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An Analysis of Mental Health Specialization among Zimbabwean Health Professionals, Against the Backdrop of a Soaring Global Mental Health Burden

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ABSTRACT

Background: an estimated 1.3 million Zimbabweans suffer from various forms of mental illness. The problem is compounded by an extremely low number of practicing mental health professionals. The harsh economic environment in the country has had a toll on the mental well-being of many people. The country has several training programs in mental health despite the shortage of these professionals.

Aim: The aim of the study was to explore non-mental health professionals perceptions on specialization, especially concerning the field of mental health.

Methods: The study was qualitative in nature. 12 participants from each of the professions of social workers, occupational therapists, nurses, and doctors were recruited for the study using purposive sampling. The subjects were from Parirenyatwa Hospital and St Giles Rehabilitation Centre in Harare, Zimbabwe. The instrument was a 7 question semi-structured interview administered either face to face or via telephone calls. Data were analyzed using thematic analysis.

Results: A total of 3 themes emerged and these related to: the factors considered when choosing a profession or specialty, factors that discourage health professionals from specializing in mental health and, the views of non-mental health staff towards mental health professionals. Aspects of a high job market, high income, prestige, passion to save lives, family traditions and, inspirational role models were important for career choices.

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Introduction

This research project explores the specialty of mental health in the Zimbabwean context, in light of the global mental health burden. WHO's Mental Health Atlas 2017 shows that although some nations have some progress in regards to mental health policy making, many still grapple with the shortage of mental health workers due to mental health plans that are not supported by enough financial and human resources. Mental, neurological, and substance use (MNS) disorders constitute about 14% of the global disease burden and yet the area of mental health is known to be lowly funded by governments of several countries [1-4]. The low- and middle-income countries (LMIC) remain the mostly affected and the 2005 figures for the shortage of the staff was estimated to be 1.18 million health workers, including 55 000 psychiatrists, 628 000 mental health nurses and 493 000 psychosocial service providers [5].

The burden of disease caused by mental health disorders often affects functioning, quality of life and may result in premature death. The approximated lost economic output due to untreated mental disorders' impact on work productivity, decreased rates of labor participation, flouted tax receipts, and increased welfare payments total to over than 10 billion days of lost work annually [6]. Avows that there can be no genuine physical health without mental health because mental wellness directly impacts physical health outcomes [7].

According to a report mental disorders constitute about 7.4% of the disability-adjusted life years and more than 37% of healthy life years lost as a result of communicable diseases [8]. This portrays that mental and behavioral disorders account for healthier life years lost than cancer or heart disease and yet, low-income countries spend less than 1% of their health-related expenditures on mental health [9]. Mental health is one of the top 5 leading causes of the diseases in Africa [10]. The WHO, posit that health systems of several countries have not heeded to the burden of mental illnesses and this has consequently yielded a huge gap between the need for treatment and its delivery globally. About 76% to 85% of those with mental disorders in middle and low-income countries do not receive treatment, and a similar trend occurs to about 35% to 50% of the mentally ill in high-income countries [1-4]. These staggering figures reveal how mental health has remained globally marginalized.

Quality mental health service provision is dependent upon an adequate number of specialized health service providers. It is estimated that about half of the world's population live in areas where an average of 200 000 people's mental health needs are catered for by a single psychiatrist, not to mention the scarcity of other allied health care providers such as mental health nurses, social workers, occupational therapists and psychologists [1-4]. Approximately, one in every 10 individuals worldwide are living

with some mental health disorder, a ratio which mismatches with the 1% total global mental health workforce [11].

Background Statement

According to the World Health Organization, WHO approximately 1,3million Zimbabweans suffer from various mental health ailments [1-4]. The shortage of staff, drugs and mental health infrastructure are some of the missing elements for a comprehensive mental health delivery system [9]. Mental health professionals are extremely scarce to the extent that the country is manned by only 14 psychiatrists thus translating to a doctor-patient ratio of 0.08 per 100 000 people [12]. Paradoxically, other essential allied mental health staff such as occupational therapists, mental health nurses, social workers, and psychologists, either divert to other careers or are lured to better-paying opportunities out of the country. Current statistics reveal that only 5 clinical psychologists and 15 occupational therapists are practicing mental health in the nation's public sector [9]. Primary healthcare workers are trained to handle mild mental health cases at district and provincial hospitals but it turns out that the majority of these workers eventually migrate to larger urban cities in search for better salaries and working conditions [13].

