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Master of Community Mental Health Nursing

Mental Health Professional's knowledge, Attitudes and Practice about Talking Therapies in Clinical Practice in Gaza Strip.

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بسم الله الرحمن الرحيم

"وَفِي أَنفُسِكُمْ أَفَلَا تُبْصِرُونَ"

صدق الله العظيم

(سورة الذاريات آية 21)

Dedication

I dedicate this work first of all to my dear parent, sisters, brothers who encouraged me across my life. Special thanks and admiration to my sweetheart (my wife) and my beloved children (Omar and Misk) for their patience, courage and endless support.

Mohanad Omar Hamdan.

Date: 22/10/2012

Declaration

I certify that this thesis submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

Signed

Mohanad Omar Hamdan.

Date: 22/10/2012

Acknowledgment

This thesis would not have been a success without the help and support of many people. I would like to express my great thanks and gratitude to all people who courage and contribute to the success of this endeavor towards obtaining my master degree.

My high recognition and appreciation to Dr. Yousef Aljeesh for his academic supervision and continuous distinctive advice.

Special thanks and admiration to my great father whom push me all time to develop myself.

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Abstract

It is clear that we need to heal emotional wounds, which means that we are looking for a psychological recovery alongside our economic recovery. Talking therapies in this study refers to evidence-based psychological therapies used by Mental health professional's including, Counseling, Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Family Therapy, and Group therapy.

The current study addresses community mental health professional's knowledge, attitudes and practice about talking therapies in clinical practice in governmental community mental health centers . A total of 118 participants 20 of them were pilot (excluded) and 90 participants completed knowledge, attitudes and practice (KAP) questionnaire, And 8 participants did not participate because of absences for different conditions.

The result of gender distribution show that the male percentages 53.3% while the female percentage is 46.7%. and Age range between 24 and 58 with mean 35 years. The Specialty was divided into five groups, Psychiatrist physician 11.1%, Psychiatric nurse 41.1%, Practical nurse 2.2%, Psychologist 24.4%,and Sociologist 21.2%.

Descriptive statistics indicated that that mental health professionals most of participants reflects positive knowledge toward talking therapies with mean 72.9, counseling therapy with mean 86,05, Cognitive Behavioral Therapy with mean 67,75, family therapy with mean 72.6, Group psychotherapy with mean 62,2, and motivational interview with mean 64,95,.Their attitudes toward talking therapies were positive with mean 70.45.(Annex 1)

Also participants reflects varies response to practice with mean 66.1 to counseling, 53,3 to Cognitive Behavioral Therapy , 51,1 to family therapy, 48,3 to group therapy, 61,1 to Motivational Interviewing, 57,60 to talking therapy in general. And 85,6 of participant have sufficient knowledge of communication skills as a basis in the talking therapy process but 72,2 of participant Said they needs training courses in talking therapy to improve knowledge and application into practice ,Also mental health professionals who have postgraduate studies have a higher level of and positive knowledge compared to those who have diploma or bachelor degree with a mean difference 5.161 and P value 0.026, participants who have (6 – 12) years of experience have higher knowledge compared to those who have less years of experience (5 years and less), mean difference was – 7.390 and P value was 0.003.(Annex 1)

Correlation analyses indicated that there was no significant relationship between mental health professional's knowledge, attitudes and practice toward talking therapies and sociodemographic characteristics.

The study conclude that with minimal education and training we can improve the knowledge and practice about talking therapies among community mental health professionals and also make their attitude positive regarding it.

ملخص الدراسة

من الواضح أننا بحاجة إلى شفاء الجروح العاطفية، وهو ما يعني أننا نبحث عن العلاج النفسي جنبا إلى جنب مع الانتعاش الاقتصادي. العلاجات القائمة على التخاطب في هذه الدراسة تشير إلى العلاجات النفسية المبنية على الأدلة العلمية المستخدمة من قبل مهنيي الصحة النفسية ، ومن بينها، الإرشاد النفسي ، العلاج السلوكي المعرفي ، مقابلات حفز الهمم ، العلاج الأسري، والعلاج الجماعي.

هذه الدراسة تتناول معرفة واتجاهات وممارسة مهنيي الصحة النفسية المجتمعية حول العلاج الكلامي في العمل العيادي في مراكز الصحة النفسية المجتمعية الحكومية وقد كان مجتمع الدراسة 118 مهني من بينهم 20 مشاركا كعينة استطلاعية تم استثنائهم من التطبيق النهائي للدراسة و 90 مشاركا آخر طبق عليهم الاستبيان النهائي و8 أشخاص لم يشاركوا بسبب تغيبهم لظروف مختلفة.

وتبين نتيجة لتوزيع الجنسين أن نسبة الذكور 53.3٪ في حين بلغت نسبة الإناث 46.7٪. وتراوح عمر المشاركين ما بين 24 و 58 سنة مع متوسط 35 عاما. وتم تقسيم الاختصاص إلى خمس مجموعات، طبيب نفسي 11.1٪، ممرض/ة نفسي/ة 41.1٪ ، ممرض عملي 2.2٪، أخصائيين نفسيين 24.4٪ ،أخصائيين اجتماعيين 21.2٪.

وأشارت نتائج الإحصاءات الوصفية أن معظم المشاركين من مهنيي الصحة النفسية عكسوا معرفة إيجابية تجاه العلاج الكلامي بالمجمل مع متوسط 72.9 ، وتقديم الإرشاد النفسي مع متوسط 86.05 ،العلاج المعرفي السلوكي67.75 ، العلاج الأسري مع متوسط 72.6، والعلاج النفسي الجماعي مع متوسط 62.2 ، والمقابلة التحفيزية 64.95، كما عكس المشاركون اتجاهات إيجابية نحو العلاج الكلامي بمتوسط 70.45 .

كما عكس المشاركون استجابات مختلفة لممارسة العلاج الكلامي مع متوسط 66.1 للإرشاد النفسي، العلاج المعرفي السلوكي 53.3 ، العلاج الأسري51.1 ، العلاج الجماعي 48.3 ، 61.1 للمقابلة التحفيزية، 57.6 للعلاج الكلامي بالمجمل. و85.6 % من المشاركين لديهم معرفة كافية بمهارات الاتصال والتواصل كأساس في عملية العلاج الكلامي ولكن 72.2% من المشاركين أجابوا أنهم بحاجة لدورات تدريبية في العلاج الكلامي لتحسين المعرفة وتطبيقها في الممارسة، أيضا لدى مهنيي الصحة النفسية من ذوي الدراسات العليا مستوى أعلى من المعرفة مقارنة مع أولئك الحاصلين على درجة الدبلوم أو درجة البكالوريوس.

أشارت التحليلات الإحصائية بعدم وجود فروق ذات دلالة إحصائية بين المعرفة والاتجاهات والممارسة نحو العلاج الكلامي تعز ىللمتغيرات الديموغرافية والخصائص الاجتماعية.

تستنتج الدراسات أن بالحد الأدنى من التعليم مع التدريب يمكننا تحسين المعرفة والممارسة حول العلاج الكلامي بين مهنيي الصحة النفسية المجتمعية وأيضا جعل اتجاهاتهم ايجابية بشأن ذلك.

Contents

List of Abbreviations

ABC	Affect, Behavioral change . and Cognitive
CBT	Cognitive Behavioral Therapy
KAP	Knowledge , Attitudes , and Practice
MOH	Ministry Of Health
OPT	Occupied Palestinian Territory
SPSS	Statistical Package For Social Sciences
WHO	World Health Organization
GDP	Gross Domestic Product
GNP	Gross National Product
GS	Gaza Strip
ICRC	International Committee of Red Cross
JD	Jordanian Dinar
MOF	Ministry Of Finance
CMHD	Community Mental Health Directorate
NGO's	Non Governmental Organizations
NIS	New Israeli Shekel
PCBS	Palestinian Central Bureau of Statistics
PNA	Palestinian National Authority
OPT	Occupied Palestinian Territory
PHC	Primary Health Care
UN	United Nations
UNRWA	United Nations Relief and Working Agency
USD	United States Dollar
WB	West Bank

APA	American Psychiatric Association
MI	Motivational Interview
GPs	General Practitioners
US	United State
ADHD	Attention Deficit Hyperactive Disorder
RCTs	Randomized Control Trials
LR	Literature Review
MHP	Mental Health Professionals
OCD	Obsessive Compulsive Disorder

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CHAPTER ONE

Chapter1

1.1 Background of the study

Mental health professional's consider that their training, knowledge and skills in evidence-based talking therapy models are essential for competent mental health practice.

Talking therapies skills are essential in mental health professionals practice. Such skills are as important to mental health professionals as the monitoring of vital signs are to medical and surgical professionals. The ability to create a therapeutic interpersonal relationship with people who have mental illness relies on the effective use of talking therapy skills to facilitate assessment, treatment and recovery in a collaborative manner.

Talking therapies have an important role to play in helping people with mental health problems, who should have access to effective treatment, both physical and psychological (National Service Framework for Mental Health, Department of Health, 1999).

There is no doubt that these therapies can have demonstrable benefit, for example in reducing distress, symptoms, risk of harm to self or others, health related quality of life and return to work. However, not all are effective for all patients, and practitioners will wish to consider which factors are important in considering a referral. All too often, access to therapy is determined by irrelevant demographic factors, such as place of residence or age, rather than evidence about benefit.

Cost effectiveness of talking therapy is clearly an important element of treatment choice decisions. However, true economic appraisal in this field is extremely sparse and basic methodological issues are only now being addressed by researchers and health economists (Miller & McGruder, 1999).

Talking therapies are provided by members of different professional disciplines, including clinical psychologists and psychiatrists, specially trained mental health nurses, occupational therapists, art and drama therapists, counselors and psychotherapists. We adopt the usage that ‘psychological therapy’, ‘psychological treatments’, ‘talking therapies’ and ‘talking treatments’ are interchangeable, representing the most generic terms.
(National Service Framework for Mental Health, Department of Health, 1999).

Garland (1994) promotes nursing as a collaborative endeavor, working with people to address their mental health needs in a holistic manner. She defines holistic nursing practice as interpersonal, intrapersonal, environmental and cultural” (Garland, 1994) needs of individuals. Garland also adds that nursing includes being “an advocate and an educator promoting autonomy and self-help where possible” The collaborative, interpersonal processes that involve

talking, listening, questioning and working holistically in partnership with people are expectations for mental health nursing practice(Garland, 1994).

This study will explore mental health professionals' knowledge, attitudes and practice about 'Talking Therapies' in clinical practice.

Talking therapies include a wide range of psychological treatment models that in practice "involve talking, questioning and listening in order to understand, educate and assist with people's problems". Talking therapies may be used in an inpatient or community treatment setting as part of crisis intervention or within a therapeutic treatment program to resolve or improve the management of mental health difficulties (Peters,2007).

The term 'talking therapies' is an inclusive term that refers to an array of psychotherapeutic treatment approaches used by mental health clinicians including nurses. Talking therapies are based on theoretical models and are used in treatment within a planned and structured therapeutic framework. And was devised by service users and their families in the United Kingdom for inclusion in national strategic documents as the preferred term for describing psychological interventions (Peters, 2007).

Internationally, training in talking therapies has been progressed in the United Kingdom, United States of America, Ireland and Australia, with research publications from the United Kingdom providing a well recognized resource for training and development programs.

More than two decades of nurses being trained in behavioral psychotherapy (Gournay, Denford, Parr, & Newell, 2000), extensive training for all health professionals in Psychosocial Interventions, including nurses, since 1989 (Brooker & Brabban, 2004; Brooker, Saul, Robinson, King, & Dudley, 2003) and more than fifteen years of Family Therapy training (eg: Bailey, Burbach, & Lea, 2003; Fadden, 1997) provides an indication of the commitment made to training and development in talking therapies in the United Kingdom. Additionally, best practice competencies in undergraduate training in the United Kingdom include the requirement to have knowledge of a range of talking therapy skills. For example; evidence based interpersonal skills, CBT and Psychosocial Interventions (Department of Health UK, 2006). Furthermore, Cognitive Behavioral Therapy (CBT) training initiatives in Ireland and CBT and Family Therapy training initiatives in Australia are reported in research literature, adding to the important body of international literature.

Talking therapies in this study refers to evidence-based psychological therapies used by mental health professionals, including Counseling, Cognitive Behavioral Therapy (CBT),Motivational Interviewing (MI), Family Therapy, and Group therapy. The above cognitive, behavioral and psychological therapies are all theory and evidence-based therapies that require specific steps and processes for their effective use in treatment.

1.2 Research problem.

Mental health problem affect entire population of Palestinian people. This problem affect the total society and interfere with the developmental process, the way which followed to treat such problem is biologically based which focus on disability rather than strength and empowerment, so there is a need to a new trends to address such issue**.**

Many people experience emotional pain at some time in their lives and may be unsure of how to deal with it or who to turn to. There are some things which may feel just too personal to communicate to family or friends. Talking therapies can provide a safe and confidential space for people to explore their feelings and experiences. Clients are encouraged to speak about difficulties from their own point of view and to express how they think and feel. Over time, people can begin to make sense of their experiences of mental distress and reveal their own resourcefulness and possibilities for change and recovery.(Code of Ethics, Irish Association of Counseling and Psychotherapy, 2005).

This study well explore mental health professionals knowledge, Attitudes and practice of talking therapies in clinical practice in Gaza Strip.

1.3 Justification of the study

Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people, The National Survey of Mental Health and Wellbeing 2007 found that one in five (20%) Australian adult's experience mental illness in any year. One in four of these people experience more than one mental disorder. Based on these prevalence rates, over 3.2 million Australians had a mental disorder in the previous 12 months. In addition, mental disorders are the leading cause of disability in the U.S. and Canada for ages 15-44. Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity, The burden of mental illness on health and productivity in the United States and throughout the world has long been underestimated. Data developed by the massive Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including

suicide, accounts for over 15 percent of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers; the mental health reports published by the Palestinian Authority (PA) from 2010 indicate increases in most mental disorder categories (see Table 1).For instance, it is known that the prevalence of affective disorders such as depression is dependent on social, economic and political conditions (Zimmerman and Katon 2005). Thus the increase in affective disorders and neurosis may reflect the deterioration of Palestinian life due to increased Israeli sieges, shelling, targeted killing and restrictions of movement. Increase in the prevalence of epilepsy, a neurological disorder, may be attributed to obstacles in early detection and optimal treatment due to military sieges and other collective punishment measures. However, it is also possible that incidence figures vary because of a gradually improving reporting system. Epidemiological studies in the Gaza Strip found women and families lacking support from relatives and community to be more vulnerable to anxiety when exposed to military violence (Punamaki et al. 2005a, 2005). Some studies indicate poorer mental health outcomes in populations exposed to war and disasters, and a strong relationship between losses of family members and distress (Mollica et al. 2001, Cardozo et al. 2004). A study comparing mental health status in four war- affected societies, including the occupied Palestinians territory (Opt), Algeria, Burma and Ethiopia, found strong associations between military atrocities and losses and psychiatric distress (de Jong et al. 2001). Increased risk of mental health problems was also found among injured young Palestinians (Khamis 2008) and children experiencing family loss and home demolition (Khamis 2005) during the second intifada, All of this facts reflect the importance to search for new way to address this burden, Talking Therapy is one of this options which have good impact as research evade in mental health filed, there is no study was conducted from the researchers on Gaza strip on area of talking therapy and the role which may be played via community mental health workers if they have enough knowledge and positive attitude and good practice toward talking therapy.

This study will contribute to the fundamental knowledge that underpins mental health professionals practice in Gaza Strip by exploring them knowledge , Attitudes and practice of talking therapies.

My justification for this study based on the following :

- The historical theoretical underpinnings that inform professional standards for mental health professionals practice infer that they have skills in talking therapies.

- Talking therapy skills are specialized skills and access to talking therapy training at an undergraduate and postgraduate levels is limited.
- Recent workforce development initiatives that propose to progress talking therapy training for all mental health professionals.
- Undesired side effects of psychopharmacotherapy.
- Influences drawn from my own clinical experience of 5 years during which I have always valued therapeutic talking therapy skills. They are integral to my mental health practice.

Table 1.1 Incidence rate of reported new cases of mental disorders in 2010 in the occupied Palestinianterritory (OPt).

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

(MOH:2010)

1.4 General objective:

This study aimed to explore mental health professional's knowledge, Attitudes and practice about talking therapies in clinical practice in Gaza Strip.

