



Awareness and Knowledge on Antipsychotics and Mental Illness among the Public in West – Bank.

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ABSTRACT

Use of antipsychotic drugs and attitude to mentally be affected by their knowledge and beliefs about psychotropic drugs, the underlying cause (s) of mental disorders, and mental health. To evaluate the extent at which knowledge, beliefs and socioeconomic factors affect people attitudes towards mental illness in West Bank. Between March and December, 2015 we conducted a survey about the extent at which knowledge, beliefs and socioeconomic factors affect people attitudes towards mental illness in West Bank (n = 462) using a face-to-face questionnaire. The questionnaire consisted of 5 parts: socio-demographic information, health self-evaluation, causes of mental illness, the preferred way for help-seeking in case of mental health problems and peoples' attitudes toward antipsychotic drugs and mental illness. There was an overall positive attitude to mental illness; mean response \pm (SD), 3.48 (0.33). Females had more positive attitude toward antipsychotics compared to males, t-test (-3.382; $p = 0.001$). Religion made no difference on total degree at $\alpha \leq 0.05$, average response \pm SD = 3.48 \pm 0.34 and 3.45 \pm 0.29 for Muslims and Christians. One-way ANOVA test results showed significant difference due to age at the 4th Dimension, $F = 6.158$; $p = 0.000$. For profession, difference at 1st Dimension, $F = 2.282$ at $p = 0.064$ and the 4th Dimension; $F = 5.683$; $p = 0.000$. Residence place made a difference in 1st and 4th Dimensions; $F = 3.504$ at $P = 0.031$, and $F = 4.157$; $p = 0.016$, respectively. People with intermediate to high income showed positive attitude in 2nd, 3rd, and 4th dimensions comparing to low income people; $F = 6.502$; $p = 0.000$, $F = 5.090$; $p = 0.002$, and $F = 8.268$; $p = 0.000$, respectively. People in general in West Bank have positive attitude to mental illness. Better awareness and understanding is still needed in villages to change the way they deal with mentally ill people.

Keywords: Beliefs, knowledge, attitude, psychotropic drugs, mental illness, mentally ill people, help-seeking behavior.

INTRODUCTION

Research proved that beliefs about mental illness and attributing causes of mental illnesses affect people attitude toward afflicted patients and correlates well to help-seeking behavior^{1,2}.

There is also accumulative evidence that beliefs about medications affects attitude toward their use and determines patient's compliance³.

There is across cultural differences in beliefs, attitudes and practices of help seeking for mental health illnesses. These differences are due to various factors such as religion, ethnicity, social cynicism, interpersonal harmony, perceived stress and reward for application⁴⁻⁷.

So for example in a large survey⁷, Japanese public was found to be more reluctant to use psychiatric labels, particularly for the depression cases or to discuss mental disorders with others outside the family.

They had a strong belief in counselors, but not in GPs. They generally believe in the benefits of treatment, but are not optimistic about full recovery. By contrast, Australians used psychiatric labels more often, particularly "depression".

Arabs live in the Middle East constitutes a multi-ethnic diverse nation with cultural and historical richness and have their own beliefs about mental illness and about the

use of psychotropic medications and help-seeking behavior for mental disorders. They have their own way of expressing sadness, grief, distress and depression. They attribute these feelings to different causes and associate them with the heart rather than the mind or the brain as in Western communities^{6,8-16}.

In one study in Qatar⁶ that included 2514 Qatari and non-Qatari Arabs, it was shown that 44.5% of Qatari and 50.6% of non-Qatari; $p = 0.002$ thought that mental illness can be a punishment from God and that people with mental illness are mentally retarded (35.1% vs 45.1%; $p < 0.001$). They attribute mental illness to possession of evil spirits (40.5% vs 37.6%) and they think psychiatric medications will cause addiction (61% vs. 57.3%).