Asserts that the current harsh economic climate prevailing in Zimbabwe has impacted negatively on the mental well-being of citizens [14]. The situation has been compounded by the scarcity of mental health professionals countrywide. However, the country provides training of mental health personnel such as psychiatrists and mental health nurses despite their shortage. The University of Zimbabwe College of Health Sciences (UZ-CHS) offers a four-year Master of Medicine degree in Psychiatry and a one-year post-graduate mental health diploma for those desiring to advance their skills in psychiatry [13]. Conversely, a handful of medical graduates choose to take these offers and on average, four diploma students and two Masters students get enrolled each year. Mental health nurses are also trained at Ingutsheni hospital for one and half years but similarly, the year to year intakes remains dismally low, averaging only 12 students annually [15]. In the same vein, of a total of 150 trained occupational therapists in Zimbabwe, only 15 of them are known to be working in the field of psychiatry [9].

Problem Statement

With the ever-increasing cases of mental illness in Zimbabwe, the expected trend has to be a subsequent surge in the numbers of mental health staff. However, when that fails to materialize, questions may be asked as to, "what could be reasons that may be barring health professionals from taking up careers in mental health"?

Research Question, aims, and Objectives

Research Topic

An analysis of mental health specialization among Zimbabwean health professionals, against the backdrop of a soaring global mental health burden.

Research Question

What are the perceptions of non-mental health specialized Zimbabwean health professionals on mental health specialization

Aim of the study

To explore health professionals' perceptions on specialization, especially concerning the field of mental health.

Objectives

1. To review the literature on how health professionals in other parts of the globe perceive mental health and how that impacts their decision to, or not to pursue its specialization.
2. To explore the views and attitudes of Zimbabwean health professional regarding specialization, including in the area of mental health by conducting 12 semi-structured interviews.
3. To identify the barriers that dissuade Zimbabwean health professionals from pursuing specialization in mental health, using thematic content analysis.
4. To recommend some viable strategies to encourage more health professionals to favor careers in mental health.

Significance of the Study

The knowledge gained on how the health professionals perceive mental health will be used as a framework for guiding better mental health service provision. The findings of the study will also be used to inform the Ministry of Health on some possible measures to tackle the low uptake of the specialty.

Research Design

The research question seeking reasons for the low numbers of mental health professionals suited a qualitative research design. This design aims at understanding the deeper meaning of information, unlike the quantitative design whose explanation is based on numbers and hypotheses testing. Data were analyzed by the thematic analysis method of open and axial coding [16]. The data collection tool was a semi-structured interview administered either face to face or via telephone. Empirical data in qualitative research is best collected thorough interviews because it gives participants the opportunity to share their individual experiences [17].

Research Setting

Research setting refers to the general set up of the environment in which a study is conducted [18]. According to Ritchie & Lewis, the environment has to be free from distractions that the participants can freely express their views [19]. The study was undertaken at St Giles Medical Rehabilitation Centre and Parirenyatwa Group of Hospitals, both in Harare, Zimbabwe. Some of the interviews were conducted via telephone calls. At the St Giles Centre, the interviews were held in a private and quiet room in the occupational therapy department. For the Parirenyatwa participants, the interviews were held the rehabilitation department conference room. The interviews were conducted either during lunch times or outside working hours to avoid interferences with the participant's work.

Sampling Strategy and Procedures

The principal sampling method applied was purposive. This is a non-probability sampling strategy applied when the researcher wishes to study specific cultural trends of a certain group of people [20]. It aims at producing a sample that is representative of the population in a non-randomized manner [21]. The participant selection constituted of four categories of health professionals, namely, doctors, nurses, social workers, and occupational therapists. Another additional sampling strategy called snowball sampling was used when some of the initially recruited subjects assisted with the identification of other suitable participants [17]. All participants had at least one year of post qualification working experience.

