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Between modern and traditional values: Informal mental health help-seeking attitudes according to Israeli Arab women, primary care patients and their providers

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Abstract

Background: Israeli Arab women under-utilize mental health services.

Objectives: The present study evaluated the use of alternative services for dealing with depression and anxiety among Israeli Arab women and primary care providers.

Material: Four focus groups with primary care patients and two focus groups with primary care providers were conducted. Constant comparisons were employed in order to identify major themes related to informal help-seeking behaviors.

Discussion: Three informal help-seeking behaviors were identified: (a) social support, divided into extended family and neighbors versus nuclear family and close friends; (b) religiosity, divided into inner, direct practices and beliefs versus externally mediated ones; and (c) self-help techniques, such as engagement in activities and distancing oneself from the situation. Both social support and religiosity were viewed with ambivalence by primary care patients and providers.

Conclusion: The findings suggest that the Arab population in Israel might be lacking informal sources of support at times of mental health needs.

Keywords

Primary care, formal, informal, service use, mental health, depression, anxiety, ethnic minorities, Israeli Arabs

Background

Research has shown that the prevalence of depression among primary care patients is as high as 9.6%, whereas the prevalence of anxiety disorders is almost as high (Serrano-Blanco et al., 2010). As a result of the high prevalence of depression and anxiety in primary care and the fact that primary care providers often serve as gate keepers for patients with depression and anxiety, many evidence-based interventions have been developed over the years in order to manage depression and anxiety in primary care (Katon et al., 2010; Roy-Byrne et al., 2010). Consistently, in Israel, about half of the individuals with mental illness seek services in primary care (Laufer et al., 2013; Lerner & Levinson, 2012). Moreover, officially, by July 2015, mental health treatment will come under the responsibility of the healthcare funds as part of the services offered in primary care (Mizrachi, 2007).

The present study examined alternative mental health help-seeking attitudes among Israeli Arab primary care women and primary care providers. Israeli Arabs constitute about 21% of the population. The majority are Muslim (83%), 9% are Christian and the remaining are Druze (Israel Central Bureau of Statistics, 2013). Despite great differences among these groups, researchers tend to group them together due to limited sample size and certain common characterizes (Levav et al., 2007). Past research has

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shown that compared with Israeli Jews, Israeli Arabs tend to report higher levels of distress and lower levels of self-appraisal of mental health (Levav et al., 2007). Consistently, a study conducted following exposure to terrorism and political violence found that Israeli Arabs are at a greater risk for post-traumatic stress disorder and distress compared to their Jewish Israeli counterparts (Johnson et al., 2009). Similarly, when compared to Jewish Israeli students, Israeli Arab students report lower life satisfaction. One potential explanation for these findings is the fact that Israeli Arabs also report fewer personal resources (Zeidner & Ben-Zur, 2013). A different explanation addresses the minority status of this group that might expose it to stressors due to the Israeli Arab conflict (Johnson et al., 2009; Levav et al., 2007).

Israeli Arab women constitute a unique subgroup potentially exposed to double-jeopardy associated with their status as an ethnic minority group in Israel and women in a patriarchic society (Elnekave & Gross, 2004). Despite transitions toward modernization which tend to improve the status of Israeli Arab women (Baker, 2003; Ibrahim, 1998; Oplatka & Lapidot, 2012), men still hold superior positions as heads of the family and women are expected to accept their authority (Baker, 2003; Elnekave & Gross, 2004; Kulik & Klein, 2010). Consistent with worldwide epidemiological findings, Israeli Arab women report higher levels of depression and anxiety than men (Kaplan et al., 2010). Hence, this is a particularly vulnerable population.