In a study in Oman⁸, it was shown that Omani community believes in supernatural powers (Jinn), contemptuous envy (Hassad), evil eye (Ain) and sorcery (Sihr) which are often used to explain the etiology of mental illness.

In one study in Egypt⁹, among 100 hospitalized psychiatric patients, it was shown that seventy two percent of them believed that medications will affect their normal life, 83 % thought it will cause agitation, and 70 % thought it will initiate a negative attitude from people.

In another study on 76 hospitalized psychiatric patients in Saudi Arabia¹⁰, it was shown that 91% of the patients thought that they have to take their medications for life,



while 76 % thought they would discontinue it when they get better. Seventy-eight percent thought that medication reduced agitation, and 41 % thought it reduced anxiety. Small proportion (29 %) believed that medication made them feel afraid.

In Israel¹², a study found that 13% would seek help from a mental health professional at their own initiative which similar to percentage of who would go to their general practitioner, 14%.

There are no studies in Palestine to explore the public opinions and views about mental disorders, psychotropic drug use or attitude toward people with mental illness. In this study we confronted the issue from different angles and try to focus on public attitude and level of awareness, knowledge and beliefs about mental illness in general. What is the attitude toward taking psychotropic drugs or seeking help for mental illness? We tried to assess for the first time the stigma toward mentally ill people from a social perspective.

Taking into consideration that public awareness of and attitude toward mentally ill people and toward the use of psychotropic drugs is expected to play a major role in promoting mental health awareness in West Bank.

Assessing this issue is the first step among several steps in order to reveal the public perception of mental health. It points to major barriers¹⁷ to mental health improvement in the community. This will pave the road for future studies directed toward major educational programs, intervention trials, implementing new policies and adopting additional programs for mental health improvement in West- Bank and integrating mental ill people in the community.

MATERIALS AND METHODS

This study adopted the descriptive analysis method where beliefs and opinions of the public about mental illness and antipsychotic drugs were measured using a self-delivered questionnaire. Then SPSS analysis was done to find out the relation between participants' opinions and the socioeconomic factors of interest.

The questionnaire gathered information about the 4 main sections of the study; socio-demographic information, self-health evaluation, causes of mental illness and the preferred way for help- seeking in case of mental health problems and Part 4 of the study which consisted of 31 paragraphs that measured peoples' attitudes toward antipsychotic drugs and mental illness. It was built mostly in the positive direction where it measured the four dimensions of the mental illness described in the study.

A 5 point likert self-evaluation scale was used in part IV where every answer was given a numeric value depending on the degree of agreeing or disagreeing with phrases and information in the paragraphs: strongly agree (5 points); agree (4 points); agree sometimes (3 points); disagree (2 points); disagree strongly (1 point). This scale was applied for all the 31 paragraphs of part 4,

except for the negative paragraphs where the scale was used in the opposite direction.

Validity of the tool: The questionnaire was prepared, translated, then reverse translated, pilot pre-studied on a random small sample (40) of the public, modified, and presented to four experts in the field to be evaluated. Cronbachs alpha for the consistency in the 4 dimensions was 0.81 for 1st D, 0.79 for 2nd D, 0.78 for 3rd D, and 0.67 for 4th D. Over all Cronbachs alpha for the 4 dimensions was 0.82 which indicates high consistency of the study tool.

RESULTS

Demographic Characteristics

In this study, 462 (51.9% females), age 18 to \geq 50 years finished the questionnaire successfully and their data was entered for analysis. Socio-demographic characteristics such as education, religion, and income are shown in Table 1.

Most participants in the study indicated that their health status was very good (48.9%), or excellent (25.5%) or good (23.2%) at the time of the study. The degree of their self-care ranges from good (31.6%) to very good (40.7%).

People showed an overall high values in all 4 dimensions of the study toward the positive attitude; mean \pm (SD), 3.48 (0.33). The lowest degree was for 1st D (attitudes toward antipsychotics), mean \pm (SD); 2.85(0.55), followed by 2ndD (fear from mentally ill people and exclusion of them from the community), mean \pm (SD); 3.35(0.78).