1.4.1 Specific objectives:

- To determine the level of mental health professional's knowledge, Attitudes and practice about talking therapies in clinical practice.
- To identify the significant differences between mental health professional's qualification and knowledge, Attitudes and practice about talking therapies.
- To verify the level of mental health professional's knowledge, Attitudes and practice about talking therapies in relation to sociodemographic characteristics(age-gender- and living area).
- To explore the significant differences between mental health professional's years of experience and knowledge, Attitudes and practice about talking therapies.
- To verify the significant differences between mental health professional's specialty and knowledge, Attitudes and practice about talking therapies in clinical practice **.**
- To provide recommendations and suggestions about using talking therapies in clinical practice **.**

1.4.2 Research questions:

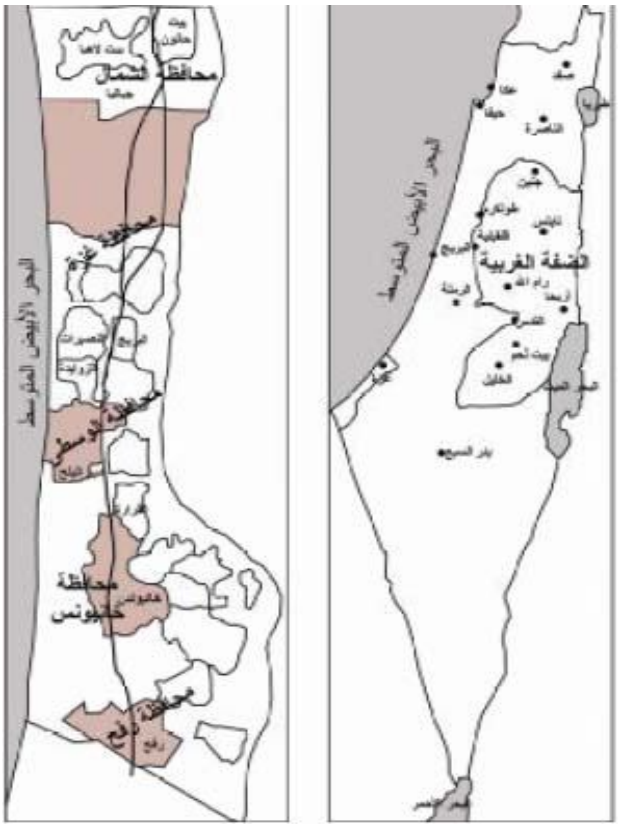
- What is the level of knowledge, Attitudes and practice about talking therapies among mental health professionals in clinical practice?
- Is there a significant differences between mental health professional's qualification and knowledge, attitudes and practice about talking therapies in clinical practice?
- What is the level of mental health professional's knowledge, Attitudes and practice about talking therapies in relation to sociodemographic characteristics(age-gender- and living area)**?**
- Is there a significant differences between mental health professional's years of experience and knowledge, Attitudes and practice about talking therapies in clinical practice**?**
- Are there a differences between mental health professionals specialty and knowledge, Attitudes and practice about talking therapies in clinical practice?

1.5 Context of the study

The demographic, socioeconomic, and political situations greatly impact health in general and mental health in specific and health care services in Gaza strip and west bank, this context influence the services by specific way to suit these situations and to overcome our permanents emergency situation.

1.5.1 Demographic context

The entire area of historical Palestine is about 27,000 Km2, Palatine stretches from Ras Al- Nakoura in the north to Rafah in the south. Palestine is boarded by Lebanon in the north, the Gulf of Aqaba in the south, Syria and Jordan in the east and by Egypt and Mediterranean Sea in the west. Palestine was places under British mandate, finished by Israel establishment in 1948 in implementing The Balfour Declaration in 1917 to providing a homeland for Jews, the result was uprooted most of Palestinian from their cities, towns, and Villages and migrate to West bank, Gaza strip, Jordan, Lebanon, Syria, and others countries (Abu-Lughod, 1971).



Annex 1 Palestine map (Gaza Strip-left)

Gaza Strip is a narrow land, located on the south of Palestine on the coast of Mediterranean sea. Gaza Strip is high crowded area, where approximately 1.5 million live in 365 km2, estimated density is 4,000 people per square kilometer, the Population is concentrated in 7 town, 10 villages, and 8camps (PCBS, 2008). And establishment census 2007 which indicates that the number of population in the Palestinian Territory during the fourth quarter 2009 was 3,743,050 (PCBS, 2010). The density is increase refugee camps (UNRWA, 2005). GS is classified into five governorates, North of Gaza, Gaza city, Mid-Zone, Khan-younis and Rafah. The population under 15 year old percentage in Gaza Strip is 49% and 2.5%of age 65 years and more(MOH, 2006).

1.5.2 Socio-economic and political situation

The past years witnessed one of the most violent periods experienced by Palestinian civilians since the beginning of Israel's occupation in 1967. Between 27 December 2008 and 18 January 2009, 1.4 million Palestinian residents of the Gaza Strip endured intensive and continuous bombardment from land, sea and air in the course of Israel's "Cast Lead" military offensive, launched with the stated purpose of preventing indiscriminate rocket fire from Gaza (OCHA, 2009a).

As a result of the last ware against Gaza, at 31 January the MOH and Palestinian health information center reported that 1380 Palestinian people had been killed since 27 December 2008, of whom 431 were children and 112 women. Approximately 5380 people were reported injured, including 1872 children and 800 women. Injuries were often multiple traumas with head injuries, thorax and abdominal wounds. Among the casualties, 16 health staffs were killed and 22 injured while on duty (MOH& PHIC, 2009).

Israel, the United States, Canada, and the European Union have frozen all funds to the Palestinian government, the severity of closure increased after political unrest in June, 2007, causing the closure of most factories to the lack of raw materials, loss of farmers by preventing the export of their crops. Prosecute deteriorating economic situation on the Gaza Strip led to the rise in unemployment rate to 65%, and 85% of households are living under the poverty line After Palestinian legislative election in 2006, (UNCTAD, 2007). According to Palestinian Ministry of Finance (MOF), the gross national product (GNP) in Palestine was 5.454 million US$ in 1999 and decreased to 3.720 million US$ in 2004. However, the gross domestic product (GDP) was 4.517 million US$ in 1999 and decreased to 3.286 million US$ in 2004 (World Bank, 2003).

The gross national product per capita (GNP / capita) was 1.806 US$ in 1999 and decreased to 979 US$ in 2004. While, the gross domestic production per capita (GDP /Capita) was 1.496 US$ in 1999 and decreased to 865 US$ in 2004.

1.6 Palestinian Health Care System

The Palestinian health care system is a combination of four major actors providing health care services to the Palestinian people inside the occupied Palestinian territory and to refugees from Palestine in the surrounding Arabs countries, Syria, Lebanon, Egypt, and Iraq. The four major subsystems are the MOH, Non Governmental Organization (NGOs), United Nations Relief and Working Agency (UNRWA), and private sector (MOH, 2006).

The MOH is still responsible for the largest portion of primary, secondary, and tertiary health care services for the Palestinian people resident in GS and WB, but no health services provided for the Palestinian people outside the occupied Palestinian territory by the MOH. The UNRWA is the largest humanitarian organization in the Near East; it has been the main primary health care provider for the refugees from Palestine not only in the occupied Palestinian territory but also in the surrounding Arabs countries.

1.7. Mental Health Service

The Palestinian Authority's Ministry of Health inherited from the Israeli military administration health services that had been neglected and starved for funds during the years of Israeli occupation (Giacaman et al. 2009). Mental health was particularly neglected. While the Palestinian Ministry of Health, with support from the World Health Organization (WHO), is continuing to make attempts to expand services beyond the hospital, most services continue to be hospital-based, fragmented and rooted in a biomedical oriented approach (WHO, West Bank and Gaza Office 2006). Currently, the Palestinian Ministry of Health (2006, p. 35) operates two psychiatric hospitals, one in Bethlehem with 280 beds serving the West Bank, and another in Gaza City with 39 beds serving the Gaza Strip. These hospitals have dominated in formally providing for the mentally ill, with community services remaining patchy. In 2004 the Ministry was operating 13 mental health outpatient clinics, nine on the West Bank and four in the Gaza Strip. The mental health department of the Ministry of Education and Higher Education assures the presence of school counselors on a full-time or half-time basis to all public schools. In addition, the United Nations Relief and Works Agency (UNRWA) has been running a mixture of mental health and counseling services within the health and school system in the West Bank and Gaza Strip with programs fluctuating in response to the vagaries of funding (Steering Committee on Mental Health 2004). By 1995 ministry of health run 6 community mental health center distributed through Gaza governorates, one of them based in Rafah governorate, one in Khan-Younis governorate, one in Mid-Zone, two in Gaza city and one in north Gaza, according MOH planning to cover mental health services in community based, these mental health center provide counseling for mentally ill client and psychopharmacology treatments.

CHAPTER TWO

Conceptual Framework and Literature Review

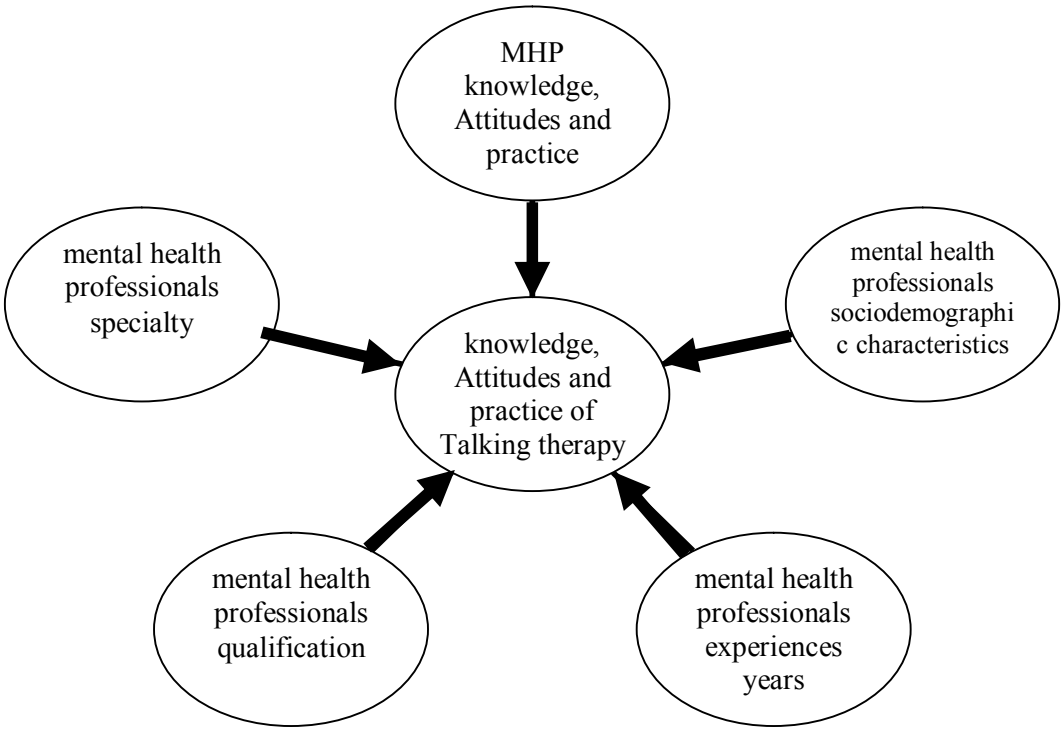
Chapter2:

2. Literature review and conceptual framework

This chapter reviews the literature about talking therapy in mental health, historical development of talking therapy, process and components of talking therapy, key principles in talking therapy approach, Views of talking therapy, The Role of Mental Health Professionals in talking therapy, and other thing related to the topic.

2.1 Conceptual framework

Conceptual framework of the research study is self developed**.** This frame work shows the domains in this study including mental health professionals knowledge, attitude and practice, mental health professionals sociodemographic characteristics, mental health professionals experiences years, mental health professionals qualification, mental health professionals specialty, knowledge, Attitudes and practice of Talking therapy as a guide for the research process. The framework shows The dependent variables include mental health professionals knowledge, Attitudes and practice about talking therapies, mental health professionals qualification, years of experiences , sociodemographic characteristics, and specialty ,where as the independents variables .



2.2 Definitions:

2.2.1 Theoretical Definitions

2.2.1.1 Knowledge :

Knowledge is defined as expertise, and skills acquired by a person through experience or education , the theoretical or practical understanding of a subject, what is known in a particular field , facts and information or awareness or familiarity gained by experience of a fact of situation. Philosophical debates in general start with Plato's formulation of knowledge as "justified true belief". There is however no single agreed definition of knowledge presently, or any prospect of one, and there remain numerous competing theories (Mullins,1997). And this definition adopted by researcher in this study.

2.2.1.2 Attitude :

An attitude is an opinion that one has about someone or something. It can reflect a favorable, unfavorable, or neutral judgment. Attitudes are thought to reflect the "mental readiness" or learned "disposition" that influence actions and reactions (Haddow M et al, 1995). And this definition adopted by researcher in this study.

Components of attitude :

Attitudes are composed from various form of judgments. Attitudes develop on the ABC mode (affect , behavioral change and cognition). The affective response is a physiological response that expresses an individual's preference for an entity . The behavioral intention is a verbal indication of the intention of an individual . The cognitive response is a cognitive evaluation of the entity to form an attitude . Most attitudes in individuals are a result of observational learning from their environment (Jung, 1966).

We may have attitudes about many things. For example, we have attitudes about people, political issues, pets, music, art, movies, books, and education.

Attitudes may reflect both beliefs and feelings. For example, a positive attitude concerning a psychology course may include the belief that the course involves learning about something that is important to your life and the feeling that you like the course.

2.2.1.3 Practice :

Sager had proposed a very realistic definition and description of practice, as practice is frequently repeated or customary action , habitual performance, a succession of acts of a similar kind, usage, habit, custom, as, the practice of rising early , the practice of making regular entries of accounts, the practice of daily exercise (Sager, 1993).

Practice is conceived of as activities or sets of activities. How these are demarcated, labeled and analyzed may vary. Activities have to be defined in a meaningful way, where the labels make sense for the people or the practice being analyzed. Activities are embedded in practice. Activities are built on knowledge, skills or competences of those performing the activities or of the community in which the activities are performed knowledge may be expressed in ways of communicating, in routines or procedures applied or in patters through which the world is made sense of. Practice involves humans. It is people performing activities, utilizing or using and creating knowledge. People are of highest importance (Postill, 2002). And this definition adopted by researcher in this study.

2.2.1.4 Talking Therapies : The term 'talking therapies' is an inclusive term that refers to an array of psychotherapeutic treatment approaches used by mental health clinicians, including nurses. Talking therapies are based on theoretical models and are used in treatment within a planned and structured therapeutic framework. And was devised by service users and their families in the United Kingdom for inclusion in national strategic documents as the preferred term for describing psychological interventions (Peters, 2007).

Talking Therapies : involves conversations with a listener who is trained to help you make sense of, and try to change, things that are troubling you. It is something you take an active working part in, rather than something you are just prescribed or given, such as medication. (Bateman, A., Brown, D., Pedder, J. (2003) And this definition adopted by researcher in this study.

2.2.1.5 Cognitive Behavioral therapy : Cognitive Behavioral therapy is defined as "an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders (for example, depression, anxiety, phobias, pain problems, etc.)" (Beck et al., 1979).

Cognitive behavioral therapy refers to a range of techniques which focus on the construction and re-construction of people's cognitions, emotions and behaviors. Generally in CBT, the therapist, through a wide array of modalities, helps clients assess, recognize and deal with problematic and dysfunctional ways of thinking, emoting and behaving (Williams C J & Garland A ,2002)**.** And this definition adopted by researcher in this study.

2.2.1.6 Motivational Interviewing : The concept of Motivational Interviewing (MI) was first developed by William Miller in response to his clinical experience in the treatment of alcoholism (Miller, 1983).

Motivational interviewing : is defined as a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence (Rollnick & Miller, 1995,). And this definition adopted by researcher in this study. The efficacy of motivational interviewing does not rely on the application of a set of techniques, but relies on the strength of the interpersonal relationship to assist people to work through ambivalence and achieve behavior change (Rollnick & Miller, 1995).

2.2.1.7 Family therapy : Family therapy is a branch of psychotherapy focusing specifically on family relationships. It works from the premise that a problem lies within the family as a whole, rather than with a single person within the family unit. It is also referred to as couples therapy and family systems therapy. Family therapy encourages change and development, and the combined resolution of family conflicts and problems. The focus is on how families interact relationally together, emphasizing the importance of a functioning family unit for psychological health and wellbeing. Regardless of the origin of an issue, or whom the problem lies with, the therapist's aim is to engage the family in beneficial solutions, seeking constructive ways for family members to support each other through direct participation. A skilled family therapist will have the ability to influence conversations in such a way as to harness the strength and the wisdom of the family unit as a whole, taking into consideration the wider economic, social, cultural, political and religious context in which the family lives, and respecting each individual's different perspectives, beliefs, views and stories (www.psychotherapy.org.uk). And this definition adopted by researcher in this study.

2.2.1.8 Group psychotherapy : Group psychotherapy is a branch of psychotherapy intended to help people who would like to improve their ability to cope with life's difficulties and problems but in a group situation. In group therapy, one or more therapists, work with a small group of clients together. Although initially created to decrease costs and increase efficiency, practitioners soon recognized positive therapeutic benefits that could not be gained from one-on-one therapies. For example - interpersonal problems are addressed well within groups. Group therapy is not based on one single psychotherapeutic theory, but many and often revolves around talking, and may also include other approaches such as psychodrama, movement work, body psychotherapy or constellations work. In group therapy, eight to 12 people meet, together with a therapist. It's a useful way for

people who share a common problem to get support and advice from each other. It can help you realize you're not alone in your experiences, which is itself beneficial. Some people prefer to be part of a group or find that it suits them better than individual therapy. (www.psychotherapy.org.uk)

Definitions of Group Psychotherapy

1. A type of psychiatric care in which several patients meet with one or more therapists at the same time. The patients form a support group for each other as well as receiving expert care and advice. The group therapy model is particularly appropriate for psychiatric illnesses that are support-intensive, such as anxiety disorders, but is not well suited for treatment of some other psychiatric disorders.
2. A type of psychoanalysis in which patients analyze each other with the assistance of one or more psychotherapists, as in an "encounter group
3. A form of psychotherapy that involves sessions guided by a therapist and attended by several clients who confront their personal problems together. The interaction among clients is considered to be an integral part of the therapeutic process.
4. Group therapy is a form of psychosocial treatment where a small group of patients meet regularly to talk, interact, and discuss problems with each other and the group leader (therapist). (Andersson, G., & Cuijpers, P. 2008). And this definition adopted by researcher in this study.