No matter what the reason for the higher levels of mental illness among Israeli Arabs is, one would expect, accordingly, higher levels of mental health service use in this population. Unexpectedly, however, this group underutilizes mental health services (Levav et al., 2007). In a nationally representative study, we found lower levels of psychotropic medication use among Israeli Arab primary care patients compared with Jewish Israeli primary care patients (Ayalon et al., 2011). Others have shown that psychological or psychiatric treatments are also under-utilized in this population (Levav et al., 2007). Among the reasons for underutilization of mental health services in the Arab population are the stigma associated with mental illness (Al-Krenawi & Graham, 2011), the tendency to rely on informal support in the form of one's extended kin, religious beliefs that advocate for the acceptance of misfortunes as part of God's will and the attribution of mental illness to one's sins (Savaya, 1998) and the scarcity of culturally sensitive services (Levav et al., 2007). Arab women, in particular, were more likely to adhere to traditional beliefs concerning the nature of mental illness, rather than to the bio-psychosocial model (Al-Krenawi & Graham, 1999; Bener & Ghuloum, 2011).

Given the discrepancy between the high levels of mental health needs reported by Israeli Arab women and the low levels of mental health service use, there is an urgent need to identify potential alternative sources of support in this population. This study examined attitudes concerning informal help-seeking behaviors (e.g. family, friends or religious figures) in an attempt to better characterize the mental health service use patterns in this population and potentially tailor future services to better meet the needs of this population.

Methods

The study was funded by the Israel National Institute for Health Policy Research and approved by the Institutional review board (Helsinki committee) of the Clalit Health Services. All participants signed an informed consent prior to participating in the study. Inclusion criteria were belonging to one of the following three population groups: veteran Israeli Jews, immigrants from the former Soviet Union and Israeli Arabs. Patients had to be over the age of 20. We recruited both patients who had a diagnosis of mental illness and patients with no diagnosis. Physicians had to work in primary care clinics as family physicians. We recruited physicians who specialized in family medicine and internal medicine. Because of the unique contents brought up in interviews with Israeli Arabs, this article is solely dedicated to this group with an attempt to obtain an in-depth understanding of this particular group. Data for this study concern two focus group interviews with Israeli Arab primary care providers and four focus group interviews with primary care patients. Table 1 summarizes the characteristics of focus group participants.

Primary care patients were recruited through advertisements at the clinic as well as through a direct approach by primary care providers and nurses. Primary care providers were recruited through a direct approach of the study investigators. In selecting participants for this study, we attempted to reach maximum variations in terms of distress level (only relevant for primary care patients) geographic region, religion and age.

Procedure

Focus group methodology encourages informal discussions among group members (Morgan, 1997). This methodology was employed because of our interest in public views concerning depression and anxiety in an attempt to capture socially accepted and unaccepted attitudes held by group members. Some of the theoretical origins of this methodology stem from the theory of symbolic interaction which is concerned with the presentation of the self in everyday lives. According to this theory, individuals represent themselves differently in different social contexts and the interaction between the individual and his or her social realm creates the social reality (Benzies & Allen, 2001). In the present study, we were particularly interested in the intersection between the individual and his or her group of reference. As such, we attempted to keep each focus group

Table 1. Sample characteristics.

	Primary care providers (2 focus groups; 13 physicians)	Primary care patients (4 focus groups; 32 patients)
Gender		
Men	13	
Women		32
Age, Mean (*SD*)	43 (7.7)	53 (7.7)
Geographic region		
North	9	4
Center	4	28
Religion		
Muslim	11	29
Christian	1	3
Druze	1	
Mental health training	5	
Education, Mean (*SD*)		10 (5.2)
Ever told by a physicians that suffers from mental illness		7
Ever took psychotropic medication		4
PHQ-9; range (0–27), Mean (*SD*)		8.7 (5.7)
GAD-7; range (0–21), Mean (*SD*)		6.9 (4.9)

SD: standard deviation; PHQ-9: 9-Item Patient Health Questionnaire; GAD-7: 7-Item Generalized Anxiety Disorder scale.

as homogenous as possible in terms of geographic location, religion and education.