Understanding and tolerance (3rd D) came in first place followed by the (4th D)-integration in the community - where it came in the 2nd place, Mean \pm (SD); 4.01(0.52), 3.68(0.54), respectively, see Table (2) below.

In order to see if there is any statistically significant difference at ($\alpha \leq 0.05$) in people responses in the 4 dimensions of the study due to the socioeconomic variables (sex, religion, age, place of residence, education, profession, and income), different tests were utilized as shown in the following discussion and summarized in Tables 3 and 4:

Gender: Females were found to have more positive attitude toward antipsychotics compared to males, t-test (-3.382 at $p = 0.001$), but there was no significant difference in the other 3 dimensions between men and women of the study.

Religion: There was no significant difference according to religion on the total degree at $\alpha \leq 0.05$ of all 4 dimensions; (average response \pm SD = 3.48 \pm 0.34 and 3.45 \pm 0.29 for Muslims and Christians, respectively).

There wasn't a significant difference at the individual level of each dimension, $t = 0.601$ at $p=0.548$ (statistically insignificant). Table (3).

Age: response as mean \pm SD was calculated for different age groups where it was found that the averages were



close to each other; 3.44 ± 0.33 , 3.48 ± 0.34 , 3.53 ± 0.34 , and 3.54 ± 0.31 for age groups: 18-29, 30-39, 40-49, and ≥ 50 , respectively. This result reflects the fact that 71 % of participants are young people.

One-way ANOVA test showed no statistically significant difference among age groups; total F value for all dimensions was (2.524 at $p=0.057$), see table (4), except for the 4th D (integration in community). In order to investigate the source of this difference, Tukey test was done on the 4th D, data not shown.

The difference was found mainly between the young age group (18-29) and the older age groups {(40-49), (≥ 50)} to the favor of older age groups.

Place of residence: The average response was close to each other for the four dimensions at $\alpha \leq 0.05$. There was difference in the 1st and 4th D, $F = 3.504$ $p=0.031$, and 4.157 $p=0.016$ respectively comparing to the total degree response, $F=0.317$ $p=0.728$.

To know the source of difference, Tukey test, data not shown, was done where it was found that people lives in towns, villages, refugee camps or the country side have

positive attitude toward antipsychotics more than people in cities.

Education: there was no difference in the four dimensions of the study attributable to different education levels.

Profession: at $\alpha \leq 0.05$, there was statistically significant difference between the total degree and the 1st and 4th D's among people whose jobs were; business, had no job or students at one side and professionals/workers at the other side; ($F = 4.243$, $p = 0.001$). A difference was also found in 1st and 4th dimensions among people from different professions.

Tukey test showed differences between people who do business or who have no job and people who are professionals or workers for the favor of the latter group at the 1st D.

Differences were also found between employees at one hand and retired or students at the other hand at 4th D for the favor of employees where they showed acceptance to the idea of integration in the community. Table (4).

Table 1: Socio-demographic characters of the study sample

Variable		Frequency	Percent
Gender	Male	222	48.1
	Female	240	51.9
Religion	Muslim	417	90.3
	Christian	45	9.7
Age (years)	(18-29)	236	51.1
	(30-39)	95	20.6
	(40-49)	75	16.2
	(≥ 50)	56	12.1
Residence place	Town, village	203	43.9
	Camp	36	7.8
	City	223	48.3
Education	\leq Primary	40	8.7
	Secondary	76	16.5
	\geq University	346	74.9
Profession	Employee	203	43.9
	Business	43	9.3
	Worker	39	8.4
	Retired	43	9.3
	No job	30	6.5
	Student	104	22.5
Income (Shekels; NIS)	< 2000.00	188	40.7
	2000-2999	102	22.1
	3000-3999	92	19.9
	>4000.00	80	17.3