2.2.1.9 Counseling : counseling can be thought of as a relationship in which the client experiences another person (the therapist) as one that accepts the client's subjective world, and who endeavors to understand the client's experiencing and meaning system. Therapeutic progress follows from the client experiencing empathic understanding without judgment.(Merry & Tudor, 2006)

Counselling : is an interactive learning process contracted between counsellor(s) and client(s), be they individuals, families, groups or institutions, which approaches in a holistic way, social, cultural, economic and/or emotional issues.

Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crisis, improving relationships, developmental issues, promoting and developing personal awareness, working with feelings, thoughts, perceptions and internal or external conflict. The overall aim is to provide clients with

opportunities to work in self-defined ways, towards living in more satisfying and resourceful ways as individuals and as members of the broader society. *(*European Association for Counselling 2000*)*

2.2.2. Operational definitions :

Mental health professionals : It includes of Mental health professionals whom work in community mental health directorate as fixed term employers.

Talking Therapies: Talking therapies in this study refers to evidence-based psychological therapies used by Mental health professional's including, Counseling, Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Family Therapy, and Group therapy.

Mental health professionals specialty: Mental health doctors- Mental health nurses- Psychologists and Social workers .

Mental health professionals qualification: Diploma, Bachelor degree, or Post graduate (diploma or master degree).

Mental health professionals Sociodemographic characteristics: Age – Gender – and Living place.

Mental health professionals experiences: Years of practicing and Training experiences.

Clinical Practice: Applications of Talking therapies Will take place and used.

2.3. Literatures reviews

After reviewing the literature regarding Talking therapy , the researcher find that the efforts in this area of mental health concerned were became the focused of researchers in the last years, aiming to explore this option of dealing with mentally ill, that promote strengths and empowerment of people with mental disorders, and shifting them from dysfunctional behaviors to be more Functional in daily life routine.

2.3.1 Talking therapy

There is a strong body of evidence to support the effectiveness of a range of talking therapies to achieve reductions in, or abstinence from, problematic substance use». In addition, a combination of prescribed substitutes and talking therapies is frequently more effective than either medication or talking therapies alone, particularly for opiate, tranquilizer and alcohol users. (Wanigaratne, S., Davis, P., Pryce, K., & Brotchie, J. 2005).

Talking therapies can cover a broad range of interventions. This was reflected in the consultation where practitioners provided a wide variety of definitions. The working definitionused in this guide defines talking therapy as:

• based on one or more theories of human behavior
• involves a relationship between the practitioner and consumer
• explores issues relating to development, experience, relationships, cognition, emotion and behavior
• holds the goal of increasing the consumer's self-understanding and making changes in their cognition, emotion or behavior. (Gowing, L., Proudfoot. H., Henry-Edwards, S., & Teesson, M.2001).
based reviews of the literature do present some evidence that certain talking therapies may be more effective for different groups.
• For tranquilizer users, the evidence is largely limited to cognitive behavioral therapy, which appears effective with this group.
• For stimulant users, any psychological treatment is better than no treatment. However, there is strongest evidence for combining cognitive behavioral therapy with motivational interviewing, relapse prevention, and contingency reinforcement approaches.
• For cannabis users, motivational interviewing, cognitive behavioral therapy and family therapy appear to be most effective. (Wanigaratne, S., Davis, P., Pryce, K., & Brotchie, J. 2005).

2.3.2 The History of Talking Therapy

The first recorded instance of psychotherapy is the case of Anna O. in the early 1880's. Anna, whose real name was Bertha Pappenheim, developed severe symptoms, such as paralysis, loss of sensation, the inability to drink even though thirsty and a greatly reduced ability to speak or understand language. She also experienced periods of delusions.

Dr. Josef Breuer, who was treating Anna, observed that during the periods of delusions, she would repeatedly mutter a few words which seemed to be related to her train of thought. He had the idea to put her into a state of hypnosis while she was not in a state of delusion and repeat the words to her. By doing so, he was able to get at the root cause of her symptoms, which were previous events in her life, such as a vivid nightmare she experienced while caring for her ill father. This process caused her symptoms to disappear.

Later Sigmund Freud began employing this "talking cure" on his own patients, which lead to the development of psychoanalysis. (Peters, 2007).

2.3.3 Types of talking therapies

There are now a variety of therapeutic approaches, in addition to psychoanalysis, which are available. These include: cognitive behavioral therapy, behavioral therapy, interpersonal therapy, counseling, group therapy, motivational interview, Couples therapy, Interpersonal Therapy,Humanistic therapy, mindfulness, rational emotive therapy and family approaches**.** (Forbes, et al(2007).

2.3.4 Who gives talking therapies?

Talking therapies may be given by:

- Counselors
- GPs
- Occupational therapists
- Psychiatrists
- Psychologists and clinical psychologists
- Psychotherapists
- Registered nurses working in mental health or addiction services
- Social workers

Each talking therapy requires its own training. The above professionals may be fully qualified to practice the therapy they have trained in, or they may have learnt some skills from a particular type of therapy. Some therapies take years to train in. Some talking therapies require the therapist to also have talking therapy. (Forbes, et al:2007).

2.3.5 Talking therapies : rationale and role

Traditionally, talking therapies have been considered to have little role as an intervention for psychosis. The prevailing view has been that psychosis is purely a medical issue. Service users and their cares often ask for counseling, frequently wanting to talk about their distress, their problems, their psychotic experiences.

They are often informed that counseling would not be good for them, indeed it would be likely to cause a deterioration in their condition. They are often told
that therapy may be considered well down the line, but in practice this rarely occurs. In my opinion, this is a misguided view, one which needs to be revisited. The obvious benefits of medication, particularly in the acute stages, does not negate the role of talking therapies.

Talking therapies can play an important role in enabling the person to live well, understanding themselves and their symptoms, to work towards living the life they want to live, a safe place and space to begin rebuilding their sense of self and interacting more effectively with the world.

Talk therapies need to be regulated to protect people from practitioners who are inadequately trained or personally unsuitable. In the meantime, it is important
that therapists be well trained, accredited with a recognized professional body, have regular supervision and partake in regular ongoing training. (Carr 2006).

Researches shows that talking therapies work just as well whether you're old or young, male or female, white or black, gay or straight, working class or middle class. Your educational background makes no difference either. Talking therapy is for anyone who's going through a bad time or who has emotional problems they can't sort out on their own. Sometimes, it's easier to talk to a stranger than to relatives or friends. During talking therapy, a trained therapist listens to you and helps you find your own answers to problems, without judging you. The therapist will give you time to talk, cry, shout or just think. It's an opportunity to look at your problems in a different way with someone who'll respect and encourage your opinions and decisions.

2.3.6 Talking therapies can help if you have :

Mental health problems

- depression
- anxiety
- an eating disorder
- a phobia
- an addiction

Difficult life events

If you're going through a sad and upsetting time, talking therapies can help you deal with it. This could be after a relative or friend has died, after finding out you have cancer, if you're struggling with infertility or if you've lost your job.

Physical illness

Talking therapies can improve your quality of life if you have a lifelong physical illness, such as:

- diabetes
- multiple sclerosis
- heart disease
- a stroke

People with long-term health conditions are particularly vulnerable to depression, and talking therapies have been proven to help.

Over-65s

Older people, especially those with depression, are as likely to benefit from talking therapies as everyone else. Depression in later life, especially over the age of 65, is often dismissed as a normal part of ageing. However, this isn't the case and talking therapy can improve your enjoyment of life if you're feeling low.

Past abuse

If you've been sexually abused or experienced discrimination or racism, you may feel better able to cope with life after a course of talking therapy.

Relationship problems

Couples therapy can save a relationship that's in trouble or help you through separation and divorce. Ideally, a couple should go to counseling together, but if your partner refuses to join you, counseling can help you sort out lots of things on your own.

Troubled families

Family therapy is talking therapy that involves the whole family. It can be especially helpful for children with depression or a behavioral problem, or whose parents are splitting up. It can also help families in which a child or parent has an eating disorder, mental health condition or drug problem.

Anger

Talking therapy can help people who find it difficult to keep their anger under control.

2.3.7 The role of the “talking therapist”

Roth AD & Pilling S. 2007 described the task of the “talking therapist” as :

Common elements that the therapist can use his/her skills to:

• successfully engage and form a therapeutic alliance with the service user .

• undertake a thorough assessment .

• make an assessment of the type of therapy most suited for the person’s problems – underpinning such an assessment is knowledge and experience of:

o a wide range of therapies.

o the range of mental illnesses .

o the person’s strengths.

o what strategies have worked well for the person before/what have not.

o cultural issues (and where to seek cultural advice if needed)

o family supports .

o community agencies.

• undertake therapy in a safe, informed, culturally appropriate way (if they are not of the service user’s culture)

• work with the family wherever possible

• clearly document the process

• keep checking with the service user at various pre-defined times about progress

• “change tack” in the therapy process if required

• successfully disengage from therapy – this is an integral part of the therapeutic relationship .

• overall, to ensure that the service user feels valued and affirmed during the therapeutic process.

2.3.8 Benefits of Talking Therapy

The benefits of talk therapy are numerous. The process allows the patient to discuss issues that may be too difficult or painful to discuss with anyone else in the individual's life, and to work through, process, and deal with these issues. Talk therapy also offers the benefit of a "disinterested third party," or a nonjudgmental therapist to listen to the patient's concerns without making assumptions, or making the individual feel uncomfortable. Therapy is often used in conjunction with other forms of treatment for mental illness, such as medication.

Talk therapy is used in many different settings, including individual or group settings. Family therapy is very common, as well as group therapy for people who may be suffering from a similar issue as other people, such as a drug or alcohol addiction. Individual therapy refers to the instance when an individual meets one on one with a therapist to discuss any potential issues that he or she is having. Couples counseling or marital counseling is another type of talk therapy, when a couple who is having relationship troubles will seek the advice of a therapist; in some instances, such as a divorce, this therapy can be mandated by the court at the request of one member of the couple.

Talk therapy can be beneficial for people who are suffering from many different types of mental disorders. Studies have shown that therapy, when used in conjunction with medication, is a more effective treatment for disorders such as depression than just medication alone. This is because medication can treat the symptoms, but may not be able to get to the root of the cause; talk therapy, on the other hand, allows the individual to determine any potential causes or triggers for mental distress.

A talk therapist will also be able to help an individual develop coping mechanisms or techniques for overcoming obstacles in life. For instance, people who are suffering from anxiety might learn the issues that tend to trigger an anxiety attack, and they might then learn how to head off an anxiety attack, or put a stop to it once one starts. A therapist might also be able to teach more effective communication techniques, among others. Some people may only need to attend talk therapy for a few weeks or months until they feel as if they can stop, while others may need to attend for years or the rest of their lives.(Karmarkar, U.R., & Tormala, Z.L. 2010).

2.3.9 Cognitive behavioral therapy

Cognitive behavioral therapy (commonly referred to as CBT) is a form of therapy that aims to adjust thoughts and behavioral patterns to create more adaptive outcomes. Sessions are highly structured and focus on identifying the cognitive and environmental factors controlling the problem behavior. Cognitive techniques (e.g. challenging negative thinking) and behavioral work (e.g. rehearsing new skills and increasing pleasant activity) are employed to achieve behavioral change. These may be provided in a group or individual format. (Wanigaratne, S., Davis, P., Pryce, K., & Brotchie, J. 2005).

2.3.10 How does CBT work?

CBT can be particularly useful at helping you to make sense of problems you are facing in everyday life by breaking them down into five areas. This makes it easier to see how they are connected and how they might affect you. These five areas are:

• ***Situation*** - a problem, event or difficult situation in any aspect of your life
• ***Thoughts*** (things going through your mind)
• ***Feelings*** (the emotions you might be experiencing)
• ***Physical reactions*** (the physiological sensations in your body)
• ***Behavior*** (the actions you might/might not follow through)

Each of these different areas often affects the others- the way in which you think **(thoughts)** about a problem can affect how your body reacts physiologically **(physical)** and emotionally **(feelings)**. It can also alter what you do about it **(behaviors).** When difficult situations arise, the way that we interpret those situations can have an impact on the way we feel and how we behave. Sometimes the way we respond to situations can be unhelpful, which may lead to more distress.

2.3.11 The History of Cognitive Behavioral Therapy

In the 1960s, Aaron T. Beck, a psychiatrist, observed that during his analytical sessions, his patients tended to have an **internal dialogue** going on in their minds, almost as if they were talking to themselves. But they would only report a fraction of this kind of thinking to him. For example, in a therapy session the client might be thinking to him- or herself: "He (the therapist) hasn't said much today. I wonder if he's annoyed with me?" These thoughts might make the client feel slightly anxious or perhaps annoyed. He or she could then respond to this thought with a further thought: "He's probably tired, or perhaps I haven't been talking about the most important things." The second thought might change how the client was feeling.

Beck realized that the link between thoughts and feelings was very important. He invented the term **automatic thoughts** to describe emotion-filled thoughts that might pop up in the mind. Beck found that people weren't always fully aware of such thoughts, but could learn to identify and report them. If a person was feeling upset in some way, the thoughts were usually negative and neither realistic nor helpful. Beck found that identifying these thoughts was the key to the client understanding and overcoming his or her difficulties.

Beck called it cognitive therapy because of the importance it places on thinking. It's now known as cognitive-behavioral therapy (CBT) because the therapy employs behavioral techniques as well. The balance between the cognitive and the behavioral elements varies among the different therapies of this type, but all come under the umbrella term cognitive behavior therapy. CBT has since undergone successful scientific trials in many places by different teams, and has been applied to a wide variety of problems.

CBT can be an effective therapy for the following problems:

- anger management.
- anxiety and panic attacks.
- child and adolescent problems.
- chronic fatigue syndrome.
- chronic pain.
- depression.
- drug or alcohol problems.
- eating problems habits, such as facial tics.
- general health problems.
- sexual and relationship problems .
- sleep problems.
- phobias .
- obsessive-compulsive disorder.
- mood swings .
- post-traumatic stress disorder .

2.3.12 Motivational interviewing

Motivational interviewing aims to generate behavior change by assisting the consumer to resolve ambivalence about treatment and reduce their substance use. This is achieved through assisting the consumer to become more aware of the implications of change, or not changing, in a non-judgmental interview where the consumer does most of the talking(Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B.L. 2010).

While person-centered, the approach is also directive in that it guides the consumer towards behavioral change. During the interview, four key skills are employed by the practitioner to enable this change:

• expressing empathy

• developing discrepancy where the consumer can begin to see gaps between their values and current problematic behaviors

• rolling with resistance, where reluctance to change is respected

• supporting the consumer's self-efficacy. (Lundahl,B.W., Kunz,C., Brownell,C., Tollefson, D., & Burke, B.L. 2010).

Motivational interviewing can be used alongside other treatments, to build motivation to address emotional distress or engage in other forms of therapy. Motivational enhancement therapy uses the principles of motivational interviewing and incorporates them into a more structured series of four sessions that include assessment, development and monitoring of strategies for substance use reduction (National Institute on Drug Abuse. 2010).

2.3.13 Key Assumptions of Motivational Interview:

• Motivation is the end product of a complex interaction between person/client elements and environmental influences.
• Motivation is interpersonal.
• Resistance is interpersonal.
• Clinician approach and behaviors matter.
• Persuasion is usually not an effective method to increase motivation and change.

2.3.14 Basic Motivational Interview Principles

consists of four principles that underpin its skills (Miller and Rollnick, 2002):

• Develop Discrepancy
• Roll with Resistance
• Express Empathy
• Support Self-efficacy

The spirit of Motivational Interview Rollnick, Miller, and Butler (2008) have defined the so-called MI spirit in terms of three key characteristics:

· collaborative
· evocative
· honoring client autonomy

2.3.15 Motivational Interview skills

Five foundational MI skills (also known as techniques or methods) that are consistent with the principles and spirit of MI have been described by (Miller and Rollnick 2002):

· asking open-ended questions
· reflective listening
· affirmations
· summarizing
· eliciting change talk

2.3.16 Family therapy: Family therapy refers to therapy that focuses on the relationships and systems of the family. Other forms of talking therapy may involve families, but still maintain their focus on the individual. Family therapy typically draws on methods from other therapies, with the aim of improving communication, supporting family strengths and using these as a mechanism for change.(Te Pou. :2010).

In family therapy, a therapist (or pair of therapists) meets the whole family. The therapist explores their views and relationships to understand the problems the family is having. It helps family members communicate better with each other. Sessions are between 45 minutes and an hour-and-a-half long, and usually take place several weeks apart.

Family therapy is useful for any family in which a child, young person or adult (a parent or a grandparent) has a serious problem that's affecting the rest of the family. Many types of cases are seen by family therapists, including:

- child and adolescent behavioral problems
- mental health conditions, illness and disability in the family
- separation, divorce and step-family life
- domestic violence
- drug or alcohol addiction

2.3.17 A brief history of family therapy.

Family therapy did not become a popular mode of treatment until the late 1950s and early 1960s. However, when researching the history of family therapy, there are several psychologists in the early part of the 20th century that had an influence on how family therapy developed. These early pioneers came to the understanding that a patient's progress in therapy often was influenced by the relationship within the family unit. Patients with good family dynamics faired much better than those that were in less stable families. In the early 1920's, social psychologists studying group dynamics, realized the behaviors of individual members within the group influenced how the group functioned as a whole. Psychologists began to understand that this same group process could be applied to a family unit. One of the early psychologists that greatly influenced the history of family therapy is Virginia Satir. She began working with families in 1951, and she held the belief that families need to share their feelings and affections to have a healthy family life. Ms. Satir also strongly believed love and nurturing were of the highest importance to healing the family unit. She provided training, lectures and workshops about these aspects of family therapy across the United States.

