do you cover?

      b.   How flexible is your personal practice?

      c.   Who is the key authority person in your service?

      d.   How many sessions per week do you generally conduct with your client?

      e.   What is the general period of frequency of psychiatry with each client?

      j.   How easy is it to have additional sessions with your clients

5. Please identify other additional roles in your psychiatric practice you would like to undertake?

Awareness

1. How do you see the role and function of the Psychiatric hospital?

2. What are you personal needed for additional training?

3. Do you perceive that this training can be realistically achieved?

4. Describe your level of experience and the degree of integration into the psychiatric hospital you have attained so far? To what degree do you consider it is essential for the psychiatrists and the hospital physicians and related hospital staff support ought to be integrated and working together with the patient?

Effectiveness

1. Describe how effective you are in your work as a psychiatrist?

2. Does your performance have a significant influence on your clients?

A. How do you measure this?

B. How do you measure patients satisfaction with your sessions?
(Feedback; Reviews: Other. If yes, how often does this happen?)

C. How is your performance measured by the hospital?
(Feedback; Reviews, Appraisals: Other. If yes, how often does this happen?)

3. What factors that effect the success of your performance?

4. Are there any further services and support that a psychiatrist can give to patients?

5. Are there any further services and support that a hospital can give to a patient?

Referral

1. Please describe typical sources of referral in your psychiatric unit?

- Hospital
- Other Psychiatrist
- Agent
- Religious
- Police
- Family
- Other

2. How is referral initiated? (Letter, Telephone, Face to face, Other).

3. Please describe the type of referral details and information you initially receive and which you are most comfortable with.

4. Typically how long do patient have to wait to an appropriate referral.

5. Describe the main types of problems and your personal opinion of the existing referral process?

6. How frequently do you receive inappropriate referrals and define why they were deemed inappropriate?

Personal Development

3. What factors give you satisfaction when working as a psychiatrist?

4. Describe qualities in the working environment necessary for a psychiatrist to perform well within the context of your hospital.

General

1. Can you offer any further suggestions or recommendations for improving the existing mental health services?

2. Are there any other issues, or comments you wish to make at this time?

Thank you very much for giving of your time and for assisting me with my research..

Counsellors Perspective

Background

Question 1 will be asked so as to establish a relaxed atmosphere before proceeding with the specific research questions:

1. Can you briefly outline your experience before becoming a Mental Health
    Counsellor?
2. What qualifications do you hold?
3. Is your position as a Mental Health Counsellor your only job in the hospital? If not what other jobs are you required to do?

Aims and Objectives

1. What date did you join the Mental Health Hospital Counselling Service?
2. What were your initial expectations?
3. What are your aims, objectives and goals related to your role and practice?
4. How far have these goals been met?
5. Can you tell me what you believe the Mental Health Hospital Counselling Service expects you to achieve?

Roles and Counselling Services details

1. Please tell me about the roles and regulations related to Mental Health Councillors.
2. Are there other roles you feel should be undertaken by a Counsellor? If yes, please give details.
4. In your hospital:
    a.   How many regions do you cover?
    b.   How "flexible" is your personal counselling practice?
    c.   Who is your main organizational contact?
    d.   Who is the key authority person in your service?
    e.   How many sessions per week do you generally conduct with each client?

f.   What is the general duration of each counselling session with each client?

g.   How easy is it to have additional sessions with your clients?

h.   Where are the locations of the counselling services?

i.   How many counsellor colleagues are undertaking the same role as yourself?

Awareness

1. Do think the hospital has introduced a Counselling service?

2. How do you see the role and function of the Psychiatric hospital?

3. What are your personal needs for additional training?

4. Do you perceive that this training can be realistically achieved?

5. Can you explain the psychiatric assessment process and how you think if has influenced your professional performance?

Effectiveness

1. How effective do you think you are in your work as a counsellor?

2. Does your performance have a significant influence on your patients?

     a.   How do you measure this?

     b.   How do you measure patientsatisfaction with your sessions?

             (Feedback; Reviews: Other. If yes, how often does this happen?)