Table 2: Overall people response and attitude to the 4 dimensions of the study shown as average \pm SD and its corresponding degree as measured by the 5- point likert scale

Variable	N	Mean	Std. Deviation	Degree*
1. Attitudes toward antipsychotics	462	2.85	0.55	Intermediate
2. Fear and exclusion	462	3.35	0.78	Intermediate
3. Understanding & tolerance	462	4.01	0.52	High
4. Integration in community	462	3.68	0.54	High
Total degree	462	3.48	0.33	High

*1-1.79 (Very low), 1.8-2.59 (Low), 2.6-3.39 (Intermediate), 3.4-4.19 (High) 4.2-5.00 (Very high)

Table 3: t-test results for age and religion showing their impact on the 4 dimensions of part four of the study.

Variables	Response	Mean \pm SD		t	df	Sig. (2-tailed)
		Males	Females			
Gender [†]	Attitude to meds	2.67(0.56)	2.93(0.53)	3.382-	460	0.001**
	Fear and exclusion	3.41(0.77)	3.31(0.79)	1.37	460	0.171
	Understating	4.00(0.55)	4.03(0.48)	- 0.504	460	0.615
	Integration	3.67(0.57)	3.70(0.50)	- 0.749	460	0.454
Religion [§]		Muslims	Christians			
	Attitude to meds	2.85 (0.56)	2.81 (0.54)	0.521	460	0.603
	Fear and exclusion	3.37 (0.79)	3.20 (0.66)	1.35	460	0.178
	Understating	4.01(0.52)	4.03(0.47)	- 0.208	460	0.836
	Integration	3.68(0.55)	3.75(0.47)	- 0.801	460	0.423

†N= 222 males, 240 females. § N= 417 Muslims, 45 Christians. ** Significant value at $\alpha \leq 0.01$

Table 4: ANOVA Analysis results for age, education, profession, residence and income showing their impact on the 4 dimensions of part four of the study.

Variables	Responses /dimensions	Sum of Squares	df	Mean Square		F	Sig.
				B	W		
Age	Attitudes to meds	141.653	3	0.706	0.305	2.318	0.075
	Fear and exclusion	281.529	3	1.008	0.608	1.657	0.176
	Understanding	124.020	3	0.489	0.268	1.829	0.141
	Integration	133.663	3	1.727	0.281	6.158	0.000**
Education	Attitude to meds	133.663	2	0.142	0.308	0.462	0.631
	Fear and exclusion	281.529	2	0.282	0.612	0.461	0.631
	Understanding	124.020	2	0.013	0.270	0.051	0.950
	Integration	133.663	2	0.229	0.290	0.788	0.455
Profession	Attitudes to meds	141.653	5	0.692	0.303	2.282	0.046*
	Fear and exclusion	281.529	5	1.047	0.606	1.728	0.127
	Understanding	124.020	5	0.160	0.270	0.593	0.705
	Integration	133.663	5	1.568	0.276	5.683	0.000**
Residence	Attitudes to meds	141.653	2	1.065	0.304	3.504	0.031*
	Fear and exclusion	281.529	2	0.116	0.613	0.190	0.827
	Understanding	124.020	2	0.297	0.269	1.103	0.333
	Integration	133.663	2	1.189	0.286	4.157	0.016*
Income	Attitudes to meds	141.653	3	0.758	0.304	2.491	0.060
	Fear and exclusion	281.529	3	3.834	0.590	6.502	0.000**
	Understanding	124.020	3	1.334	0.262	5.090	0.002**
	Integration	133.663	3	2.289	0.277	8.268	0.000**

* Significant value at $\alpha \leq 0.05$. ** Higher significant value at $\alpha \leq 0.01$. B: Between groups, W: within

Income: People with intermediate to high income showed positive attitude in all dimensions especially 2nd, 3rd, and 4th dimension comparing to low income people. Table (4)

Cause of Mental illness: When people were asked what it could be a cause of mental illness, exposure to traumatic event or shock came in first place (76.4 %) with frequency 353. This cause was chosen 353 times by responders as a cause for mental illness, followed by substance misuse like alcohol or drugs (63.0 %), (291responses).