Recruitment

Participants were recruited at Parirenyatwa hospital and St Giles Medical Centre after the approvals were granted. The approval letters were taken to the heads of departments of the doctors, nurses, social workers, and occupational therapists. Once that was done, the staff was asked if they could participate in the interviews and those who agreed were given the participant debriefing. All the details of the study and interview procedures were explained to the potential participants. Each participant then stated the day and time he/she would be free to be interviewed.

Data Collection Methods

Posits that the choice of research methods relies on the methodology used [22]. The methodological approach of the study suited well with semi-structured interviews as the method of data collection. The researcher used a written interview guide (see appendix 4) to maintain the interviews on track. Each interview began with the researcher briefly explaining its purpose, stating that participation was voluntary, giving the assurance of confidentiality and, recording the necessary demographic information. The interviewer also had a notebook to record any pertinent issues that might have risen during the interview. Every participant agreed that the interviews be tape-recorded as the researcher applied the strategies of probing, using open-ended questions and, follow up questions [17]. A total of 10 interviews were conducted face-to-face while 2 were conducted via telephone.

Instrument

The instrument used in gathering data was a 7 question interview guide broken down into 3 sections, namely; the introduction, the interview, and the conclusion. In the introduction stage, the investigator started by thanking the participant for agreeing to be interviewed, followed by the signing of the consent form. The instrument was developed by the researcher. The investigator asked the participants about their reasons for choosing their respective professional careers, how they viewed subjects relating to mental health during their trainings, their encounters with mentally ill patients during placements, their reasons for or against specializing in mental health and, what their colleagues thought about those working in the mental health sector.

Results

The researcher applied thematic content analysis to analyze the data after it was initially transcribed verbatim. The data were then coded from participant 1 to 12 and themes and sub-themes were formed. The results were also consistent with the aims and objectives of the study. The respondents gave in-depth accounts of their perceptions concerning mental health specialization with probing being applied by the interviewer to draw specific information. Some of the utterances of the participants were scripted using direct quotes and the information was stated exactly the way it was said. All the participants were not employed in the mental health sector at the time of data collection which was a pre-requisite for participating. More so, all manner of confidentiality and the security of the recorded data were adhered to as highlighted in the methodology chapter.

A total of three themes emerged from the data and these were as follows:

1. Factors considered when choosing a profession or specialty.
2. Factors that discourage health professionals from specializing in mental health.
3. Views of non-mental health staff towards mental health professionals.

Summary of Results

The results discussed the factors that were important in choosing a health specialty, as well as the demotivating attributes. Prestige, income, family traditions, role model influence, personal interest and a high job market were some of the pull factors towards a specialty. On the contrary, the treatment approaches, stigma, fear of patients, curriculum structure, and a lack of community support structures discouraged specialization in psychiatry. All the doctors stated that they chose their professions because of the anticipated financial gains. Among occupational therapists, most of them concurred that their mental health placements were fun and enjoyable. The stigma of the transference of mental illness to healthcare staff was common among the nurses. Lastly, the issue of not having had the chance of experiencing mental health placements emerged from social worker participants.

Evaluation of Findings

The objectives of this study were to identify the important factors considered by healthcare workers in their choices of specialty areas, the reasons for the low numbers specializing in mental health and, how non-mental health staff perceive their mental health colleagues. A number of the findings of the study corresponded to some of the findings in the literature review section.

Both the study and the literature review identified similar aspects of personal interest in specialty, income, and, prestige as reasons for choosing a specialty. The influences of role models, the family, and passion to save lives were unique to this research. For the discouraging factors against mental health specialization, aspects of traditional and cultural beliefs, stigmatization, mental health training, and, the fear of patients were similar to the findings in the literature, while issues relating to poor community mental health support were some of the new findings of this study.

The Choice of a Profession or Specialty

Participants noted that being fascinated by a specialty area generated the interest to specialize in it, findings similar to the studies [23, 24]. Another common finding was the impact of role models and how they inspired some participants towards specialization. This aspect was highlighted by some participants who stated that their decisions to be specialized doctors was influenced by the conduct of their senior medical consultants, akin to the findings by [25].