Other psychologists whose influence contributed to the history of family therapy include, John Elderkin Bell. Although not as well known as other therapists, Edward Bell's approach to family therapy was to develop a step-by-step plan to treat problems within the family. He believed these steps would help families improve communications and aid in resolving family issues. Nathan Ackerman strongly advocated for all members of a family to be included in treatment, not just the member having difficulties, and said this was the best form of treatment for children. He also founded the Family Mental Health Clinic in New York City in 1957 and the Family Institute in 1960, which was later renamed the Ackerman Institute. Paul Watzlawick believed communication was the key to the well being of the family unit; Edward Sapir, an anthropologist, also thought communication in the family unit was important, and Gregory Bateson added to the history of family therapy by coining the term "system thinking", referring to a system of interacting within a family. Over time, due to the major impact of the above therapists and many others as well, the history of family therapy has evolved from treating just the involved individual, to blaming the family for a members mental problems, to the use of only medications in treatment and eventually to the combination of family therapy and medications as a mode of treatment. (Kuipers, 2006).

2.3.18 Group Psychotherapy

Human beings live in a social world in which their ability to gain esteem and self definition significantly follows from their success in their personal relationships. Psychotherapy in a group setting provides a social arena in which the members can learn about their assets and deficits through interactions with peers and authority. Members also have opportunity to experiment with newly learned behaviors in the protected environment of the group in preparation for using them in the external world.

2.3.19 History of Group Psychotherapy

Group psychotherapy began at the turn of the century when Joseph Pratt, a Boston physician, recognized the positive effects of bringing the tuberculosis patients who did not have access to sanatoria. Their recovery requires strict hygienic regimens in their impoverished homes. Using regular group meetings he educated his patients as to how to combat the diseases. Other psychiatrists were influenced by this method. Cody Marsh even included dance classes in his hospital, he said that "By the crowd they have been broken; by the crowd they shall be healed". The role of the charismatic leader and the dynamics of group relationships were recognized by Freud later. (Howard B. Roback, 2003)

Group therapy received a stimulus during World War II when many therapists were initially exposed to group works during their military experience. Theoreticians from England and US applied psychoanalytic or interpersonal theory to group therapy concepts. Interest in group process, stimulated by the work of Kurt Lewin. The social revolutions in the 1960s resulted in the beginning of sensitivity training experiences (T groups), and a variety of personal growth groups. The emergence of transactional analysis, gestalt theory, bioenergetics, existential models for group therapy and many additional innovative variations have enriched the group therapy fields. In Britain and America during the second world war, an appreciation of group psychology lead to a wide range of innovations, the most important are the following- the use of the group approaches for the selection and allocation of work responsibilities, studies of group morale, the integration of psychiatric knowledge in the management of large groups through the role of the command psychiatrist. (Howard B. Roback, 2003)

2.3.20 Role of Group therapist

The therapist should actively structure the discussion in a way that encourages the group members to stay in a topic.

1. Decision to establish a group
    - Determine setting and size of the group
    - Choose frequency and length of the group sessions
    - Decide on open Vs closed groups
    - Select a co-therapist for the group
    - Formulate policy on the group therapy with other therapeutic modalities
2. Act of creating a therapy group

    - Formulate appropriate group
    - Select patients who can perform the group task
    - Prepare patient for group therapy

3. Construction and maintenance of the therapeutic environment

    - Build the culture of the group explicitly and simplicity
    - Identify and resolve common problems (membership turn over, sub-grouping, conflict)

4. Therapist should take cue from the process of the group.
5. When members interact spontaneously around an appropriate issue, the therapist should be quiet and allow the patients to feel a sense of mastery.
6. If members are trying to form some sub-groups, therapist should discourage them by asking the group to discuss the reasons for their formation or try to find some similarity with all members.
7. Therapist should try to include all members in the group discussion by asking each one to express their views and feelings. Therapist should assist silent members to speak and should understand their reasons for silence.
8. When there is conflict between members then therapist should not take sides rather encourage whole group to discuss issue in a way that leads them to understand why conflict has arisen.
9. Above all, it is the therapist's task to help the group develop into a cohesive unit with an atmosphere maximally conducive to the operation of curative factors and where confidentiality and non judgmental approach can be communicated to the group members. (Franco Veltro et,al, 2006)

2.3.21 Benefits of Group Psychotherapy

It is common for those suffering from a mental illness or problem behavior to feel alone, isolated or different. Group therapy can help clients by providing a peer group of individuals that are currently experiencing the same symptoms or who have recovered from a similar problem. Group members can also provide emotional support and a safe forum to practice new behaviors. Montgomery C (2002)

2.3.22 Counseling:

Counseling helps people to increase their understanding of themselves and their relationships with others, to develop resourceful ways of living, and to bring about change in their lives. Counseling can involve sessions with an individual or with couples, families, or groups. Counselors are usually trained in a number of techniques and can help with a variety of issues. Te Pou. (2009).

2.3.23 The History of Counseling.

In the 18th century an Austrian physician named Franz Anton Mesmer discovered animal magnetism (more information concerning Mesmer in the "History of Hypnotherapy" section of my site). James Braid studied Mesmer's theory and developed hypnotherapy from Mesmer's concepts. Sigmund Freud became interested in the benefits of hypnotherapy and utilized this technique during his early years as a therapist in Vienna.

Freud's research into the human mind began in 1881. Trained as a neurologist, he set up his own practice in 1886. By 1896 he had developed a method of working with hysterical patients which he called `psychoanalysis`. This method of assisting patients was based more on conscious communication than hypnosis. During this time span Freud incorporated less hypnotherapy and more psychoanalysis techniques for which he became internationally recognized. Other well known therapists from that period had training from Freud before becoming well respected psychoanalysis in their own right, Alfred Adler, Snador Ferencze, Karl Abraham and Otto Rank were among those well published therapists. Freud continued to practice until the 1930`s. Many of the therapists he had trained began to develop their own theories and approaches which were some times in conflict with Freud's. Carl Jung who had been groomed by Sigmund Freud to be his intellectual successor, also split from Freud and incorporated concepts from both Freud and Alder, as well as developing and including some of his own principles.

The 1940`s and 1950`s were important decades for the expansion of counseling. The American psychologist Carl Rogers (influenced by Alfred Adler and Otto Rank) established the 'person centered' approach which is the bases of most current practices today. Rogers work was classified as 'Humanistic Therapy' and fits within the three main forms of psychological therapies. These 3 therapies are:

*Behavioral Therapies
* Psychoanalytical and Psychodynamic Therapies
* Humanistic Therapies

There have been many other therapists who have contributed to counseling as we know it today. The above information is just the tip of the ice berg. Counseling has grown and improved over the years to a point where clients can feel comfortable knowing that a

well trained, empathetic counselor has the skills to assist with the day to day issues they may be struggling with. (Anthony, K. (2006).

2.3.24 The benefits of Counseling

- The experience of exploring your thoughts and feelings with another individual can relieve your sense that you are entirely alone with your problems.
- Greater self knowledge and understanding can enhance your relationship with your self and others and improve your sense of choice and self esteem. This in turn can cultivate the feeling that life can be enjoyed rather than endured.
- At the core of therapy is a confidential and collaborative relationship where the therapist guides the person on a journey of increased understanding. Therapy offers a relationship with the intent of alleviating distress and rekindling hope.
- Many situations in life leave us feeling powerless and a feeling of no choices. My hope is to help the person move from a position of self doubt or insecurity to one where they feel more in control; to give you back choice in your life and hopefully the confidence to use that choice. (Alleman, J. R. (2002).

2.4 Success Stories From The Researcher's Experience Regarding Talking Therapy

Female patient a17 years old, single– nussierat community mental health center- complain of positive psychotic features due to sexual harassment and anal Raping . Talking therapy using by choosing of CBT and motivation interview in parallel with antipsychotic drugs . fortunately after 8 months and 16 sessions this client complete recovered and get married .

Male client 26years old . – nussierat community mental health center- computer an-engineer , unemployed complain of sever symptoms of depression , isolation, helplessness , hopelessness , negative thoughts about himself and others , by using CBT for 6 months and antidepressant for 3 months patient well recovered and get social well .

Group of students in American school in north Gaza Strip - Gaza Community Mental Health Program - complains of fear, anxiety, insomnia and low achievement due to Israel attacks. We use group therapy, catharses ,and psycho drugs and every client allowed to take about his and her fears and symptoms, after 6 sessions the event was accepted to the students and they express felling and return to previous life with reducing a lot of symptoms .

Two Families in Bethanon, complain of Post Traumatic Stress Disorder and Depression post of Israel attack and 2 martyrs of each family , we intervene by family psychotherapy and psychosocial support with psych education , after 2 months of following session those family functional well .

Female patient 43 years old – nussierat community mental health center- married and she has 7 children complain of abnormal habit of eating (eating a lot of candles and chalk daily) since 12 years ago . Just by two motivation interview and counseling and empowerment to client , she came after one week with a lot thanks because she take off eating that things .

A lot of cases with substance Abuse (Tramdole Addiction) – nussierat community mental health center- post 3 to 4 sessions of taking therapy with medication intervention completely recovered and cured .

Female patient 21 years old single – nussierat community mental health center- complain of Post Traumatic Stress Disorder , sever guilt feeling, low academic achievement and crying, after 10 sessions of taking therapy without medication intervention Just by CBT and motivational intervention , she completely recovered and become well .

A lot of children complain of fear, Post Traumatic Stress Disorder and enuresis – Jessor Association for Trauma Recovery - by motivational intervention and behavioral therapy they became well and functional daily routine and reduce most symptoms specially enuresis .

Female client , single , 19 years old – nussierat community mental health center- complain of delusional disorder, by taking therapy and medication intervention, she became well reemission of symptoms and returned to school .

Coble of married– Jessor Association for Trauma Recovery - complain of relational problem negative about each other after marriage , Bad communications ,cable were treated by taking therapy and CBT for 3 session , each one know his and her blind spots , positive and negative points they returned to functional life away from continues problems .

A lot of psychotic clients in our clinic by using taking therapy and medication interventions the relapses reducing by observed level and reducing time of hospitalization.

2.5 Previous studies

David Richards(2011) reports on a study led by him of the University of Exeter which found that about half of patients with depression or anxiety receiving stepped care at one of the Improving Access to Psychological Therapies services of the British government make a recovery. A combination of talk therapy and drugs often worked best. Drugs had a quicker impact on symptoms than talk therapy, but it often took trial and error to find a drug that worked without unacceptable side effects. David concludes a comparisons between talk therapy and drugs as:

Talking therapies	**Medication**
Up side	**Up side**
Talking Therapies work in many conditions where other medicines are less effective e.g. eating disorders. There are a lots of different types of talking therapies so the right one can be chosen for the right person. They clearly work and help people for many conditions Can help where physical conditions (e.g. pregnancy) or side effects don't allow or restrict medicines The therapy is aimed at the person (personalized) They are "holistic" i.e. treat the whole person, not just the symptoms They help the person understand why they are like they are, so feel more in control and understand more about themselves Some of them teach the person how to deal with their problems long-term, by changing the way they think so are less likely to get ill again (because they recognized signs and symptoms or relapse and know what to do) Have no "side effects"	Medicines work in many conditions where other therapies can't e.g. when someone is very ill or in a crisis. For example acute mania, acute psychosis and OCD, where the person wouldn't be able to do any talking therapies until the symptoms are under control There are a lots of different types of medicine so can be chosen according to personal choice Medicines work no matter how good the doctor is (assuming you get the right drug and dose!) Medicines just require taking a dose every day. You don't really have to get "involved" Medicines don't depend on you e.g. your age, background, what language you speak etc. Fairly quick acting (usually a week or two) Many symptoms of mental health problems are caused by an imbalance (too much, too little) of transmitters in the brain. Medicines help these directly and quickly. Might protect against some of the long-term brain changes in some conditions

Down side	Down side
Can make you feel worse before you feel better - they might uncover things you would rather forget about. So, they might not have "side effects" but do have "adverse effects". But you may have to get over something first before improving. Talking Therapies often work best when they are part of a package of care. The research studies on many conditions haven't been done yet - although many people say they like them, we don't actually know how effective they are. People can expect too much from therapy and be disappointed - you have to put something of yourself into it Talking Therapies don't work in everyone and don't work at all in some conditions e.g. mania, acute psychosis. Talking Therapies rely on the skill of the person doing it. And on you being willing to put the ideas into practice Talking Therapies also need to have a trusting relationship with the therapist. You might not want to share your personal thoughts with another person. There can be a longer wait to start Talking Therapies (can be a couple of weeks), but this varies by area and service. Not everyone is suitable for talking therapies. And not everyone is accepted for talking therapies	Medicines can make you feel worse before you feel better. All medicines have side effects. They can vary a lot from person to person. Some wear off after a while, others do not. Some can appear after several years. Medicines often work best when they are part of a package of care. Many studies on medicines have been done by drug companies, and we know the results tend to favor their medicines (although to be fair it has to be said that the independent studies tend to show the same results) Can expect too much from therapy and be disappointed, have to make the most of it once symptoms controlled Doesn't work in everyone and don't work at all in some conditions e.g. eating disorders. Medicines are adding chemicals to a delicate brain, and we don't know the full effects they might have. You might have to take medicines for many years to prevent the symptoms coming back again. There are several conditions where medicines don't help Medicines (probably) don't cure anything

Asay, T. P., & Lambert, M. J. (2009).said that Extensive international research has assessed the efficacy of talking therapies for people with problematic substance use. This research has been summarized in a number of meta-analyses, which have highlighted the effectiveness of a variety of modalities, including motivational interviewing, contingency management and brief interventions. These meta-analyses have also demonstrated the importance of the therapeutic relationship in predicting successful outcomes.

Ramsay &Rostain, (2008) conducted an open study in which 43 patients received combination treatment with medication and CBT. Patients who received combination treatment were found to improve on self report of ADHD symptoms, anxiety and depression and clinician ratings of functioning.

Geertrui Wilhelmina (2008)A survey questionnaire was sent to 227 registered nurses from a District Health Board (DHB), Mental Health Service and a sample of eight nurses participated in a semi-structured interview. Content analysis based on the headings "knowledge views, skill acquisition and skill transfer" established the major themes from the data collection processes. The findings of this study confirmed that nurses believe their knowledge and skills in evidence-based talking therapies to be vitally important in mental health nursing practice. Nurses identified that talking therapy training courses needed to be clinically relevant and that some learning strategies were advantageous. The identification of some knowledge gaps for, nurses with limited post graduate experience, and for nurses who currently work in inpatient areas suggests that further consideration must be given to ensure that a cohesive, sustainable approach is ensured for progression of workforce development projects relevant to training in talking therapies for mental health nurses in new zealand.

Study of Curran and Brooker (2007) conducted a systematic review that sought to identify randomized control trials (RCTs) reporting on mental health nurses contribution to the implementation and evaluation of effective delivery of psychological interventions in the United Kingdom. Fifty-two RCTs were included in the review. Curran and Brooker concluded that mental health nurses in a variety of treatment settings were involved in the effective delivery of psychological interventions and that CBT was the predominant intervention.

Carr (2006) mentions the benefits of talking therapy of 25 clients who experience psychosis as; helping clients to adhere to their antipsychotic medication, developing strategies for reducing the negative impact of delusions and hallucinations, not controlled by medication, on their quality of life. talking therapy can play a significant role in enabling the person to recover their sense of self and dealing more effectively with the world over time.

Pfammatter et al. (2006) conducted an extensive review of 21 meta-analyses of psychological therapies for schizophrenia involving thousands of clients, and conducted further meta-analyses of the most methodologically robust randomized controlled trials for four distinct types of psychological interventions: psychoeducational family therapy; cognitive behavior therapy; social skills raining and cognitive rehabilitation. They found that each of the four classes of interventions had a positive impact on specific aspects of adjustment.

Pfammatter et al. (2006) new meta-analysis of 31 randomized controlled trials involving over 3,500 clients, found that compared with medication alone, a multimodal program including psychoeducational family therapy and medication led to lower relapse and rehospitalization rates, and improved medication adherence. One to two years after treatment, the average effect sizes across these four meta-analyses for relapse and rehospitalization rates were .32 and .48, which are equivalent to approximate success rates of 57 and 61%.The effect size for medication adherence was .30, which is equivalent to an approximate success rate of 57%.

In other Study conducting by Ryan et al. (2005) conducted a cross sectional study, sending out 257 nurses a postal survey that evaluated training provided from 1986-1999 in behavioral and cognitive techniques. Training was delivered over one calendar year and met specific requirements for theoretical content and the supervision of participants. A sample of 137 respondents provided their views on the benefits of training and the subsequent impact of training on their clinical practice. The first section of questionnaire sought information relevant to the respondent's skills and knowledge of behaviors therapy prior to training. The remaining three sections of the questionnaire sought to clarify respondents experience during the course (course structure and content, teaching and supervision); their current clinical position (whether behaviors therapy was the main focus of clinical work; job changes and professional development opportunities); and respondents perception of their current use of behavior therapy skills in practice. Although the results indicated a high level of satisfaction with the course

structure, content, teaching and quality of clinical supervision offered throughout the training program the findings signaled a deficit in terms of the usage of skills in clinical practice. Ryan et al. (2005) identified that over a thirteen year period, only 17% of respondents indicated that behavior therapy was still the focus of their current work.