3. What factors affect the success of your performance?

4. Are there any further services and support that a psychiatrist can give to a patient?

5. Are there any further services and support that a hospital can give to a patient?

Referral

2.   Can you describe a typical process of referral to you for counselling?

3.   What are the typical sources of referral in your counselling unit?

- Hospital
- Psychiatrist
- Agent
- Religious

- Police
- Family
- Other).

2. How is referral initiated? (Letter, Telephone, Face to face, other).

3. What type of referral details and information do you initially receive? Which you are most comfortable with?

4. Typically how long do patients have to wait for an appropriate referral?

5. What is your personal opinion of the existing referral process?

6. How frequently do you receive inappropriate referrals?

Why were they deemed inappropriate?

Personal Development

1. What gives you satisfaction when working as a mental health Counsellor?

2. What qualities in the working environment are necessary for a mental health Counsellor to perform well within the context of your hospital?

General

1. Can you offer any further suggestions or recommendations for improving the existing mental health Counselling services?

2. Are there any other comments you wish to make at this time?

Thank you very much for giving of your time and for assisting me with my research.

1) Please describe for me your role and responsibilities as an administration in your hospital?

Role

Responsibilities

Do you have a referral role in you hospital?

....

- If yes, please describe the types of problem your hospital deals with?

If not, why is this so?

What types of problems do you refer to the Psychiatric unit?

......

- Procedures,
- staff knowledge of referral procedures

2) What types of problems do you refer to the Counselling services?

- staff knowledge of referral procedures

3) Please describe you level of satisfaction with the referral procedure in your hospital.

4) What firm of feedback do you receive from patient's?

- Verbal,

Are there regular meeting between the psychiatrists, counsellors and the staff in your hospitals?

- If yes, How often?

How useful for the hospital?

- Do these meeting serve a positive function?
- If not? Why?

5) Are there any government agencies that provide help to your hospital?

- What are their reasons?

6) What are your expectations and goals for the mental health service?

7) Describe the ways in which the counselling and psychiatry can be improved?

8) Are there any views or comments that you would like to make concerning your

experience of mental health provision for an administrative perspectives?

Thank you very much for giving this time today to sharing your experiences with the researcher.

Patients Interview

1) How long did you have to wait before your first appointment with the Psychiatric Counsellor?

....

....

....

2) What was your initial problem when you first contacted this hospital?

....

....

3) How long have you had the problem(s)?

....

....

4) Did you seek help for the problem(s) elsewhere?

....

- (if yes, from whom?)
- ....

....

- (If no, why?)
- ....

....

5) Had you any fears/social stigma about using the mental health services?

....

6) What were your expectations about using mental health services?

....

....

7) What ways did you hope the services might be able to help you?

....

....

8) Was there any specific agreement made between you and your psychiatrist such as roles and responsibility?

....

9) At the beginning of your treatment, did you and your psychiatrist agree to a set number of sessions?

....

10) Did you tell any of your family that you were using the services?

....

- Why?

....

....

....

11) At the beginning of your treatment, did you receive any counselling?

....

12) Was there any specific agreement made between you and your counsellor such as roles and responsibility?

....

13) At the beginning of your treatment, did you and your counsellor agree to a set number of sessions?

....

14) During your treatment, have you experienced any change? (Positive or Negative)

....

....

15) Can you draw any link between the services you received and your satisfaction with treatment?

....

....

16) Did you psychiatrists suggest at any time that you may require help from another source of help? (religions, counselling, family, etc)

....

- If yes, how did you feel about that help?

....

....

....
....

- If no, should he have?

....
....
....
....

17) Have you ended your treatment yet?

....

- If yes why?

....
....
....

- If not why?

....
....
....

18) Do you think you need to seek further help from elsewhere, and what kind of treatment you think you well use?

....

19) What is your view of the treatment you have had in the hospital?

....
....
....

20) Would you recommend the service to other?

....

- If yes, why?

....
....
....

- If not, why not?

....

....

....

21) Do you feel your referral was appropriate?

....

- (Why?)

....

....

....

....

22) What would you have done to solve your problem without the hospital treatment you received?

....

....

23) What kind of changes you would like to see happen to improve functions of the mental health service?

....

....

....

24) Can you offer any further suggestions or recommendations for improving the existing mental health services?

....

....

Are there any other issues, or comments you wish to make at this time?

....

....