The influences of income and prestige were also notable research findings to both this study and the literature section. Some subjects favored specializing in areas with high income prospects. The participants particularly indicated that the financial rewards were a top priority for their specialization in anesthesia or theatre nursing. Besides the financial rewards, professions like theatre nursing were considered highly prestigious and that attracted specialization in them. These findings concurred with studies by who noted that, because of its low prestige and financial status, psychiatry was the least selected specialty compared to surgery, internal medicine and obstetrics & gynecology [26].

Some subjects stated that their love for psychiatry came from the pleasure and fun they developed when dealing with mentally ill patients. Supported this finding in his studies where he noted that students opted to pursue mental health careers because of the fascination associated with the profession [23].

Conversely, reasons such as, the need to fill a societal health gap or, the influence of the family in specialization were some of the particular outcomes of the study.

Factors against Mental Health Specialization

The stigma associated with mental illness deterred mental health specialization. Social stigmatization of psychiatric patients was noted as a common occurrence by the participants, a view that was identical to studies by [27, 28]. The participants also posited that the locations of the biggest mental health hospitals in Zimbabwe, which was further away from the main hospital wings also lead to discrimination as that literally meant segregating both the patients and the health staff.

The methods of mental health teaching plus the structuring of the curricula at the leaning institutions were other significant aspects affecting the future decisions to specialize. Participants felt that the curriculum in mental health was narrow, let alone introduced way late during training. This made some subjects to presume that psychiatry was not that important. Theories by supported the impact of the curriculum and undergraduate experiences in directing future specialty choices [29]. Similarly, nurses in studies by cited how inadequately trained they were to effectively deal with the mentally ill [30].

Traditional and cultural beliefs regarding mental illness were also imperative phenomena that had a say on the choices of specialty. Participants believed in the supernatural causes and remedies for mental illnesses and consequently gave little room for the scientific therapeutic approaches. The supernatural mental illness causative agents such as bad omens and witches were confirmed in studies by [31]. Similarly, cultural beliefs that working with psychiatric patients for a long time could result in the transference of the illness to the staff certainly drove many away from pursuing mental health. Some participants confirmed noticing some subtle behavioral changes in their colleagues who were working in the mental health sector.

The fear of being harmed by psychiatric patients as alluded to was another pertinent finding of this research [32, 30]. Subjects encountered incidences of being threatened by some patients during their mental health placements, an occurrence that again swayed them away from mental health. The negative impact of psychiatry placements on students' choices of mental health as a future career pathway was also confirmed in studies [33].

Concerns were raised by some subjects on how the area of community mental health and follow-up after discharge was thought to have been lacking the support of the government. Advancing one's career in psychiatry was also labeled difficult because of the shortage of meaningful career development programs.

Non-Mental Health Workers' Views About Mental Health Staff

Non-mental health staff considered the careers of their mental health counterparts as generally stagnant because of the challenge of developing and advancing oneself in the mental health sector. They also assumed that the motivations for working in mental health emanated from either the prospects of making more money or previous encounter with mental illness in a close relative. However, other participants viewed mental health professionals as people with strong personalities important when dealing with the mentally ill.

Discussion and Recommendations

Public Health Relevance

Mental illnesses are one of the top causes of disease burden in Zimbabwe, yet, there are a lot of obstacles that prevent the population from fully accessing mental health services [9]. Part of the hindrances is the scarcity of health professionals in the mental health sector. Addressing the shortage of mental health workers is crucial in having a mentally healthy population. Studies outline that almost everybody succumbs to mental health issues at some point in life.

Results from this study found that some of the health professionals were unwilling to specialize in psychiatry because of the stigma attached to the profession, the fear of mentally ill patients, traditional and cultural beliefs on the causes of the illnesses and, the poor mental health curricula during training. Another pertinent discovery from the study was that healthcare workers in Zimbabwe also had their mental health concerns that they felt needed to be addressed, emanating from the harsh economic climate in the country. The areas of importance that emerged from the results were, the need to destigmatize the specialty of mental health, educating the public on the causes of mental illness, revising the curricula in mental health training institutions and, increasing security at psychiatric institutions for the safety of staff. The ultimate goal is to have more staff in mental health where an estimated 1.3million Zimbabweans are living with mental illnesses [1-4].