Study of Bee, Richards et al. (2005). The researchers aimed to illicit the attitudes of 61 nurses from four acute inpatient units following completion of an 18-day 'Addressing Acute Concerns' training program on the course delivery, content and personal impact of the training. The training program was specifically developed to provide training for the staff team in the acute unit, in contrast to individual health professionals attending specialist courses delivered through universities. A mixture of qualified and unqualified nursing staff attended the course that covered assessment and engagement skills, care planning, psychopharmacology, risk assessment, observation and de-escalation practices. Program modules utilized didactic teaching methods, large and small group work and presentations from external speakers. Skills practice and role plays were used to assist with transfer of theoretical and practical knowledge into the clinical setting.

Kingdon, D., & Turkington, D. (2005).by a new meta-analysis of 17 randomized controlled trials involving over 480 clients, found that compared with medication alone, a multimodal program including cognitive behavioral therapy and medication led to a significant reduction in positive symptoms in clients with schizophrenia. For positive symptoms, the average effect sizes across these five meta-analyses was .54 after treatment and .64 at follow-up. These effect sizes are equivalent to approximate success rates of 62 and 65%.

Study of (McCabe et al, 2002) which analyzed 32 consultations between psychiatrists and people diagnosed with schizophrenia or schizo-affective disorder in London. The researchers found that the patients actively attempted to talk about the content of their psychotic symptoms such as hallucinations and delusions, and the distress they experienced with these symptoms. However, doctors tended to hesitate and avoid answering the patients' questions, indicating a reluctance to engage with these concerns. The researchers concluded that doctors have trouble talking to patients about psychotic symptoms. They stated that proactively addressing patients' distress about their psychotic symptoms may lead to a more satisfactory outcome of the consultation itself and improve engagement of such patients with healthcare services.

Wilens et al. (1999) conducted a retrospective case review in which they looked at 26 patients, most of whom were on some medication, had had previous psychotherapy, and had significant comorbidity. All patients still had residual ADHD symptoms. CBT resulted in significant improvement in ADHD symptoms, anxiety, depression, and functioning. Wilens et al.'s emphasize the importance of talking therapy in providing an avenue of treatment for those who have a partial response to medication. Their application of intervention was ambitious in that it attempted to target core neuropsychiatric symptoms of inattention, hyperactivity, and impulsivity per se, as well as the broader spectrum of associated problems faced by adults with ADHD. Of patients with partial improvement on medication, 69% showed further improvement in ADHD, anxiety, depression, and functioning with the addition of CBT.

In a large meta-analysis of 106 studies of interventions for schizophrenia, Mojtabai et al. (1998) found that compared with medication alone, multimodal programs which included both psychotherapy and pharmacological interventions yielded an effect size of 39%, which is approximately equivalent to a comparative success rate of 60%.They also found that, after an average of 17 months, the relapse rate for service users with schizophrenia who received psychotherapy plus medication was 20% lower than that of those who received medication only. The relapse rate for medication only was 52% and that for medication combined with psychotherapy was 32%.

Five Australian studies have contributed to a body of research literature on nurses' talking therapy training and skills. Hafner, Crago, Christensen, Lia, and Scarborough (1996) aimed to introduce and evaluate a cognitive behavior therapy (CBT) training program for four case managers who took part in a six month, part time course to develop basic skills and knowledge in CBT. The training program conducted in South Australia included, self directed learning, group and individual supervision and weekly meetings to discuss relevant practical and theoretical issues. At the conclusion of training, participants reported that they valued their skills and knowledge, and that the training enabled the incorporation of basic CBT strategies into clinical practice. Hafner et al.(1996) recommend increasing the availability of training in CBT for mental health nurses.

Becker and Comstock (1992) reported group psychotherapy is quite helpful to most patients with multiple personality and dissociative disorders at some point during the recovery process. It is usually most effective when combined with individual

psychotherapy and other treatment modalities according to the needs of the individual patient. Group processes, however, can serve quite different purposes at various stages of treatment Members of the group learn that talking helps, not only because it soothes but also because it illuminates cause and effect, thereby facilitating self-understanding and insight.

2.5.1 Summary of LR

The previous literature review has shown that there is an extensive body of literature pertaining to mental health professionals talking therapies knowledge, attitudes, training and skills in clinical practice. In particular research literature from the United Kingdom. As part of the search process for this review, research conducted in the United States of America, Canada and Germany that reported on mental health professionals talking therapies training and skills in practice was found. However, it has been identified that the research from these countries did not add new knowledge to the review process. Most literature from these countries referred to workforce development and talking therapies training programs from the United Kingdom as an important resource. Therefore the scope of this review was limited to research literature from New Zealand, Australia, Ireland, and the United Kingdom.

Mental health professionals' views on their talking therapy skills have been reported. Specific aspects that nurses valued about their talking therapies training were identified in research literature. In particular training delivered concurrently with the opportunity for mental health professionals to trial and use new skills in clinical practice.

Most researchers recommended increasing the availability of talking therapies training for all health professionals and in particular for nurses. The cost-benefit advantages for training nurses in Talking Therapies to manage people with complex mental health needs was identified.

The identified international research in which mental health professionals' attitudes on their talking therapy training and skills in clinical practice have been described. The important elements of training that support effective skill acquisition were identified. Aspects of talking therapies training that assisted with effective skill transfer or aspects that have represented barriers to skill transfer have been highlighted. In contrast to the extensive body of international literature pertaining to mental health professionals talking therapies training and skills in clinical practice there is little evidence of this in Gaza Strip mental

health professionals literature. Therefore, it is vital to understand what talking therapy knowledge, attitudes and practice mental health professionals have in Gaza Strip.

From the previous studies the researcher noted that Most of the studies show positive attitudes toward talking therapy, and some studies explore the important of training in psychotherapy intervention specially and there effectiveness in clinical practice to deal with varies psychiatric disorders. .

Some studies show the important of increasing the availability of training in CBT for mental health nurses. But other studies represent that the transfer of theoretical and practical knowledge into the clinical setting will be effective, Also studies focused in the same principle that underpin this study with the difference in the way of taking the sample and the different variables of respondents. And other studies explore the effectiveness of combinations of talking therapy and drugs in mentally ill prognosis and recovery process

The researcher point of view that the important of consumer provider relationships, and the important role which played by mental health provider in the talking therapy, and how can we with little effort improve the knowledge , attitude and practice of provider toward talking therapy, also these studies confirmed the effectiveness of talking therapy, as a suitable therapy in combination with drugs in mental health care, The research support that talking therapies often work better with medicines, and vice versa. The best outcomes in many conditions are from a combination of:

- Self-help (learning how to cope)
- Help from others (e.g. support, talking therapies)
- Medicines (to reduce the symptoms)

CHAPTER THREE
METHODOLOGY

Chapter3
3. Methodology

3.1 Overview

This chapter presents issues and titles which related to methodology used by the researcher to provide answers to the research questions. This chapter contains the following heading, study design, period of study, place of study, study population, sample size and sampling methods, eligibility, validity and reliability, pilot study, ethical consideration, data collection and data analysis.

3.2 Study design

This study was used a quantitative analytical descriptive research design methodology to summarize mental health professionals knowledge ,attitudes and practice of talking therapy in clinical mental health practice.

3.3 Period of study

The study was conducted in the period between January 2012 and October 2012.

3.4 Place of study

The study was carried out in community mental health directorate in Gaza Governorates includes one hospital and six community mental health centers(Abu shbak, Al mashtal, Alsorany, Alnuserat martyrs', Khanyuonis and Rafah clinic).

. 3.5 Study population

Table (3.1) Study population

Jobs	Number	percent
Mental Health Doctors	**19**	**16%**
Mental Health Nurses	**52**	**44%**
Psychologist	**24**	**20.6%**
Social worker	**23**	**19.4%**
Total	**118**	**100%**

The study population includes all Mental health professionals which workers in mental health directorate in Gaza governorate (Census); above table shows the distribution and percentage of the mental health professionals which work according to the job title.

3.6. Eligibility

3.6.1. Inclusion criteria

All registered mental health professionals which work in governmental sector in Gaza Governorates were included in the study.

3.6.2. Exclusion criteria

Part time employees.

Internship and volunteers.

Employees in long vacation or outside Gaza strip.

3.7. Ethical Consideration

Approval from community mental health directorate was obtained to conduct the study. The researcher was explained the purpose and objectives of the study to all participants. The participation in the study was optional and confidential. Neither name nor personal data were mentioned (anonymity).

3.8. Data Collection and instrumentation

Data were collected by using Knowledge, Attitudes and Practice questionnaires, the researcher explained to the participant that they have to complete the questionnaire for to one time.. The information gathered in these questionnaires revolves around Mental health professionals knowledge Attitudes and Practice of talking therapy in clinical practice.

3.8.1 Questionnaire:

The questionnaire was developed by researcher after long time of reading and researching related KAP questionnaires and how to measure or explore such topics a self report, using likert scale. Duplication, double parallel and leading questions were avoided. High concern was given to be clear, easy language and it was formulated in Arabic language. The questionnaire was reviewed by a panel of experts to evaluate it from face and content validity and then the questionnaire translated into English language by two different institutions, to ensure reliability of the questionnaire, small scale reliability test was conducted to evaluate the ambiguity, length and misunderstanding of the questionnaire. The questionnaire was include 4 domains, first is demographic data, the second domain is Mental health professionals knowledge's, the third one is attitudes, and fourth one is talking therapy in clinical practice.

3.9. Validity of the questionnaire

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

3.9.1. Structure Validity of each dimension and the whole of questionnaire

To test the appropriateness of data collection instrument, and standardize the suitable way for data collection, the researcher was conducted a pilot study concerning the instrument.

3.9.1.1 Pilot study

A pilot study concerning the instrument, consists of (20) questionnaires to get a clear feedback. The participants were selected randomly from all Mental health professionals . It was helped in estimation of the time needed to answer the questionnaire, then many changes were applied and the questionnaire was finalized, the researcher calculated the correlation between each statement and the dimension it belongs to. The results are illustrated below.

1. Validity

Internal consistency:

To check internal consistency, the researcher calculated the correlation between each statement and the dimension it belongs to. The results are illustrated below.

Table (3.2): Correlation between each statement and total score of knowledge domain

No.	Correlation value	No.	Correlation value
1	0.714 **	9	0.741 **
2	0.512 *	10	0.759 **
3	0.731 **	11	0.824 **
4	0.537 *	12	0.824 **
5	0.617 **	13	0.736 **
6	0.765 **	14	0.473 *
7	0.822 **	15	0.763 **
8	0.792 **		

** = significance at 0.01 * = significant at 0.05

Table (3.3): Correlation between each statement and total score of attitudes domain

No.	Correlation value	No.	Correlation value
16	0.532 *	21	0.685 **
17	0.538 *	22	0.734 **
18	0.588 **	23	0.676 **
19	0.693 **	24	0.695 **
20	0.463 *	25	0.774 **

** = signifi3cance at 0.01 * = significance at 0.05

Table (3.4): Correlation between each statement and total score of practice domain

No.	Correlation value	No.	Correlation value
26	0.820 **	33	0.510 *
27	0.792 **	34	0.446 *
28	0.681 **	35	0.567 **
29	0.731 **	36	0.651 **
30	0.608 **	37	0.713 **
31	0.884 **	38	0.748 **
32	0.487 *	39	0.733 **

** = significance at 0.01 * = significant at 0.05

Table (3.2) ,(3.3) and(3.4) clarifies the correlation coefficient for each filed and the whole questionnaire. The p-values (Sig.) are less than 0.05, so the correlation coefficients of all the fields are significant at $\alpha = 0.05$, so it can be said that the fields are valid to be measured what it was set for to achieve the main aim of the study**.**

Table (3.5): Correlation between each domain and total score of the scale

Domain	Correlation value
Knowledge	0.844 **
Attitudes	0.557 *
Practice	0.928 **

** = significance at 0.01 * = significance at 0.05

The table (3.5) show's that Correlation between each domain and total score of the scale are statistically significant.

2. Reliability

The reliability of an instrument is the degree of consistency which measures the attribute; it is supposed to be measuring (Polit & Hunger, 1985). The less variation an instrument produces in repeated measurements of an attribute, the higher its reliability. Reliability can be equated with the stability, consistency, or dependability of a measuring tool. The reliability of scale questions was tested immediately after data cleaning and it was improved by standardization of the instrument and its implementation, design of questionnaire manual and data re-entry.

a. Split-half method

The researcher calculated the correlation coefficient between the total scores of odd statements and the total score of even statements, then the researcher used Spearman-Brown equation. The results are presented in the following table.

Table (3.6): Correlation coefficient using split-half method

Dimension	No. of items	Correlation	Spearman-Brown equation
Knowledge	15	0.632	0.775
Attitudes	10	0.705	0.827
Practice	14	0.845	0.916

table (3.6) show the correlation coefficient between the total scores of odd statements and the total score of even statements, and then the researcher used Spearman-Brown equation.

b. Cronbache alpha method

The researcher used Cronbache's alpha coefficient method as shown in the following table.

Table (3.7): Correlation coefficient using Cronbache alpha method

Dimension	No. of items	Coefficient value
Knowledge	15	0.748 **
Attitudes	10	0.502 *
Practice	14	0.823 **

** = significance at 0.01 * = significance at 0.05

The table (3.7) show's that all alpha cronbach are statistically significant and the questionnaire is reliable and suitable to be used in this study.

3.10. Response rate

From the total of 118 subjects, (110) subjects had responded and gave answers, the response rate was 93%.

3.11. Statistical Analysis

All participants were given a numeric code to aid matching of questionnaires. Quantitative data were entered into the Statistical Package for the Social Sciences version 16 (SPSS) for analysis. Both descriptive and inferential statistics were generated. Questionnaires that could not be matched were excluded from this analysis.

3.12. Summary

Through following the appropriate steps of methodology on this chapter particularly taking into account the study design, the study population, the study instruments, the pilot study, data collection procedures, and data analysis procedures; the researcher found that the Knowledge, Attitudes, and Practice questionnaire considered valid and reliable instruments and can be used in this study which try to explore mental health professionals knowledge ,attitudes and practice of talking therapy in clinical practice..

Chapter four

Results

4.1 Introduction

This chapter presenting the result and the finding according to the questionnaire of mental health professionals knowledge ,attitudes and practice about talking therapy in clinical practice. The researcher was discussing the result and the finding of analysis in relation to research objective, and to answer the research question. Also the researcher gives interpretation of statistical analyses of the study finding.

4.2 Results of the study

4.2.1 population characteristics

The population of the study consisted of 90 participants (48 males and 42 females), their age ranged between 24 – 58 years (m = 35.055 ±7.619). Their experience ranged between 1 – 29 years (m = 8.188 ± 6.918). Participants characteristics are illustrated in table 4.1.

Table (4.1): Distribution of study participants according to demographic variables

Items	Frequency	%
Age in years		
24 – 33	51	56.7
34 – 43	23	25.6
44 - 58	16	17.8
Total	**90**	**100.0**
Gender		
Male	48	53.3
Female	42	46.7
Total	**90**	**100.0**
Place of residency (governorate)		
North	19	21.1
Gaza	32	35.6
Middle	18	20.0
Khanyounis	11	12.2
Rafah	10	11.1
Total	**90**	**100**
Marital status		
Single	13	14.4
Married	77	85.6
Total	**90**	**100.0**
Level of education		
Diploma	5	5.6
Bachelor	36	40.0
Postgraduate	49	54.4
Total	**90**	**100.0**

Specialty		
Psychiatrist physician	10	11.1
Psychiatric nurse	37	41.1
Practical nurse	2	2.2
Psychologist	22	24.4
Sociologist	19	21.2
Total	**90**	**100.0**
Years of experience		
5 and less years	47	52.2
6 – 12 years	24	26.7
13 years and more	19	21.1
Total	**90**	**100.0**
Place of work		
Psychiatric hospital	36	40.0
West Gaza clinic	6	6.7
Al soraney clinic	9	10.0
Abu Shbak clinic	9	10.0
Al Nussierat clinic	9	10.0
Khan Younis clinic	12	13.3
Rafah clinic	9	10.0
Total	**90**	**100.0**

4.2.1.1 Age:

Table (4.2) Distribution of study population according to age

Age in years	Frequency	%
24 – 33	51	56.7
34 – 43	23	25.6
44 - 58	16	17.8
Total	**90**	**100.0**

Table (4.2) show the Age distributions, range between 24 and 58 with mean 33, 3 years, and this distribution reflect most mental health professionals are young and less expertise. On the other hand this training offered to these categories makes the program fruitful because they have long time before retirement.

4.2.1.2 Gender

Table (4.3) Distribution of study population according to gender

Gender	Frequency	%
Male	48	53.3
Female	42	46.7
Total	**90**	**100.0**

Table (4.3) show the gender distribution that the male percentages 53.3% while the female percentage is 46.7%.This reflect that policy makers supporting women empowerment and gender respect in Palestinian society, and giving good opportunity in work filed for the female. This may also related to decrease culture constrains and barriers the facing female employment in Gaza Strips.

4.2.1.3 Residency place:

Table (4.4) Distribution of study population according to residency place

Place of residency (governorate)	Frequency	%
North	19	21.1
Gaza	32	35.6
Middle	18	20.0
Khanyounis	11	12.2
Rafah	10	11.1
Total	**90**	**100**

Table (4.4) shows the distribution of mental health professionals according to their residency. The highest percentage of mental health professionals employees from Gaza governorate, this related to geographical location of community mental health directorate and psychiatric hospital.