Thank you very much for giving this time to sharing your experiences and views about mental health services with me

Appendix 6- Interview Arabic Copy

اشرح مدى الفاعلية التى تقوم بها كطبيب نفسي؟

هل مجال عملك كطبيب يعطى نتائج ايجابيه مع المرضى؟

كيف تقيس ذلك؟

كيف تقيس مدى رضى المريض؟

كيف للمستشفى ان تقيس هذه الفاعلية وماهى الادوارت المتاحه؟

ماهي العوامل التى تساعد على تحقيق النجاح في هذا المجال؟

هل هناك خدمات اخرى يمكن للطبيب ان يقدمها للمرضى؟

هل هناك خدمات اخرى يمكن للمستشفى ان تقدمها للمريض؟

عملية التحويل

ارجو منك ان تشرح اساليب وطرق تحويل المرضى اليكم:

عن طريق مستشفيات اخرى/ مراكز اخرى/ منظمات دينيه/ الشرطه/ الامن والامن/ الاسره/ اخرى حدد.

هل عمليه التحويل تمت عن طريق : خطاب رسمي/ عن طريق الهاتف/ وجها لوجه / اخرى حدد.

ارجو منك ان تشرح نوع التحويل والمعلومات التى استقبلتها من خلال تحويل المرضى؟

كم من الوقت يحتاج المريض من اجل الحصول على التحويل؟

اشرح اهم واشهر الامراض التى تكون مصحوبه للمرضى حينما يتم تحويلهم اليكم؟

كم عدد المرات التى شعرت فيها ان عملية التحويل كانت خاطئه؟

المهارات والنمو الشخصي

ماهي العوامل المحفزه لك حينما تعمل كطبيب نفسي؟

هل من الممكن ان تشرح الجو العام للعمل كطبيب نفسي بالمستشفى؟

نقاط عامه

هل هناك اي اقتراحات او توصيات تعتقد انها مهمه من اجل تحسين مستوى الخدمات النفسيه ؟

هل هناك اي نقاط اخرى تود ذكرها او بكون الباحث قد اغفلها؟

شكرا جزيلا لك ولوقت الثمين في مساعدة الباحث

بسم الله الرحمن الرحيم

مقابلة اجرائيه معالاخصائيين النفسيين

بعد الاستعداد للمقابله و تهيئة الجو العام قام الباحث بطرح الاسئلة الاتيه:

معلومات عامه

ماهي خبرات قبل الالتحاق بمجال الصحة النفسية؟
ماهي مؤهلاتك التي تحملها حاليا؟
هل وظيفتك الحالية بالمستشفى اخصائي نفسي ام ان هناك وظائف اخرى تقوم بها؟

الاهداف والمبادي

ماهي خبرات الحاليه؟
ماهي اهدافك وادورك المناط بك العمل بها؟
الى اي مدى تم تحقيق هذه الاهداف؟
هل من الممكن ان تخبرني ماهي توقعات المستشفى منك ان تحقق؟

الادوار

هل من الممكن ان تخبرني عن دورك بالمستشفى؟
هناك هناك ادوار محدده تقوم بها؟

في المستشفى التي تعمل بها:

كم عدد المناطق التة تغطيها المستشفى
الى اي مدى تجد مجال عملك مرن؟
من هو الشخص الذي يتخذ القرار بالمستشفى؟
كم عدد الجلسات النفسيه كل اسبوع مع المرضى؟
ماهي المده المحدده عموما للجلسات مع المرضى؟
هل تعتقد انه من السهل القيام بزيادة عدد الجلسات مع المرضى؟

هل من الممكن ان تعطي تصورا اكثر وضوحا عن دورك كمرشد او اخصائي نفسي بالمستشفى؟

الوعي

كيف ترى الدور والمسؤليات تعمل بالمستشفى؟

ماهي احتاجاتك الخاصه في مجال التدريب؟

بسم الله الرحمن الرحيم

مقابلة اجرائية مع ادارة المستشفى

بعد الاستعداد للمقابله وتنية الجو العام قام الباحث بطرح الاسئلة الاتيه:

ارجو منك ان تشرح دورك الاساسي ومهامك الاساسيه للعمل في هذا المستشفى؟
الادور
المسؤوليات
هل لديك بهذ المستشفى نظام محدد لتحويل المرضى؟