Recommendations

De-Stigmatizing Mental Illness and the Mental Health Specialty

Public education is important to destigmatize mental illnesses. The social stigma attached to both mental illness and mental health professions was held accountable for the low number of professionals in the sector. There is a strong need to educate the public on what mental illness really is and that it can be treated by modern medicine like any other disease. Utilizing media such as radio and the internet can be effective in disseminating the information to the public.

Measures to destigmatize mental health professions should be implemented during undergraduate training. The attitude of undergraduate students towards psychiatry is paramount because these are the key people who will be involved in patient care after they graduate [34].

Improved Teaching Approach in Mental Health

The teaching and learning approach of mental health in Zimbabwe needs to be revised if the specialty is to attract more health staff. It is imperative to introduce psychiatry related topics early during the undergraduate training of doctors to improve how the students value it. The curriculum has to be broader and fraught with the latest evidence based intervention strategies. The learning hours in psychiatry need to be equal with the other disciplines. For trainee social workers, it is necessary that mental health placements be mandatory for all, so that nobody loses the chance of getting practical hands on experience. Gaining practical experience boosts confidence when dealing with psychiatric patients which is needed if the students are to pursue careers in mental health later in life.

Enhanced security at mental health institutions

The issue of the safety of health staff, particularly females, in relation to the mentally ill was another critical outcome of the study. In in-patient mental health settings, the risk posed by the patient is understood to be a threat, not only the individual, but

also other patients, healthcare staff and, the general public [35]. One strategy to address this is by thoroughly assessing the patients and identifying those with the potential of being harmful and dangerous. Close monitoring, avoidance of one-on-one contacts, and adhering to every manner of safety precautions need to be practiced all times with these patients. If resources permit, beefing up security at the mental health institutions can make a huge difference as far as the safety of staff is concerned. Professionals would obviously be attracted to a specialty that does not put their lives in danger and vice versa.

Support structures for mental health in the community

The research found that mental illness intervention strategies are available only in hospital settings and there is a lack of the continuation of therapies in the communities after the patients have been discharged. This was cited as one of the detriments to mental health specialization. The few available psychiatric institutions were also found to be constantly overwhelmed with patients. There is a need for the government to erect cost-effective mental health facilities in communities especially in high density suburbs where there are lot of people. These facilities will help serve the patients with the needed community support as well as creating a bridge of the continuation of care between the hospital and the community [36-50].

Future research

The responses and concerns of the subjects were somehow similar with respect to their professions. Future research addressing each profession's views towards mental health specialization would be of benefit, rather than grouping the four professions together as was done in this study. This will help, not only policy makers in clearly outlining each profession's individual concerns but the studies will also be more reliable as more participants will definitely be involved.

Conclusion

The research addressed the different views of occupational therapists, doctors, nurses and social workers towards specializing in mental health. The qualitative design of the study in conjunction with the purposive sampling method were well suited for the thematic data analysis applied. All the ethical considerations in relation to seeking the necessary approvals and participants' consent were adhered to.12 subjects were recruited and interviewed using the semi-structured interviews. The perceptions among the health personnel varied although negative perceptions overrode the positive ones. The main issues of concern regarding mental health specialization centered on the undergraduate training experiences, stigma, poor community support structures and unclear opportunities for professional development. Public awareness campaigns targeting destigmatizing mental illness, an enhanced leaning approach to mental health, beefing up security at mental health institutions and, viable mental health support structures in communities are some of the suggested measures to attract more staff to psychiatry. Future studies should target unraveling the specific perceptions of healthcare workers in each individual profession [51-69].