Focus groups with primary care patients were conducted in Arabic by a social work student or a psychologist. Focus groups with primary care providers were conducted by a social worker in Hebrew, as Hebrew is the medical language of these physicians who had to complete their licensure exam in Hebrew, attend trainings provided by the healthcare fund in Hebrew and maintain medical records in Hebrew. All interviewers were trained by the primary author prior to conducting their first interview.

Interviews followed a funnel approach starting from a broad question, asking participants to discuss their thoughts about depression and anxiety, followed by more detailed questions, asking participants to discuss their treatment options for depression and anxiety as well as barriers to and facilitators of mental health treatment. Supplement 1 provides a detailed overview of the interview guide. Focus group interviews lasted between one and one and a half hour. All focus groups were recorded and transcribed verbatim. Focus groups conducted in Arabic were translated verbatim into Hebrew prior to analysis.

Analysis

Open coding, based on themes that emerged from the interview data, was employed by the first author, a clinical psychologist of more than 10 years of experience in qualitative research. Subsequently, constant comparisons were conducted both at the individual, interview-level and across focus group interviews and sources (primary care patients vs. providers) in order to capture broader thematic categories of relevance to participants (Miles, Huberman, & Saldana, 2014). The final stage included selective coding in an attempt to present a coherent story line (Corbin & Strauss, 1990). Only themes that were directly related to the topic of informal mental health help seeking and were addressed by at least 50% of the focus groups within each source (e.g. primary care patients and/or providers) were included. Hence, although additional themes concerning the stigma of mental illness, barriers to mental health service use and perceptions concerning the etiology of depression and anxiety emerged during the interviews, these are not discussed in the present study. The additional study authors (family physicians, a social worker and a nurse; one of them an Israeli Arab), each with more than two decades of experience in primary care, actively participated at this stage of selective coding.

Results

The present study is focused on attitudes toward informal mental health services by Israeli Arab primary care women patients and providers. Three main informal help-seeking behaviors were identified: (a) social support, (b) religious support and (c) self-help. Direct quotes from interviews with both patient and providers are provided in order to support the conclusions reached from the analysis.

Social support

Society as a source of support. Participants tended to make a distinction between extended kin and neighbors on the one side and close friends and nuclear family on the other side:

'There is a big difference between extended kin and nuclear family … if you talk with your sister about your daughter, she (sister) is going to be happy to hear your problems', said a patient. Whereas extended kin and neighbors were almost unanimously viewed as inadequate sources of support at times of emotional distress and even as sources of distress, perceptions concerning the effective support provided by friends and nuclear family were somewhat more positive, though still regarded with caution.

Extended family and neighbors as inadequate sources of support. Both primary care provider and patients were clear that in most cases it was better not to share negative mental health experiences with extended kin. This was attributed to several reasons, including a lack of awareness or acceptance of mental illness, the stigma of mental illness and the bad reputation it brings upon the entire clan as well as gossip, which may intentionally or unintentionally harm the individual with mental illness.

The following statement by a patient demonstrates this clearly:

> R1: But, there are some people who misbehave. Perhaps these people constitute about 10% and 90% are good, the rest aren't. We will skip these 10%, even 20%. About 80% are supportive and relate to you. This is good. R2: most people are not good. It really depends on the environment you live in. Not everyone is good. Not everyone is supportive. Some people stand against you and this just adds to your sorrow.

This was consistent with statements made by primary care providers:

> Society looks at … most often, they refuse to agree or to admit that he (patient) is in a state of anxiety or depression or that something is bothering him mentally. The word mental in general is seen as an insult.

The social environment as a source of mental distress. The social environment was identified as a potential source of substantial distress and agony. Participants attributed the development of mental illness to the multiple negative events that are so prevalent in their social surroundings: 'we all hear and see murder, problems all the time. It creates stress'.