4.2.1.4 Marital status:

Table (4.5) Distribution of study population according to marital status

Marital status	Frequency	%
Single	13	14.4
Married	77	85.6
Total	**90**	**100.0**

Table (4.5) show The frequency distribution that the majority of the study population is married75.6% this result reflect Palestinian culture. The median age at first marriage for male about 24 years, while for female is about 19 years old (PCBS. 2007). The percentage of single employees is about 29.8%.

4.2.1.5. Level of education:

Table (4.6): Distribution of study population according to the level of education

Level of education	Frequency	%
Diploma	5	5.6
Bachelor	36	40.0
Postgraduate	49	54.4
Total	**90**	**100.0**

Table (4.6) shows that postgraduate degree(high diploma and master degree) is around the number of Bachelor's qualification in mental health professionals employments in community mental health directorate which result from improvements and building capacity.

4.2.1.6 Specialty:

Table (4.7) Distribution of study population according to Specialty

Specialty	Frequency	%
Psychiatric physician	10	11.1
Psychiatric nurse	37	41.1
Practical nurse	2	2.2
Psychologist	22	24.4
Sociologist	19	21.2
Total	**90**	**100.0**

The Specialty was divided into five groups, Psychiatrist physician 11.1**%,** Psychiatric nurse 41.1**%,** Practical nurse 2.2**%,** Psychologist 24.4**%,**and Sociologist 21.2**%.**

4.2.1.7 Years of Experience:

Table (4.8): Distribution of study population according to years of experience

Years of experience	Frequency	%
5 and less years	47	52.2
6 – 12 years	24	26.7
13 years and more	19	21.1
Total	**90**	**100.0**

Table (3.8) show years of experience range of (5 and less years) around 52.2%. This percentage relate to short history of community mental health directorate at Gaza and internal conflict which lead to employ new workers.

4.2.1.8 Work Setting:

Table (4.9): Distribution of study population according to work setting

Place of work	Frequency	%
Psychiatric hospital	36	40.0
West Gaza clinic	6	6.7
Al soraney clinic	9	10.0
Abu Shbak clinic	9	10.0
Al Nussierat clinic	9	10.0
Khan Younis clinic	12	13.3
Rafah clinic	9	10.0
Total	**90**	**100.0**

Table (4.9) show that the highest percentage of mental health professionals employees is working in service directorate 60%. These departments contain 6 community mental health centers, while the second percentage of employment 40% is working in psychiatric hospital.

4.3 Data Analysis

4.3.1 Knowledge, attitudes and practice of mental health professionals

To determine mental health professional's level of knowledge, attitudes and practice the researcher calculated the frequencies and percentage of respondents on the scale. The results are illustrated below.

Table (4.10): Level of knowledge of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	psychological counseling can help the client to return to his natural life	27.8	70.0	1.1	1.1	0
2	I know the counseling process steps	25.6	58.9	4.4	11.1	0
3	I have sufficient knowledge to use talking therapy techniques	18.9	48.9	10.0	22.2	0
4	I think there is a suitable possibility for the practice of psychological counseling in clinical work	16.7	60.0	6.7	16.7	0
5	I need a training course to find out what types of talking therapy in clinical work	33.3	41.1	6.7	14.4	4.4
6	I have sufficient knowledge of communication skills as a basis in the talking therapy process	25.6	60.0	8.9	5.6	0
7	I have sufficient knowledge of cognitive behavioral therapy	16.7	52.2	8.9	21.1	1.1
8	I have sufficient knowledge of the steps and techniques of cognitive behavioral therapy	14.4	52.2	6.7	25.6	1.1
9	I have sufficient knowledge about group psychotherapy	13.3	51.1	10.0	25.6	0
10	I have sufficient knowledge of the steps and techniques group psychotherapy	10.0	50.0	13.3	26.7	0
11	I have sufficient knowledge of motivational interview	14.4	53.3	6.7	23.3	2.2
12	I have sufficient knowledge of the steps and techniques of motivational interviewing	8.9	53.3	8.9	28.9	0
13	I have sufficient knowledge about the process of family psychotherapy	17.8	51.1	10.0	20.0	1.1
14	family psychotherapy can help client to return for his natural life	33.3	55.6	5.6	4.4	1.1
15	I know the steps and techniques of family psychotherapy	11.1	48.9	11.1	28.9	0
	Mean percent	**19.13**	**53.77**	**7.93**	**18.37**	**0.73**

Table (4.11): Level of attitudes of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
16	I see that psychiatric clients are recovering by using talking therapy more than drug therapy	5.6	52.2	15.6	23.3	3.3
17	talking therapy more effective and less expensive compared to drug therapy	20.0	44.4	16.7	16.7	2.2
18	different person's ability to practicing professional talking therapy methods different depending on specialization	45.6	48.9	3.3	2.2	0
19	people who suffer from mental illness can recover by using talking therapy methods with them	10.0	54.4	15.6	20.0	0
20	talking therapy is applicable in mental health centers	10.0	25.6	20.0	40.0	4.4
21	people at the stage of mental disorder in need of support and advice from others	37.8	45.6	2.2	11.1	3.3
22	I think that cooperation between the medical team in the clinical work is important in enhancing talking therapy	58.9	34.4	5.6	1.1	0
23	talking therapy is ineffective in improving the situation of the mentally ill as drug treatment	8.9	22.2	11.1	42.2	15.6
24	talking therapy need for cooperation and interaction the client unlike pharmacological treatment	36.7	54.4	3.3	5.6	0
25	I believe that the talking therapy is important and effective for the treatment of psychiatric patients such as drug treatment	35.6	53.3	5.6	5.6	0
	Mean percent	**26.91**	**43.54**	**9.90**	**16.78**	**2.88**

Table (4.12): Level of practice of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
26	I practicing talking therapy of various kinds in a professional and effective manner	14.4	43.3	11.1	30.0	1.1
27	I Mastered and pass steps of psychological counseling in clinical work with different clients	11.1	46.7	8.9	33.3	0
28	I use cognitive behavioral therapy practical steps in clinical work	8.9	44.4	7.8	37.8	1.1
29	I mastered and clenching steps of motivational interviews as a kind of talking therapy in clinical work with different clients	6.7	54.4	8.9	28.9	1.1
30	I use group therapy scientific and clinical steps at clinical work	4.4	42.2	17.8	33.3	2.2
31	I use communication skills as a basis in various talking therapy processes	17.8	61.1	7.8	13.3	0
32	I need a training course in how to practice talking therapy in clinical work	34.4	37.8	6.7	18.9	2.2
33	I have received sufficient training to practice talking therapy	6.7	28.9	13.3	42.2	8.9
34	policy of the institution that I work help and encourage the practice of talking therapy methods	8.9	40.0	15.6	25.6	10.0
35	I document talking therapy stages of with the client in relays and professional at the mental health clinic	7.8	52.2	11.1	26.7	2.2
36	there is a suitable possibility for the practice of counseling in clinical work	13.3	61.1	11.1	12.2	2.2
37	I mastered and I pass the family psychotherapy steps in clinical work	4.4	46.7	13.3	33.3	2.2
38	I mastered and I pass the group psychotherapy steps in clinical work	4.4	45.6	15.6	34.4	0
39	I follow each new regard to talking therapy via the Internet	14.4	44.4	15.6	23.3	2.2
	Mean percent	**11.25**	**46.35**	**11.75**	**28.08**	**2.52**

The previous tables represent response ratings of participant to each item according his or here point of view ,and the items of 1,2,4,27and 36 reflecting knowledge and practice of participant to counseling , also the items of 7,8,and 28 reflecting knowledge and practice of participant to cognitive behavioral therapy, the items of 13,14,15and 37 reflecting knowledge and practice of participant to family psychotherapy, and the items of 9,10,30and 38 reflecting knowledge and practice of participant to group psychotherapy, the items of 11,12and 29 reflecting knowledge and practice of participant to motivational interview , also the items of 3,5,6,16-26, 31,32,33,34,35and 39 reflecting knowledge , attitudes and practice of participant to talking therapy in general.

Tables (4.10- 4.11- 4.12) show most of participants reflects positive knowledge toward talking therapy with mean 72.9 and positive knowledge And toward counseling therapy with mean 86,05. positive knowledge toward CBT with mean 67,75. positive knowledge toward family therapy with mean 72.6. positive knowledge toward Group psychotherapy with mean 62,2, and positive knowledge toward motivational interview with mean 64,95(annex1 table1-5).

Participants reflects positive attitudes toward talking therapy with mean70.45. Participants with rate of 97.8% see that the psychological counseling can help the client to return to his natural life in question number 1 in KAP questionnaire.

Also participants reflects varies response to practicing varies types of talking therapy with mean percent 66.1% to counseling, 53,3% to CBT, 51,1% to family therapy, 48,3% to group therapy, 61,1% to MI, 57,60 % to talking therapy in general. (annex1 table 6-10)

Participant of 85,6% of the population record that they have sufficient knowledge of communication skills as a basis in the talking therapy process in question number 6 in KAP questionnaire, 88.9% of participants believes that the talking therapy is important and effective for the treatment of psychiatric patients such as drug treatment in question number 25 in KAP questionnaire .

Also just 48.9% of participant see that the policy of the institution that they work help and encourage the practice of talking therapy methods, but 72,2% of participant Said they needs training courses in talking therapy to improve knowledge and applied into practice in question number 32 in KAP questionnaire .

4.3.2 Differences in KAP related to level of education

To determine differences in KAP in relation to participants' level of education, the researcher performed One way ANOVA test.

Table (4.13): Differences in KAP related to education level

Item	Category	Some of squares	df	Mean square	F	*P*
Knowledge	Between groups	565.584	2	282.792	3.885	0.024 *
	Within groups	6332.239	87	72.784		
	Total	6897.822	89			
Attitudes	Between groups	3.819	2	1.909	0.120	0.887 //
	Within groups	1380.637	87	15.869		
	Total	1384.456	89			
Practice	Between groups	150.898	2	75.449	0.949	0.391 //
	Within groups	6915.102	87	79.484		
	Total	7066.000	89			

* = significant at 0.05 // = not significant

Table (4.13) showed that there were no significant differences in attitudes and practice related to mental health professionals' level of education, but differences were statistically significant at 0.05 in knowledge. To determine the direction of these differences, the researcher performed post Hoc Scheffe test. The results are presented in table 4.13.1.

Table (4.13.1): Mean differences in knowledge related to level of education

	Level of education	Mean difference	*P* value
Knowledge	(postgraduate) – (diploma)	0.538	0.991 //
	(postgraduate) – (bachelor)	5.161	0.026 *

* = significant at 0.05 // = not significant

Table (4.13.1) showed that mental health professionals who have postgraduate studies have a higher level of knowledge compared to those who have diploma or bachelor degree. Differences in knowledge were significant at 0.05 between those who have postgraduate studies and those who have bachelor degree, but differences were not significant between those who have postgraduate studies and those who have diploma certificate.

4.3.3 Differences in KAP related to age

To determine differences in KAP in relation to participants' age, the researcher performed One way ANOVA test. The results are illustrated in table 4.14.

Table (4.14): Differences in KAP related to age

Item	Category	Some of squares	df	Mean square	F	*P*
Knowledge	Between groups	169.590	2	84.795	1.096	0.339 //
	Within groups	6728.232	87	77.336		
	Total	6897.822	89			
Attitudes	Between groups	12.733	2	6.366	0.404	0.669 //
	Within groups	1371.723	87	15.767		
	Total	1384.456	89			
Practice	Between groups	59.701	2	29.850	0.371	0.691 //
	Within groups	7006.299	87	80.532		
	Total	7066.000	89			

// = not significant

Table (4.14) showed that there were no significant differences in KAP related to age of mental health professionals.

4.3.4 Differences in KAP related to gender

To determine differences in KAP related to gender, the researcher performed independent sample (t) test. The results are illustrated in table 4.15.

Table (4.15): Differences in KAP related to gender

Item	Gender	N	Mean	S. deviation	t	P value
Knowledge	Male	48	57.437	8.862	1.860	0.066 //
	Female	42	54.023	8.475		
Attitudes	Male	48	37.208	4.297	- 0.691	0.491 //
	Female	42	37.785	3.523		
Practice	Male	48	48.000	8.147	1.140	0.257 //
	Female	42	45.857	9.681		

// = not significant

Table (4.15) showed that there were no significant differences in KAP related to gender.

4.3.5 Differences in KAP related to place of living

To determine differences in KAP in relation to participants' place of living, the researcher performed One way ANOVA test. The results are illustrated in table 4.16.

Table (4.16): Differences in KAP related to place of living

Item	Category	Some of squares	df	Mean square	F	*P*
Knowledge	Between groups	586.377	4	146.594	1.974	0.106 //
	Within groups	6311.445	85	74.252		
	Total	6897.822	89			
Attitudes	Between groups	61.756	4	15.439	0.992	0.416 //
	Within groups	1322.700	85	15.561		
	Total	1384.456	89			
Practice	Between groups	784.416	4	196.104	2.654	0.038 *
	Within groups	6281.584	85	73.901		
	Total	7066.000	89			

* = significant at 0.05 // = not significant

Table (4.16) showed that there were no significant differences in knowledge and attitudes related to place of living of mental health professionals, but differences were significant at 0.05 in practice. To determine the direction of these differences, the researcher performed post Hoc Scheffe test. The results are illustrated in table 4.16.1.

Table (4.16.1): Mean differences in practice related to place of living

	Place of living	Mean difference	*P* value
Practice	(Rafah) – (North)	8.226	0.209
	(Rafah) – (Gaza)	7.200	0.263
	(Rafah) – (Middle)	6.477	0.461
	(Rafah) – (Khanyounis)	0.881	1.000

* = significant at 0.05 // = not significant

Table (4.16.1) showed that even though there were differences in the mean scores between different provinces, but these differences did not reach the significance level.

4.3.6 Differences in KAP related to marital status

To determine differences in KAP related to marital status, the researcher performed independent sample (t) test. The results are illustrated in table 4.17.

Table (4.17): Differences in KAP related to marital status

Item	Gender	N	Mean	S. deviation	t	P value
Knowledge	Single	13	54.3077	8.81651	0.678	0.499 //
	Married	77	56.1039	8.83263		
Attitudes	Single	13	38.8462	3.71587	1.359	0.178 //
	Married	77	37.2468	3.95752		
Practice	Single	13	47.3846	9.51786	0.167	0.867 //
	Married	77	46.9351	8.86795		

// = not significant

Table (4.17) showed hat there were no significant differences in KAP related to marital status.

4.3.7 Differences in KAP related to specialty

To determine differences in KAP related to specialty, the researcher performed One way ANOVA test. The results are illustrated in table 4.18.

Table (4.18): Differences in KAP related to specialty

Item	Category	Some of squares	df	Mean square	F	*P*
Knowledge	Between groups	1156.012	5	231.202	3.382	0.008 *
	Within groups	5741.810	84	68.355		
	Total	6897.822	89			
Attitudes	Between groups	69.463	5	13.893	0.887	0.493 //
	Within groups	1314.992	84	15.655		
	Total	1384.456	89			
Practice	Between groups	1346.703	5	269.341	3.956	0.003 *
	Within groups	5719.297	84	68.087		
	Total	7066.000	89			

* = significant at 0.05 // = not significant

Table (4.18) showed hat there were no significant differences in attitudes related to specialty to study participants, but differences were statistically significant at 0.05 in knowledge as F = 3.382 and *P* value was 0.008 and practice as F = 3.956 and *P* value was 0.003. To determine the direction of these differences, the researcher performed post Hoc Scheffe test. The results are presented in table 4.18.1

Table (4.18.1): Mean differences in practice related to specialty

Knowledge	**Specialty**	**Mean difference**	***P* value**
	(Psychiatric physician) – (sociologist)	11.429	0.043 *
Practice	(psychologist) – (psychiatric nurse)	8.589	0.016 *

* = significant at 0.05

Table 4.18.1 showed that Psychiatric physician have a higher knowledge compared to sociologists (P value = 0.043) because the most of Psychiatric physician have at least 10 years experience and specialty compared with sociologist who have fewer experience and specialty, while psychologists have better practice compared to psychiatric nurse (P value = 0.016) because the psychologists had study some module about talking therapy in their curriculum in university .

4.3.8 Differences in KAP related to years of experience

To determine differences in KAP related to experience, the researcher performed One way ANOVA test. The results are illustrated in table 4.19.

Table (4.19): Differences in KAP related to experience

Item	**Category**	**Some of squares**	**df**	**Mean square**	**F**	***P***
Knowledge	Between groups	869.295	2	434.648	6.273	0.003 *
	Within groups	6028.527	87	69.293		
	Total	6897.822	89			
Attitudes	Between groups	2.441	2	1.221	0.077	0.926 //
	Within groups	1382.014	87	15.885		
	Total	1384.456	89			
Practice	Between groups	240.994	2	120.497	1.536	0.221 //
	Within groups	6825.006	87	78.448		
	Total	7066.000	89			

* = significant at 0.05 // = not significant

Table 4.19 showed that there were no significant differences in attitudes and practice related to years of experience, but differences were significant at 0.05 in knowledge as F = 6.273 and P value was 0.003. To determine the direction of these differences, the researcher performed post Hoc Scheffe test. The results are presented in table 4.19.1.

Table (4.19.1.): Mean differences in practice related to experience

Knowledge	Years of experience	Mean difference	*P* value
	(5 years and less) – (6 – 12)	- 7.390	0.003 *
	(5 years and less) – (13 years and more)	- 2.828	0.461 //

* = significant at 0.05 // = not significant

Table 4.19.1. showed that participants who have (6 – 12) years of experience have higher knowledge compared to those who have less years of experience (5 years and less), mean difference was – 7.390 and P value was 0.003, while differences were not significant compared to those who have more ears of experience (13 years and more).