References

1. World Health Organisation, WHO (2018) Mental Health Action Plan 2013-2020.Available at: http://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf.
2. World Health Organisation, WHO (2018) Mental Health: Massive scale-up of resources needed if global targets are to be met. Available at: http://www.who.int/mental_health/evidence/atlas/atlas_2017_web_note/en/.
3. World Health Organisation, WHO (2018) Stigma and discrimination. Available at: http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas
4. World Health Organisation, WHO (2018) Zimbabwe country Profile. Available at:http://www.who.int/mental_health/evidence/atlas/profiles/zwe_mh_profile.pdf?ua=1&ua=1.
5. World Health Organisation, WHO (2011) Human resources for mental health: workforce shortages in low- and middle-income countries. Available at: http://apps.who.int/iris/bitstream/handle/10665/44508/9789241501019_eng.pdf?sequence=1.
6. World Bank (2018) Mental Health. Available at: https://www.worldbank.org/en/topic/mental-health.
7. Cipriano PF (2016) No health without mental health. American Nurse 48: 3.
8. Murray CJL, Vos T, Lozano R, Naghavi M, Flaxman AD, etal. (2010) Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012: 2197-223.
9. Liang M, Machando D, Mangezi W, Hendler R, Crooks M, etal. (2016) Mental Health in Zimbabwe. Harare, Zimbabwe: Available at: https://www.kushinga.org/uploads/8/3/6/4/83640158/mh_in_zimbabwe.pdf.
10. Hendler R, Kidia K, Machando D, Crooks M, Mangezi W, etal. (2016) We Are Not Really Marketing Mental Health: Mental Health Advocacy in Zimbabwe. PLoS ONE 11: e0161-860.
11. Krisberg K (2015) WHO: Global shortage of mental health workers a barrier to care. Nation's Health 45: 17.
12. Financial Gazette (2017) Zimbabwe in Mental Health Crisis. The Financial Gazette p.p.1.Available at: https://www.financialgazette.co.zw/zimbabwe-in-mental-health-crisis/.
13. Refworld (2009) Zimbabwe-mental illness-social attitudes-treatment programs-support groups-legal provisions. Available at: http://www.refworld.org/pdfid/4b6fe323d.pdf.
14. Bonde, R (2014) More Attention to Mental Health Issues Urged in Zimbabwe. Available at:https://www.voanews.com/a/more-attention-mental-health-issues-urged-zimbabwe/3035500.html.
15. Mangezi W, Chibanda D (2010) Mental Health in Zimbabwe Country Profile. Available at:https://www.researchgate.net/publication/262561302_Mental_Health_in_Zimbabwe_Country_Profile.
16. Sauro J (2015) 5 types of Qualitative Methods. Available at: https://measuringu.com/qual-methods/.
17. Wahyuni D (2012) The Research Design Maze: Understanding Paradigms, Cases, Methods and Methodologies. Journal of Applied Management Accounting Research. 10: 69-80.
18. Given L (2008) The SAGE encyclopedia of qualitative research methods (Vols. 1-0). Thousand Oaks, CA: SAGE Publications. Available at: http://methods.sagepub.com/reference/sage-encyc-qualitative-research-methods/n398.xml.
19. Ritchie J, Lewis J (2003) Qualitative Research Practice, A Guide for Social Science Students and Researchers. SAGE Publications London. Available at: https://mthoyibi.files.wordpress.com/2011/10/pdf.
20. Maeresera S (2018) Public Health Research Proposal: University of Roehampton London Online. Available at: https://elearning.roehampton-online.com/webapps/discussionboard/do/message.
21. Lavrakas PJ (2008) Encyclopedia of survey research methods Thousand Oaks, CA. SAGE Publications Ltd. Available at:

http://methods.sagepub.com/reference/encyclopedia-of-survey-research-methods/n419.xml.