اذا نعم هل من الممكن ان تشرح؟

اذا لا ؟ لماذا باعتقادة ليس هناك نظام واضح المعالم؟

ماهي انواع الامراض التي تحول الى قسم الطب النفسي؟

ماهو مستوى معلوماتك عن عملية تحويل المرضى؟

ماهي اهم المشلات التي يتم تحويلها لقسم الارشاد النفسي؟

هل من الممكن ان تعطي تصورا واضحا عن مدى الرضى لديك عن عملية تحويله المرضى؟

كيف يتم الاستماع الى اراء المرضى؟ وماهو الاسلوب المفضل؟

هل هناك اجتماعات مستمر وبصوره منتظمه بين الاطباء والمعالجين وادارة المستشفى؟
اذا نعم كيف يتم ذلك؟
وهل هذا مجدى لادارة المستشفى؟

هل هناك اي منظمات حكوميه او اجتماعية تساهم في مساعده المستشفى حاليا؟

ماهي توقعاتك او اهدافك التي تريد تحقيق انجاحها؟

هل من الممكن ان تعطي تصور عن اساليب تطوير الطب والعلاج النفسي؟

هل هناك اي نقاط تود ان تشرحها او تعتقد ترتبط بمجال عملك تود ذكرها من خلال خبراتك السابقه بهذا العمل؟
شكرا جزيلا لخدمة الباحث ومشاركتك خبراتك بهذا المجال

الباحث

بسم الله الرحمن الرحيم

اذا كانت اجابتك بنعم؟ ماذا تعتقد بهذا الاسلوب من العلاج؟
اذا اجابتك بلا؟ هل تعتقد انه كان من المفترض ان يقدم لك هذه الخدمه؟

هل انهيت فتره علاج حاليا؟
اذا نعم لماذا؟
اذا لا لماذا؟

هل تعتقد ان هناك حاجه لمزيد من العلاج بطرق اخرى؟

ماهو تقييمك للعلاج الذي كان مستخدما معك بهذه المستشفى؟

هل تعتقد انك سوف توصي الاخرين بهذه الخدمات؟
اذا نعم لماذا؟
اذا لا لماذا؟

هل تشعر ان عملية تحويلك كانت مناسبه؟
لماذا؟

ماهي الاساليب العلاجيه التى كنت تعتزم استخدمها ولم تحصل على فرصه الدخول للمستشفى؟

ماهي التغيرات التى كنت ترغب بمشاهدتها والتى تساعد على نهوض الخدمات النفسيه؟

هل لديك اي اقتراحات او نقاط اخرى تهتم بمجال خدمات الصحه النفسيه؟

هل هناك نقاط اخرى تعتقد انك بحاجه لايضاحها؟

شكرا جزيل لك

Appendix 7- General Information

Dear Colleague

Counselling services and performance practice have a very important role in Mental Health services. The aim of this pilot survey is to clarify the current situation of Mental Health services on offer in Saudi Arabia and to contribute to their development

Statements have been collected from different sources, such as a Historical study of Mental Health services, plus the current literature on the subject of Mental Health in Saudi Arabian and in the Western literature

I would very much appreciate your help by completing the enclosed questionnaire, and by giving your views on the following aspects of constructing a suitable questionnaire
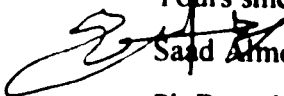
Giving an opinion of each statement

Evaluating the validity and readability of the whole questionnaire

Your advice and comments will be highly valued regarding the following

- Is the language of the questionnaire clear and readable? (If there are any mistakes, please correct them directly onto the questionnaire, or if you have any comments, please write them either in the margins or in the space left on the last page)
- Do you think all the aspects for Mental Health services have been included in the questionnaire? (If you have any more requirements, please insert them in the spaces left in the tables and if you have any aspects you believe it have not been mentioned, please add them on the same page, with the relevant statement)
- Will this questionnaire be a suitable instrument to assist in clarifying the current situation for Mental Health services in Saudi Arabia?
- How long does this questionnaire take to answer?

Thank you very much for your support and help in this matter

Yours sincerely,

Saad Almoshawah

Ph.D student, University of Hull, England