4.3.9 Differences in KAP related to place of work

To determine differences in KAP related to place of work, the researcher performed One way ANOVA test. The results are illustrated in table 4.20.

Table (4.20.): Differences in KAP related to place of work

Item	Category	Some of squares	df	Mean square	F	*P*
Knowledge	Between groups	813.767	6	135.628	1.850	0.099 //
	Within groups	6084.056	83	73.302		
	Total	6897.822	89			
Attitudes	Between groups	136.344	6	22.724	1.511	0.185 //
	Within groups	1248.111	83	15.037		
	Total	1384.456	89			
Practice	Between groups	907.861	6	151.310	2.039	0.069 //
	Within groups	6158.139	83	74.194		
	Total	7066.000	89			

// = not significant

Table 4.20. showed that there were no significant differences in KAP related to place of work.

Chapter five

Discussions

5. Discussion

Mental health professionals considers that their training, knowledge and skills in evidence-based talking therapy models are essential for competent mental health practice**.** Using a descriptive research design this study aim to explored Mental health professional's knowledge, attitudes and practice on their talking therapy in clinical practice The objectives of the study were: To determine the level of mental health professional's knowledge, Attitudes and practice of talking therapies in clinical practice, To identify the relationship between mental health professional's qualification and knowledge, Attitudes and practice of talking therapy, To verify the level of mental health professional's knowledge, Attitudes and practice of talking therapies in relation to sociodemographic characteristics(age-gender- and living area), To explore the relationship between mental health professional's years of experience and knowledge, Attitudes and practice of talking therapy**,** To verify the differences between mental health professional's specialty and knowledge, Attitudes and practice of talking therapy in clinical practice**,** and To provide recommendations and suggestions about using of talking therapy in clinical practice**,** a sum of 110 participants of Mental health professionals from a community Mental Health directorate were asked to fill a questionnaires which designed to measure the KAP of mental health professionals about talking therapy in clinical practice in community mental health directorate in Gaza strip .

Findings indicated that Content analysis using the headings "knowledge, attitudes and practices" established the major themes from the data collection processes. Reflect that mental health professionals' have knowledge of the use of talking therapies in their practice with mean of 72.9 , included identification of what they considered to be helpful or a hindrance to the integration of their talking therapies skills into practice. Their attitudes were positive with mean of 70.45 this result congruent with the studies of (Hanfer et al 1996, Ryan et al 2005, Bee 2005, Pfammatter et al 2006, and Asay T.P and Lumbert Mj 2009) based on their extensive practical and clinical experience. mental health professionals' noted that the provision of well structured training, in a manner that was considered clinically relevant was important. Additionally, appropriate supervision and supportive management and organizational structures were imperative to facilitating the effective integration of talking therapies skills into clinical practice this agree with the study of (Bee 2005, Pfammatter et al 2006 and Geertrui Wilhelmina 2008) .

Mental health professionals also identified that organizational, managerial and team based processes could also potentially act as barriers. These findings are consistent with studies of (eg; Hafner et al., 1996). However, most importantly, this descriptive study adds context to training in talking therapies for mental health professionals in Palestine.

Varies talking therapy models are underpinned by many research (Geertrui Wilhelmina 2008) that establishes their use as an evidence-based treatment approach for mental illness. The mental health professionals in this study reiterated the importance of the link between theory, research and practice. mental health professional's knowledge of the theoretical underpinnings, key concepts and practical application of the therapies informed the use of their skills in mental health care practice. Their selection of the most appropriate talking therapy model for each clinical situation supports evidence-based treatment for consumers. This finding restates the importance that talking therapy training, or more specifically, training in the individual psychotherapeutic treatment models, includes all aspects relevant to the theoretical, practical and evidential dimensions of the therapy.

In this study 97.8 % of profession see that the psychological counseling can help the client to return to his natural life in question number 1 in KAP questionnaire, this result agree with (Carr 2006, Mc Cabe et al 2002 and Becker and Comstock 1992), also from the researcher experience with many cases faced during clinical practice touch this evidence actually see success story in chapter tow, also the mental health professionals in this study evade that they have positive knowledge and attitudes toward CBT with mean of 67.75(annex1 table2) this agree with the study of (Ramsay and Rostian 2008, Ryan et al 2005, and Pfammatter et al 2006), from the researcher in clinical experience fined that using of CBT in caring mentally ill client with combination of medication had very positive effect in mentally ill prognosis and recovery process and this appears in 88.9% of participants believe that the talking therapy is important and effective for the treatment of psychiatric patients such as drug treatment and this congruent with(David Richards:2011).

Also the mental health professionals in this study evade that they have positive knowledge and attitudes toward family therapy with mean of 72.6 this agree with the study of (Pfammatter et al 2006, and Pfammatter et al 2006), from the researcher in clinical experience fined that using of family therapy in caring mentally ill client decrease relapses and hospitalization.

Also the mental health professionals in this study evade that they have positive knowledge toward group psychotherapy with mean of 62.2 (annex1 table4) this agree with the study of (Becker and Comstock1992), from the researcher in clinical experience fined that using of group psychotherapy in caring mentally ill client improve recovery process.

This study evade that Psychiatric physician have a higher knowledge compared to sociologists (P value = 0.043) the researcher think that because the most of Psychiatric physician have at least 10 years experience and specialty compared with sociologist who have fewer experience and specialty, while psychologists have better practice compared to psychiatric nurse (P value = 0.016) because the psychologists had study some module about talking therapy in their curriculum in their universities .

Also this study evade that participants who have (6 – 12) years of experience have higher knowledge compared to those who have less years of experience (5 years and less), mean difference was – 7.390 and P value was 0.003 the researcher think that because the most of the most mental health professionals works have post graduated degree and well qualified , while differences were not significant compared to those who have more ears of experience (13 years and more).

This study evade that mental health professionals who have postgraduate studies have a higher level of knowledge and positive attitudes towards talking therapy compared to those who have diploma or bachelor degree. Differences in knowledge were significant at 0.05 between those who have postgraduate studies and those who have bachelor degree, the researcher think that because the most of the most mental health professionals works have talking therapy modules and practicing that during studies in theirs universities, but differences were not significant between those who have postgraduate studies and those who have diploma certificate.

Mental health professionals identified in this study that talking therapy training courses need to be clinically relevant and that some learning strategies were advantageous by 72.2% in question number 32 in KAP questionnaire.

Correlation analyses indicated that there was no significant relationship between provider knowledge, attitudes and practice toward talking therapy and sociodemographic characteristics.

5.1. Difficulties of the study:

The Difficulties of the present study were.

- Attendance of Mental health professionals worker due to interruption of work time.
- Bureaucracy of managerial level.
- Shortage of the references, texts and relevant articles in Gaza strip and this study considered the first one in Gaza Strip .
- The questionnaire developed by researcher which take long time to measure what will be measured.
- Recurrent discontinuity of electricity.
- Recurrent discontinuity of internet.
- Financial and transportations difficulties .

Chapter six

Conclusion and Recommendation

6.1 Conclusion

The primary focus of this study was to explore Mental health professional's knowledge attitudes and practice of talking therapies in clinical practice in Gaza strip ,and what might help or hinder the integration of their skills in talking therapies into routine clinical practice. The conclusions from this study have been drawn from the key themes and objectives identified throughout the research process.

Findings from this study indicated that Content analysis using the headings "knowledge, attitudes and practices established the major themes from the data collection processes. Reflect that mental health professionals' have knowledge of the use of talking therapies in their practice with mean of 72.9 , included identification of what they considered to be helpful or a hindrance to the integration of their talking therapies skills into practice. Their attitudes were positive with mean of 70.45

Mental health professionals believe that their knowledge of evidence-based talking therapies is not an adjunct to other knowledge that informs mental health nursing practice. Instead, for Mental health professionals who use their talking therapies in routine practice, talking therapies are considered integral to practice and are important to maintain professional credibility.

Mental health professionals identified that talking therapy training courses need to be clinically relevant and that some learning strategies were advantageous. Well structured courses, with clearly defined objectives, and training that is clinically relevant and congruent with Mental health professionals' practice in mental health is important.

Using of talking therapy in caring mentally ill client with combination of medication had very positive effect in mentally ill prognosis and recovery process and this appears in 88.9% of participants believe that the talking therapy is important and effective for the treatment of psychiatric patients such as drug treatment

Finally, Palestine and Gaza strip special has a unique opportunity to develop a national strategic framework to progress training and professional development for mental health professionals in talking therapies. Mental health professionals have an important contribution to make.

6.2 Recommendations

In light of the findings from this study, the researchers make the following recommendations:

1. The Community Mental Health directorate should be developing a national mental health strategies collaborative to put talking therapy at the heart of all mental health provision through training courses and Implementation .
2. Inclusion of talking therapy principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Palestine.
3. The in service education departments in general community mental health directorate should conduct more training courses about talking therapies for mental health professionals because 72.2% of them needs that in this study (see result of question number 32, table 4.12, page 58)
4. The in service education departments in general community mental health directorate should conduct more education and training courses about talking therapies for mental health professionals who have diploma and bachelor degrees to be more positive (see table 4.13.1, page 60)
5. Improve mental health professional's practice about group psychotherapy towards positive by using training program practicing because their practice in this study was negative with mean 48.3 (see annex 1, table 9, page 84).
6. Improve mental health professional's practice about CBT towards more positive by using training program practicing because their practice mean in this study was 53.3 and CBT mostly effective to deal with mental health problems (see annex 1,table 7, page 83).
7. Improve mental health professional's practice about family psychotherapy towards more positive by using training program practicing because their practice mean in this study was 51.5 (see annex 1, table 8, page 84).
8. A follow-up study of participants be undertaken to examine whether the Changes reported in this study were maintained over time
9. Conduct observational or qualitative research that evaluates the benefits of talking therapies from client perspective.
10. Conduct observational research that evaluates the transfer of talking therapy skills from training into practice. In particular differentiate between what mental health professionals say they do and what can be observed in practice with consideration given to conscious and unconscious processes.

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Annexes

Annex (1).

Table (1): Level of knowledge about counseling of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	psychological counseling can help the client to return to his natural life	27.8	70.0	1.1	1.1	0
2	I know the counseling process steps	25.6	58.9	4.4	11.1	0
4	I think there is a suitable possibility for the practice of psychological counseling in clinical work	16.7	60.0	6.7	16.7	0
	Mean percent	**23.36**	**62.69**	**4.06**	**9.633**	**0**

This table showed that there positive knowledge about counseling reflected by study participant with mean percent 86.05.

Table (2): Level of knowledge about CBT of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
7	I have sufficient knowledge of cognitive behavioral therapy	16.7	52.2	8.9	21.1	1.1
8	I have sufficient knowledge of the steps and techniques of cognitive behavioral therapy	14.4	52.2	6.7	25.6	1.1
	Mean percent	**15.55**	**52.2**	**7.8**	**23.35**	**1.1**

This table showed that there positive knowledge about CBT reflected by study participant with mean percent 67.75.

Table (3): Level of knowledge about family psychotherapy of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
13	I have sufficient knowledge about the process of family psychotherapy	17.8	51.1	10.0	20.0	1.1
14	family psychotherapy can help client to return for his natural life	33.3	55.6	5.6	4.4	1.1
15	I know the steps and techniques of family psychotherapy	11.1	48.9	11.1	28.9	0
	Mean percent	**20.73**	**51.86**	**8.9**	**17.76**	**0.73**

This table showed that there positive knowledge about family psychotherapy reflected by study participant with mean percent 72.6.

Table (4): Level of knowledge about group therapy of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
9	I have sufficient knowledge about group psychotherapy	13.3	51.1	10.0	25.6	0
10	I have sufficient knowledge of the steps and techniques group psychotherapy	10.0	50.0	13.3	26.7	0
	Mean percent	**11.65**	**50.55**	**11.65**	**26.15**	**0**

This table showed that there positive knowledge about group therapy reflected by study participant with mean percent 62.2.

Table (5): Level of knowledge about MI of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
11	I have sufficient knowledge of motivational interview	14.4	53.3	6.7	23.3	2.2
12	I have sufficient knowledge of the steps and techniques of motivational interviewing	8.9	53.3	8.9	28.9	0
	Mean percent	**11.65**	**53.3**	**7.8**	**26.1**	**1.1**

This table showed that there positive knowledge about MI reflected by study participant with mean percent 64.95.

Table (6): Level of practice about counseling of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
27	I Mastered and pass steps of psychological counseling in clinical work with different clients	11.1	46.7	8.9	33.3	0
36	there is a suitable possibility for the practice of counseling in clinical work	13.3	61.1	11.1	12.2	2.2
	Mean percent	**12.2**	**53.9**	**10**	**22.75**	**1.1**

This table showed that there positive practice about counseling reflected by study participant with mean percent 66.1.

Table (7): Level of practice about CBT of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
28	I use cognitive behavioral therapy practical steps in clinical work	8.9	44.4	7.8	37.8	1.1
	Mean percent	**8.9**	**44.4**	**7.8**	**37.8**	**1.1**

This table showed that there positive practice about CBT reflected by study participant with mean percent 53.3.

Table (8): Level of practice about family psychotherapy of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
37	I mastered and I pass the family psychotherapy steps in clinical work	4.4	46.7	13.3	33.3	2.2
	Mean percent	**4.4**	**46.7**	**13.3**	**33.3**	**2.2**

This table showed that there positive practice about family psychotherapy reflected by study participant with mean percent 51.1.

Table (9): Level of practice about group therapy of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
30	I use group therapy scientific and clinical steps at clinical work	4.4	42.2	17.8	33.3	2.2
38	I mastered and I pass the group psychotherapy steps in clinical work	4.4	45.6	15.6	34.4	0
	Mean percent	**4.4**	**43.9**	**16.7**	**33.58**	**1.1**

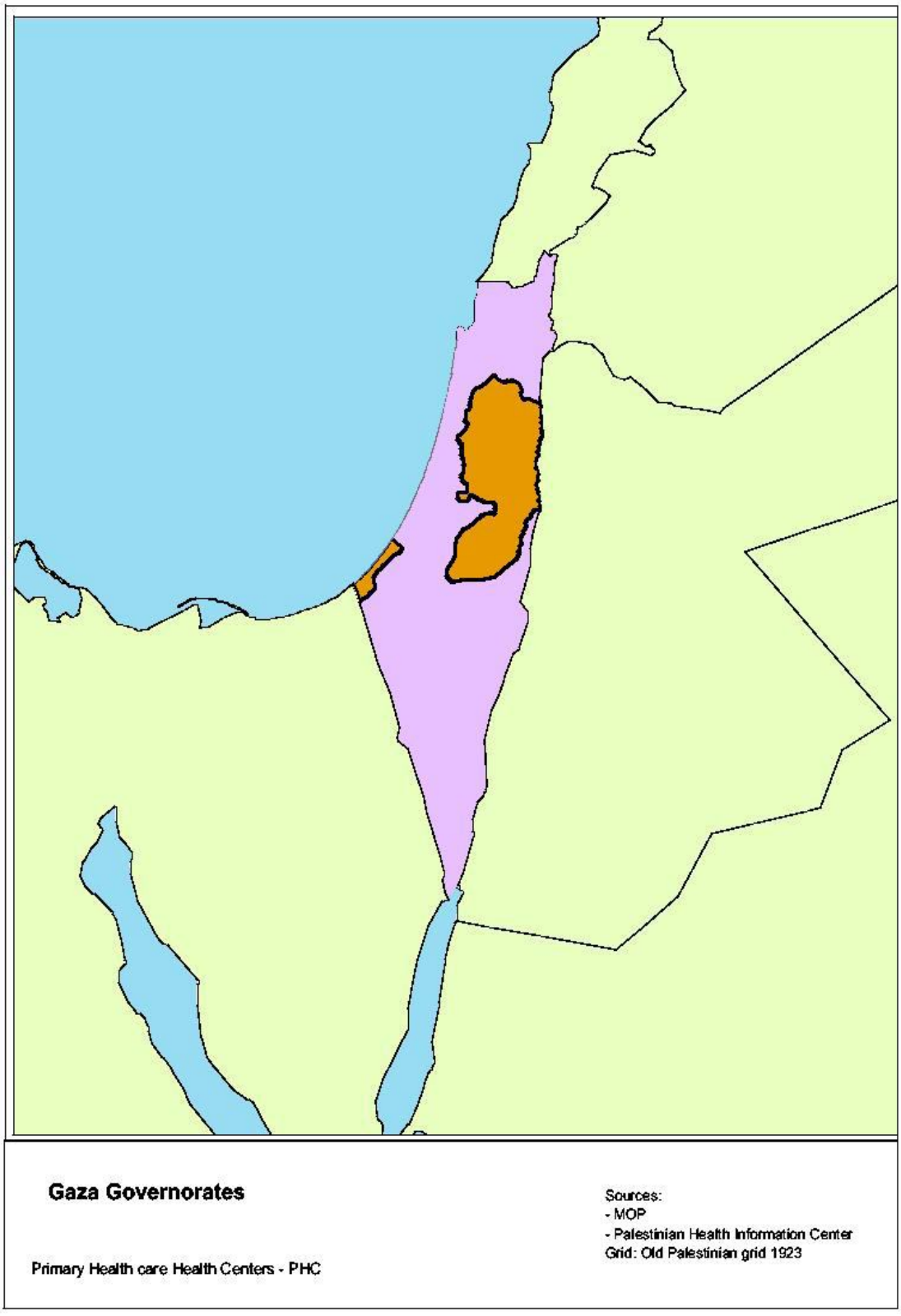
This table showed that there positive practice about group psychotherapy reflected by study participant with mean percent 48.3.