22. Gray DE (2004) Doing Research in the Real World. Sage Publications Ltd. Available at: https://uk.sagepub.com/en-gb/eur/change-location/0.
23. Sadr SS, Nayerifard R, Samimi Ardestani SM, Namjoo M (2016) Factors Affecting the Choice of Psychiatry as a Specialty in Psychiatry Residents in Iran. Iranian Journal of Psychiatry 11:185-190.
24. Galeazzi GM, Secchi C, Curci P (2003) Current factors affecting the choice of psychiatry as a specialty: An Italian study. The Journal of the American Association of Directors of Psychiatric Residency Training and The Association for Academic Psychiatry 27: 74-81.
25. Appleton A, Singh S, Eady N, Buszewicz M (2017) Why did you choose psychiatry? a qualitative study of psychiatry trainees investigating the impact of psychiatry teaching at medical school on career choice. BMC Psychiatry 17: 1-9.
26. Wang X, Xiang X, HaoW, Liu T (2013) Attitudes toward Psychiatry as a Prospective Career among Medical Students in Their Pre-Clinical Year in China- a Pilot Study PLoS ONE 8: e73395.
27. Kalra G (2012) Talking about stigma towards mental health professionals with psychiatry trainees: A movie club approach. Asian Journal of Psychiatry 3: 266-268.
28. Alshowkan, A (2017) a qualitative study of attitude toward people with mental illness among nurses in Saudi Arabia. Journal of Nursing and Health Science 6: 77-84.
29. Al-Ansari SS, Khafagy MA (2006) Factors affecting the choice of health specialty by medical graduates. Journal of family & community medicine 13: 119-23.
30. Martin PD, Daniels FM (2014) The experiences of undergraduate nursing students working in mental health care settings in the Western Cape, South Africa. African Journal for Physical Health Education, Recreation and Dance (AJPHERD) Supplement 1: 122-131.
31. Okpalauwaekwe U, Mela M, Oji C (2017) Knowledge of and Attitude to Mental Illnesses in Nigeria: A Scoping Review. Integrative Journal of Global Health 1:1-8.
32. Krupa T, Kirshl B, Cockburn L, Gewurtz R (2009) Understanding the stigma of mental illness in employment. Work 33:413-425.
33. Amini H, Nejatisafa AA, Shoar S, Kaviani H, Samimi-Ardestani M, etal. (2013) Iranian Medical Students' Perception of Psychiatry: Before and After a Psychiatry Clerkship. Iranian Journal of Psychiatry 8: 37-43.
34. Yadav T, Arya K, Kataria D, Balhara YP (2012) Impact of psychiatric education and training on attitude of medical students towards mentally ill: A comparative analysis. Industrial psychiatry journal. 21: 22-31.
35. Camuccio CA, Chambers M, Välimäki M, Farro D, Zanotti R (2012) Managing distressed and disturbed patients: The thoughts and feelings experienced by Italian nurses. Journal of Psychiatric and Mental Health Nursing 19: 807-815.
36. Atieno OP (2009) An Analysis of the Strengths and Limitation of Qualitative and Quantitative Research Paradigm. Problems of Education in the 21st Century 13: 13-18.
37. Baetz M, Griffin R, Bowen R, Marcoux G (2004) Spirituality and psychiatry in Canada: psychiatric practice compared with patient expectations. Can J Psychiatry 49: 265-271.
38. Behere PB, Das A, Yadav R, Behere AP (2013) Religion and mental health. Indian journal of psychiatry 55: 187-94.
39. Bourke B (2014) Positionality: Reflecting on the Research Process. The Qualitative Report 19:1-9.
40. Braun V, Clarke V (2006) Using thematic analysis in psychology. Qualitative Research in Psychology 3: 77-101.
41. Brikci N, Green J (2007) A guide to using qualitative research. Available at:https://cloudfront.ualberta.ca/-/media/science/research-and- teaching/teaching/qualitative-research-methodology.pdf.
42. Brown N, Vassilas CA, Oakley C (2009) Recruiting Psychiatrists-a Sisyphean Task. Psychiatry Bulletin 33: 390-392.
43. Burnard P, Gill P, Stewart K, Treasure E, Chadwick B (2008) Analysing and Presenting Qualitative Data. British Dental Journal 204: 429-432.
44. Coghlan D, Brydon-Miller M (2014) The SAGE encyclopedia of action research (Vols. 1-2). London: SAGE Publications Ltd. Available at: http://methods.sagepub.com/reference/encyclopedia-of-action-research/n254.xml.
45. El-Gilany AH, Mostafa A, Rafay I (2010) Students' attitudes towards psychiatry at Al-Hassa Medical College, Saudi Arabia. Academic Psychiatry 34: 71-74.
46. Gaebel W, Zäske H, Zielasek J, Cleveland HR, Samjeske K, etal. (2015) Stigmatization of psychiatrists and general practitioners: results of an international survey. European Archives of Psychiatry & Clinical Neuroscience 265:189-197.
47. Hailesilassie H, Kerebih H, Negash A, Girma E, Siebeck M, etal. (2017) Attitude of Medical Students towards Psychiatry: The case of Jimma University, Southwest Ethiopia. Ethiopian Journal of Health Sciences 27: 207-214.
48. Jacobsen KH (2012) Introduction to Health Research Methods: A Practical Guide. Sudbury, MA: Jones & Bartlett learning https://link.springer.com/chapter/10.1007/978-3-319-23069-6_3.
49. Jodi JF, Ting L, Saunders F (2011) Current levels of perceived stress among Mental Health Social Workers who work with Suicidal Clients. Social Work 56: 327-36.
50. Kakuma R, Minas H, Van Ginneken N (2011) Human resources for mental health care: current situation and strategies for action. Lancet 378: 1654-63.
51. Karuna, what are the merits and de-merits of multi-stage random sampling. Available at: https://www.preservearticles.com/articles/what-are-the-merits-and-demerits-of-multi-stage-random-sampling/7708.
52. Leon AC, Davis LL, Kraemer HC (2010) the role and interpretation of pilot studies in clinical research. Journal of psychiatric research. 45: 626-629.
53. Lloyd C, McKenna K, King R (2005) Sources of stress experienced by occupational therapists and social workers in mental health settings. Occupational Therapy International. 12: 81-94.
54. Mallet R, Hagen-Zanter J, Slater R, Duvendack M (2012) the benefits and challenges of using systematic reviews in international development research. Journal of Development Effectiveness 4: 445-455.
55. Merwin E, Hinton I, Dembling B, Stern S (2003) Shortages of rural mental health professionals. Archives of Psychiatric Nursing. 17: 42-51.
56. Minas H, Zamzam R, Midin M, Cohen A (2011) Attitudes of Malaysian general hospital staff towards patients with mental illness and diabetes. BMC public health. 11: 1-4.
57. Nadja PM, Dragan JS, Bojana M, Marko M, Darko S, etal. (2009) how medical students in their pre-clinical year perceive psychiatry as a career: The study from Belgrade. Psychiatria Danubina 21: 206-212.
58. Nordt C, Rössler W, Lauber C (2006) Attitudes of mental health professionals toward people with schizophrenia and