Poverty and economic distress came in the 6th place (55.6%), 257responses. Stress in daily life came in the 5th place (56.1%), (259 responses).

Notably, biologic imbalance or brain disorder came in the 3rd place (56.9%),(263 responses).

The least attributable cause was possession by evil spirits (20.3)

Help seeking Options: what do you think is the best way of dealing with mental disorders? Psychotherapist (73.2 %), psychiatrist (69.9%), taking psychotropic medications (54.1%), talking to a friend or family member (46.3%), self- dependence when solving the problem (32.9%), were the preferred ways for help seeking. Lowest percentage was for asking the pharmacist, visiting General Practice MD, going to religious people, or traditional healers.

DISCUSSION

The results of this study showed that the public has positive attitude toward mental illness in general and toward people with mental illness in specific. Acceptance, tolerance and integration into the community are all rated high.

This reflects the consistency of the sample of the study and the great similarity of the conditions of living of people in this community which comes as a result of the fast pace urbanization in the last 2 decades. Despite the differences in their places of residence, almost 75 % of the participants had university degrees or higher. Also 71 % of them are in their 18-39 years of age (youth), which reflects the tangential and close responses and attitude. See Table (1). This might be considered a drawback of the sampling method, since we could not reach to older people or people who are at home or illiterate people.

Females showed positive attitude to use of antipsychotics. This might reflect the shyness and the degree of hiding from community when afflicted with mental disorders. Despite the fact that they live in an eastern community and they should seek help from family and friends in the case of mental illness as first choice, they went to medications as their preferred choice?

This result came in paradox with the general trend of eastern communities and trend of male participants in this very study.

Women might consider psychotropic medications as first trial since it provides confidentiality and a hidden way of dealing with the problem. The relationship between her, the physician and the pharmacist could guarantee the secret nature of her condition. She is scared of social stigma.

This came in harmony with the answers of the question; “If I have to take psychotropic medications, I will hide that from everyone”, where almost 45 % of the participants express their great desire to hide it from everyone. Also using psychotropic meds came in the third place as preferred way of treatment, which reflects female trend of this study (52 % are females). See also results for help seeking options in the results section.

Christians form a minority in the community and in the study which lead to statistically indifferent input. Also both Muslims and Christians in West Bank have same living conditions, same culture, attitude, education and social beliefs, so religion didn't make a difference on response.

When it comes to age, older people were more accepting to the idea of integrating mentally ill people in the community. They might have a close friend or family member or they were themselves afflicted with mental illness by time, so they have empathy and sympathy toward them.

They might accept the fact that anyone could be afflicted with mental illness at certain point in their lives and the community had to accept them and integrate them. In the questionnaire, 53.5 % and 32.9 % responded with strongly agree or agree, to the paragraph; “virtually anyone can become mentally ill at a point in his life”.

People regardless of place of residence showed positive attitude to use of psychotropic medications. This either reflects their naïve experience with psychotropic meds and their side effects or the fear of social stigma. It indicates shyness of the community when asking for help by other ways that could be easily identified by the community such as going to traditional healers or going to psychiatrists or talking to a friend or even family member.

On the other hand, people live in cities and refugee camps showed positive trend to integration of mentally ill people into the community relative to participants who live in villages, towns and country side.

In the country side the help for mentally ill people comes in the form of strong social bonds and keeping him/her within the family as part of love, caring and / or shyness from the community to declare the fact that someone of the family is afflicted with mental illness. It is a special form of isolated integration in which the mentally ill patient will be confined to family members and close friends only. This sort of care is built on sympathy rather than empathy. It is not empowering neither giving the person the freedom of choice. It doesn't integrate



him/her completely or partially in the community as a functional person.