Table (10): Level of practice about MI of study participants

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
29	I mastered and clenching steps of motivational interviews as a kind of talking therapy in clinical work with different clients	6.7	54.4	8.9	28.9	1.1
	Mean percent	**6.7**	**54.4**	**8.9**	**28.9**	**1.1**

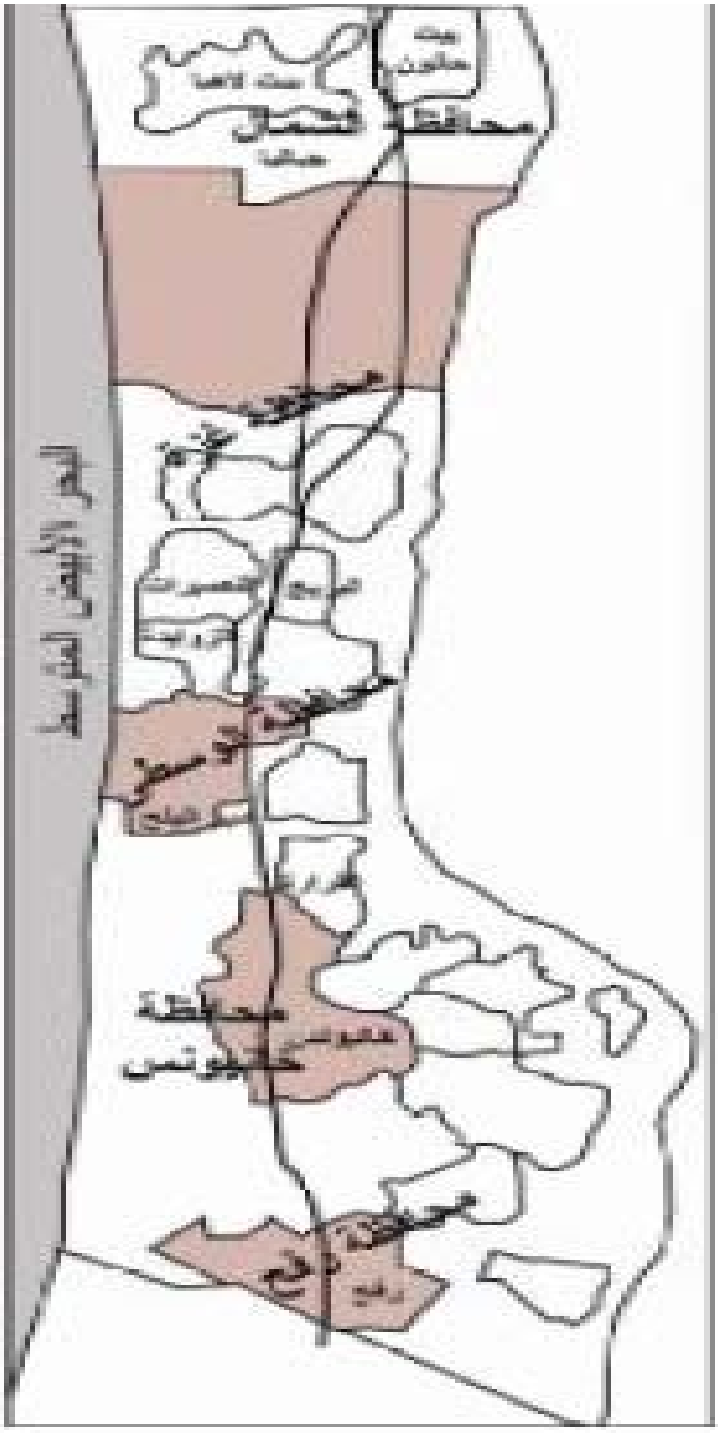
This table showed that there positive practice about MI reflected by study participant with mean percent 61.1.

Annex (2).
Map of Palestine



Annex (3)

location of community mental health center



Source:

-MOGS

-Palestine Health Information Center

Annex (4): Arabic questionnaire

بسم الله الرحمن الرحيم

استبيان

معرفة واتجاهات وممارسة المهنيين العاملين في الصحة النفسية المجتمعية عن العلاج الكلامي في العمل العيادي في قطاع غزة

الإخوة و الأخوات الزملاء الأعزاء:

هذه الدراسة يقوم بها الباحث كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية – علوم التمريض الجامعة الإسلامية – كلية التمريض

يشكر الباحث لكم حسن المشاركة في هذه الدراسة من خلال الإجابة على أسئلة المقياس والتي لا تستغرق أكثر من 20 دقيقة من وقتكم الثمين وان مشاركتكم تسهم في إنجاح الدراسة التي تهدف للتعرف على مدى معرفتكم واتجاهاتكم وممارستكم نحو العلاج الكلامي الحديث في العمل العيادي في قطاع غزة.

يود الباحث التأكيد على أن المعلومات ستبقى سرية و لهدف البحث العلمي لذلك لا داعي لذكر الأسماء علما بأنه من حق الموظف الامتناع عن إجابة أي سؤال أو رفض المشاركة.

شكرا لكم على المشاركة

الباحث

مهند عمر محمد حمدان

الإدارة العامة للصحة النفسية

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التاريخ: / / 2012 الرقم ----------

(خاص بالباحث)

البيانات الشخصية

من فضلك ضع إشارة × في المربع المناسب لك

1-العمر.....سنة

2-الجنس: ☐ ذكر ☐ أنثى

3-العنوان

☐ محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى

☐ محافظة خان يونس ☐ محافظة رفح

4-الحالة الاجتماعية:

☐ أعزب/ آنسة ☐ متزوج/ ة

☐ أرمل/ ة ☐ مطلق/ ة

5- المستوى التعليمي:

☐ دبلوم ☐ بكالوريوس ☐ دراسات عليا

6- التخصص:

☐ طبيب نفسي ☐ حكيم نفسي ☐ ممرض عملي

☐ أخصائي نفسي ☐ باحث اجتماعي ☐ أخصائي تأهيل

8- عدد سنوات الخبرة:.....

9-مكان العمل:

☐ مستشفى الطب النفسي ☐ عيادة غرب غزة ☐ عيادة الصوراني ☐ عيادة أبوشباك

☐ عيادة النصيرات ☐ عيادة خان يونس ☐ عيادة رفح

العلاج الكلامي / هو مصطلح يطلق على العلاج النفسي اللادوائي (علاج بالتحدث أو الكلام) ويشمل في هذه الدراسة الإرشاد النفسي, المقابلات التحفيزية, العلاج المعرفي السلوكي, العلاج النفسي العائلي,والعلاج النفسي الجماعي.

الرقم	العبـــارة	موافق بشدة	موافق	محايد	غير موافق	غير موافق بشدة
	المعرفة					
1	الإرشاد النفسي يمكن أن يساعد الحالة للعودة لممارسة حياته الطبيعية					
2	أعلم جيداً خطوات عملية الإرشاد النفسي					
3	لدي المعرفة الكافية لاستخدام فنيات العلاج الكلامي					
4	أعتقد أن هناك إمكانية مناسبة لممارسة الإرشاد النفسي في العمل العيادي					
5	أنا بحاجة إلى دورة تدريبية لمعرفة أنواع العلاج الكلامي في العمل العيادي					
6	لدي المعرفة الكافية بمهارات الاتصال والتواصل كأساس في عملية العلاج الكلامي					
7	لدي المعرفة الكافية بالعلاج المعرفي السلوكي					
8	لدي المعرفة الكافية بخطوات وتقنيات العلاج المعرفي السلوكي					
9	لدي المعرفة الكافية عن العلاج النفسي الجماعي					
10	لدي المعرفة الكافية بخطوات وتقنيات العلاج النفسي الجماعي					
11	لدي المعرفة الكافية بالمقابلات النفسية التحفيزية					
12	لدي المعرفة الكافية بخطوات وتقنيات المقابلات التحفيزية					
13	لدي المعرفة الكافية حول عملية العلاج النفسي العائلي					
14	العلاج النفسي العائلي يمكن أن يساعد المريض النفسي على العودة لممارسة حياته الطبيعية					
15	أعلم جيداً خطوات وتقنيات العلاج النفسي العائلي					
	الاتجاهـــات					
16	أرى أن المرضى النفسيين يتماثلون للشفاء باستخدام العلاج الكلامي أكثر من العلاج الدوائي					
17	العلاج الكلامي أكثر فاعلية وأقل تكلفة مقارنة بالعلاج الدوائي					
18	تختلف قدرة الشخص المهني على ممارسة طرق العلاج الكلامي المختلفة باختلاف تخصصه					
19	الأشخاص الذين يعانون من أمراض نفسية يمكنهم التعافي باستخدام طرق العلاج الكلامي مهم					
20	العلاج الكلامي غير قابل للتطبيق في مراكز الصحة النفسية					
21	الأشخاص في مرحلة الاضطراب النفسي بحاجة إلى الدعم والاستشارة من الآخرين					

22	أرى أن التعاون بين الفريق الطبي في العمل العيادي مهم في تعزيز طرق العلاج الكلامي					
23	العلاج الكلامي غير فعال في تحسين حالة المرضى النفسيين كالعلاج الدوائي					
24	العلاج الكلامي بحاجة لتعاون وتفاعل الحالة خلافاً للعلاج الدوائي					
25	أؤمن بأن العلاج الكلامي مهم وناجع لعلاج المرضى النفسيين كالعلاج الدوائي					
	الممارســة					
26	أمارس العلاج الكلامي بمختلف أنواعه بشكل مهني وفعال					
27	أتقن وأطبق خطوات الإرشاد النفسي في العمل العيادي مع مختلف المرضى					
28	أستخدم العلاج المعرفي السلوكي بخطواته العملية في العمل العيادي					
29	أتقن وأطبق خطوات المقابلات التحفيزية كنوع من أنواع العلاج الكلامي في العمل العيادي مع مختلف المرضى					
30	أستخدم العلاج الجماعي بخطواته العلمية والعملية في العمل العيادي					
31	أستخدم مهارات الاتصال والتواصل كأساس في عمليات العلاج الكلامي المختلفة					
32	أنا بحاجة إلى دورة تدريبية في كيفية ممارسة العلاج الكلامي في العمل العيادي					
33	تلقيت التدريب الكافي لممارسة العلاج الكلامي					
34	سياسة المؤسسة التي أعمل بها تساعد وتشجع على ممارسة طرق العلاج الكلامي					
35	أدون مراحل العلاج الكلامي مع المريض بشكل تتابعي ومهني في العيادة النفسية					
36	هناك إمكانية مناسبة لممارسة الاستشارات النفسية كنوع من أنواع العلاج الكلامي في العمل العيادي					
37	أتقن وأطبق خطوات العلاج العائلي النفسي في العمل العيادي بطرقه العلمية والعملية					
38	أتقن وأطبق خطوات العلاج النفسي الجماعي في العمل العيادي بطرقه العلمية والعملية					
39	أتابع كل جديد بما يتعلق بالعلاج الكلامي عبر الانترنت					

Annex (5): English questionnaire

Mental health professional's knowledge, Attitudes and practice of talking therapies in clinical practice in Gaza strip.

Dear colleagues,

This study is carried out by the researcher, as a requirement for the Master Degree in community mental health nursing, at Islamic University, Faculty of Nursing.

In this regard, the researcher, thankfully, appreciates your effective participation in this study, through answering the questions of the questionnaire taking no more than 20 minutes of your valuable time. Actually, your participation contributes to the success of the study that aims explore mental health professionals knowledge, Attitudes and practice of talking therapies in clinical practice in Gaza strip.

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Researcher would like to emphasize that the information will remain confidential and only for the purpose of scientific research.
Accordingly, there is no need to mention names, taking into account that a staff-member has the right to refrain from answering any question, or to refuse participation.

Thanks for your kind participation

Best Regards

The researcher
Mohanad Omar Hamdan .
Mobile: 0599386072

Date: ..../…./2010 **No.: ----------**

(for Researcher's use)

Personal Information:

Please, put × mark in the appropriate box.

1. Age: …….. years.

2. Sex: ☐ Male. ☐ Female.

3. residency:

☐ North Governorate ☐ Gaza Governorate ☐ Middle Governorate

☐ Khanyonis Governorate ☐ Rafah Governorate

4. Marital Status:

☐ Single ☐ Married

☐ Widower ☐ Divorced

5. Education:

☐ diploma ☐ Bachelor's Degree ☐ High Education

6. Years of Experience: ……

7. Work Setting**:**

☐ Psychitric hospital ☐ Weast Gaza clinic ☐ Alsorany clinic

☐ Aboshbak clinic ☐ Alnusierat clinic ☐ Khanyounis clinic

☐ Rafah clinic

No	Figure ferry	strongly agree	agree	nutral	Disagree	Strongly Disagree
Knowledge						
1	psychological counseling can help the client to return to his natural life					
2	I know the counseling process steps					
3	I have sufficient knowledge to use talking therapy techniques					
4	I think there is a suitable possibility for the practice of psychological counseling in clinical work					
5	I need a training course to find out what types of talking therapy in clinical work					
6	I have sufficient knowledge of communication skills as a basis in the talking therapy process					
7	I have sufficient knowledge of cognitive behavioral therapy					
8	I have sufficient knowledge of the steps and techniques of cognitive behavioral therapy					
9	I have sufficient knowledge about group psychotherapy					
10	I have sufficient knowledge of the steps and techniques group psychotherapy					
11	I have sufficient knowledge of motivational interview					
12	I have sufficient knowledge of the steps and techniques of motivational interviewing					
13	I have sufficient knowledge about the process of family psychotherapy					
14	family psychotherapy can help client to return for his natural life					
15	I know the steps and techniques of family psychotherapy					
Attitudes						
16	I see that psychiatric clients are recovering by using talking therapy more than drug therapy					
17	talking therapy more effective and less expensive compared to drug therapy					
18	different person's ability to practicing professional talking therapy methods different depending on specialization					
19	people who suffer from mental illness can recover by using talking therapy methods with them					
20	talking therapy is applicable in mental health centers					
21	people at the stage of mental disorder in need of support and advice from others					

22	I think that cooperation between the medical team in the clinical work is important in enhancing talking therapy					
23	talking therapy is ineffective in improving the situation of the mentally ill as drug treatment					
24	talking therapy need for cooperation and interaction the client unlike pharmacological treatment					
25	I believe that the talking therapy is important and effective for the treatment of psychiatric patients such as l drug treatment					
	Practice					
26	I practicing talking therapy of various kinds in a professional and effective manner					
27	I Mastered and pass steps of psychological counseling in clinical work with different clients					
28	I use cognitive behavioral therapy practical steps in clinical work					
29	I mastered and clenching steps of motivational interviews as a kind of talking therapy in clinical work with different clients					
30	I use group therapy scientific and clinical steps at clinical work					
31	I use communication skills as a basis in various talking therapy processes					
32	I need a training course in how to practice talking therapy in clinical work					
33	I have received sufficient training to practice talking therapy					
34	policy of the institution that I work help and encourage the practice of talking therapy methods					
35	I document talking therapy stages of with the cltient in relays and professional at the mental health clinic					
36	there is a suitable possibility for the practice of counseling in clinical work					
37	I mastered and I pass the family psychotherapy steps in clinical work					
38	I mastered and I pass the group psychotherapy steps in clinical work					
39	I follow each new l regard to talking therapy via the Internet					

Annex (6): Approval from CMHGD

Palestinian National Authority

Ministry of Health

Mental Health General Administration

السلطة الوطنية الفلسطينية

وزارة الصحة

الإدارة العامة للصحة النفسية

Date: 12/07/2012

الرقم:

السادة/ المدراء الطبيين للمراكز حفظهم الله،،،

السادة/ المدراء الإداريين للمراكز حفظهم الله،،،

السلام عليكم ورحمة الله وبركاته،،

الموضوع / تسهيل مهمة باحث

بخصوص الموضوع أعلاه يرجي تسهيل مهمة الباحث الحكيم/ **مهند عمر حمدان** رقم وظيفي **204689** الملتحق ببرنامج ماجستير الصحة النفسية بالجامعة الإسلامية و عنوان البحث:

" معرفة واتجاهات وممارسة المهنيين العاملين في الصحة النفسية للعلاج الكلامي فى العمل العيادي"

حيث سيقوم الباحث بالاستعانة بالطواقم الفنية في عيادات الصحة النفسية المجتمعية، كما سيقوم بتعبئة الاستبيانات لعينة من العاملين وذلك حيث لا يكون يتعارض مع مصلحة العمل في المراكز ويكون ضمن أخلاقيات البحث العلمي دون تحمل المراكز أي أعباء من إجراء هذا البحث.

وتفضلوا بقبول فائق الاحترام والتقدير،،،

د. عايش سمور

مدير عام الصحة النفسية

الدكتور رياض الأقرع
أخصائي الأمراض النفسية
مدير مستشفى الطب النفسي

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

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

Annex (7): list of control panel names (alphabetically)

Dr. Anwar Al-Abadsah.(Islamic University)

Dr. Anwar Al-Bana.(Alaqsa University)

Dr. Atef Al-Agha. (Islamic University)

Dr. Ayda Saleh.(Alaqsa University)

Dr. Ayish Samour.(Mental Health General Directorate)

Dr. Omer Al-Buhissy.(Mental Health General Directorate)

Dr. Samir Quota.(Islamic University)

Dr. Yousef Awadallah. (Mental Health General Directorate)