major depression. Schizophrenia Bulletin 32: 709-14.
59. Norredam M, Album D (2007) Prestige and its significance for medical specialties and diseases. Scandinavian Journal of Public Health. 35: 655-661.
60. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, etal. (2015) Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Administration and policy in mental health 42: 533-44.
61. Roberts P, Priest H, Traynor M (2006) Reliability and validity in research. Nursing Standard. 20: 41-45.
62. Sathyanath S, Mendonsa RD, Thattil AM, Chandran VM, Karkal RS (2016) Socially restrictive attitudes towards people with mental illness among the non-psychiatry medical professionals in a university teaching hospital in South India. International Journal of Social Psychiatry 62: 221-226.
63. Scotland J (2012) Exploring the Philosophical Underpinnings of Research: Relating Ontology and Epistemology to the Methodology and Methods of the Scientific, Interpretive, and Critical Research Paradigms. English Language Teaching 5: 9-16.
64. Seow LSE, Chua BY, Mahendran R, Verma S, Ong HL, etal. (2018) Psychiatry as a career choice among medical students: a cross-sectional study examining school-related and non-school factors. BMJ Open 8: 1-9.
65. Shenton AK (2004) Strategies for Ensuring Trustworthiness in Qualitative Research Projects. Education for Information 22: 63-75.
66. Stepahie K, Mantler E, Szeto A (2017) Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Sage: Healthcare management forum 30: 111-116.
67. University of Roehampton Online, UoRL (2018) Public Health Research Proposal Module 7. Available at:https://elearning.roehampton-online.com/bbcswebdav/institution/.
68. Verghese A (2008) Spirituality and Mental Health. Indian Journal of Psychiatry 50: 233-237.
69. Waugh W, Lethem C, Sherring S, Henderson C (2017) Exploring experiences of and attitudes towards mental illness and disclosure amongst health care professionals: a qualitative study. Journal of Mental Health 26: 457-463.

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