This trend in villages and towns also reflects the scarcity of other options for integration or the casualty of growing up with people with mental illness is just there in the streets.

In cities and refugee camps, there are no time to care for these people neither there is ability for carrying the financial burden of doing that. Also in cities, the social bonds are weaker and other options for integration and care are available in the community. So coping with and providing help for mentally ill people through the community institutions and other health care providers in order to create an independent functioning person, is the best option of care in cities.

The results showed that almost 75% of participants were university graduates. This might mask any differences in attitudes in the total degree or in between groups according to education. So their opinions, attitudes and knowledge came close to each other. It also becomes obvious when talking about causes of mental illness below where people in the study showed higher awareness off underlying causes comparing to other neighboring communities.

Low income people had an overall negative attitude in 3 out of four of the aspects of the study. They might think of themselves as in need for help and support rather than helping others for coping or integration. They might feel themselves a burden on the community.

This was obvious from the response to the paragraph, "People with mental illness are a burden on society", where 58.9 % and 15.9 % of respondents strongly agree or agree, respectively, to this idea. This response came in align with the fact that ~ 61 % of participants are low income people (≤ 2000.00 - ≤ 2999.00 Shekels per month).

Analyzing Response to Causes of Mental Illness

Our results were expected and matched with other studies and reports that indicated high prevalence of PTSD and other psychological disorders among Palestinians whether in Gaza or in West Bank who are suffering long time war and succumb to harsh conditions at both political and economic levels.^{9-12,23}

When analyzing ranking of causes by respondents; poverty and economic distress came in the 6th place. This indicates the low income of most of the study sample and the economic hardship that the country is living. Stress in daily life came in the 5th place which reflects the political situation on the ground such as barriers for transportation and travelling from one city to another, check points and other day to day stressful obstacles and loss of power and self-control.

Help Seeking Preferences

Talking to a friend or family member came in the 5th place which came in harmony with the eastern nature of West Bank Community when it comes to talking to friends and family about their condition. It also resembles the Japanese community in the Australian/ Japanese study above¹⁶.

In the other hand, these results represent the openness to western cultures where psychotherapists and psychiatrists were the most preferred help seeking ways. This is comparable to Switzerland and Australia in Angermeyer M. analysis¹. Despite the fact that females in this study preferred medications use, psychotropic use in general was ranked at the bottom of the scale when it comes to help-seeking. This is obvious from the less optimistic responses about psychotropic medications in the questionnaire and from the overall response to dimension 1 as shown in Table.

People are highly self-conscious when it comes to use of psychotropic medications.

Limitation

We didn't ask the participant whether he/she used or have used psycho meds before, or a friend or family member was afflicted with mental illness.

In this case they had so little practical information of what it might be to have metal illness or have a friend or family member who suffered from such a condition.

They might not know what it look like to be on psycho meds. So there answers might be ideal or close to, but not realistic which could limit our study conclusions and generalizations stemmed from this study. in a community that had suffered a lot according to the reports that showed highest level of PTSD and anxiety disorders among its people.

People are self-conscious about privacy when it comes to psychotropic medication use.

CONCLUSION

People in general in West Bank have are ready to accept, more than ever, the idea of social-based-mental health services and integration of mentally ill people in the community. People in this study strongly believed that mental illness should be addressed in the right way. They seek help from the right professional or counsel the best methods for help which reflects understanding of the condition and the underlining cause (s).

But the way people lives in villages deal with mental illness as quoted in our discussion, indicates that better awareness and understanding is still needed.

More studies are needed to assess the needs of mental ill people and their families in order to provide the right help and to facilitate the transition to community-based health services.



There is a tendency in the community to use psychotropic medications despite the fact that their knowledge about them is very low.

They do not know the exact nature of these medications, their scope of treatment, and ability of cure of the underlying condition or their side effects and long term consequences which prove the difficult situation and the high stress and tension in the community.

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