Physicians also referred to the built environment in the Arab sector, as an intensifier of negative emotions:

> if you go to a Jewish town, even a small one, with ten people … you will find in that institute … in that town, entertainment places, many pretty gardens, walking paths that can really relax. Even someone with major depression can go there and get out without medicine. If you go in an Arab village, you just look at the roads and what we've got; you will die even if you are really strong.

Nuclear family and close friends as sources of support that often are inadequate. The picture was somewhat more favorable with regard to the nuclear family and close friends. Some participants freely admitted that they would have consulted a husband, a child or a close friend at times of mental illness. Some even attributed their mental recovery to their loved ones and the important role they played in their lives, 'I have a friend that I see once every 20 years, but I tell her everything and I have another friend that I see more often, but cannot tell her things'.

Physicians too were able to identify family members as a potential resource: 'sometimes you shouldn't reveal mental illness to the family and sometimes you should. It depends'.

Nevertheless, in all focus groups, there were voices that had argued that it was better not to share experiences of mental illness even with loved ones. A common reason for not sharing one's distress was the belief that one's mental illness directly impacts other family members' mental distress: 'I am happy for them (kids), but inside, in my heart, I would cry. I would hide so that they won't notice. So that they can still dance and be happy', said a patient.

Family members and close friends were seen as potential sources of aggravation of mental illness due to conflicting relationships. Negative life events and heightened loneliness as a result of the modernization processes that have taken place in the Arab sector were also offered to explain higher levels of mental illness:

> All the time we lived together, happy, with my kids and my parents in law. Thank God nothing bad happened. All of a sudden, I stayed at home alone. This is hard. I am always afraid that something worse will happen. There is no one who speaks with you,

said a patient.

Consistently, a physician said, 'families are falling apart now. We don't have the families of the past. The family is not as powerful. This is why depression is so big and the crime rate. This is part of becoming modern. Turning "Jewish"'.

Physicians identified family members as an active barrier to mental health treatment due to stigma and lack of awareness: 'The father does not agree to treatment or to sending the daughter over there (psychiatrist) because he might see someone or she might see someone who knows her over there as this is a catastrophe'.

Religious support

Participants made a distinction between inner religious activities and religion mediated through religious figures. Whereas inner religious activities were viewed unanimously by primary care patients as potential sources of support, the attitude toward religious figures was more equivocal, especially among primary care providers: 'as

Maria [pseudonym] said, I pray to God, but do not go to church. I do not belong to a particular church'.

In contrast, primary care providers never mentioned inner religious practices as a source of support, but rather addressed only the potential role of religious figures and only in response to direct queries:

> In our religion (Islam), there is no place to send someone to a religious person. The religious person does not sit in his place giving advice. He comes, gives his pray and goes away. He doesn't sit down in one place and accept people. The Jews have the rabbi; he sits there for these things. The Christians have the priest, he sits. We don't have something like this.

Inner religious activities. Praying to God and reading religious scripts were identified as sources of comfort and support. Faith in God and the belief that things happen according to God's will were proposed as reassuring and comforting thoughts: 'I prayed for her (a woman who suffers depression) that God will help her. Inshalla (thank God)'. Even though these practices were coded under the general theme of religiosity, they could easily fall under the third theme of self-help, as participants regarded religious practices as a solar activity.

Religious figures. Official religious figures in the form of a priest (in the case of Christians) or a Sheikh (in the case of Muslims) were viewed somewhat equivocally by primary care patients. Although in all groups there was at least one voice arguing for their effectiveness and potential benefit, there were many other voices, arguing for their ineffectiveness, portraying them as a barrier, rather than as a mediator between a person with mental illness and God: 'with a psychiatrist you can actually unpack your burden. A religious person will just preach, "you need to pray. Work for God"'

The negative perception of religious figures was particularly apparent in the case of primary care physicians who did not bring up the topic spontaneously and tended to dismiss religious figures as a potential source of help. Accordingly, by the time a patient sought the assistance of a primary care provider, the patient has already sought various religious sources of assistance, who turned up to be to no avail: 'before they arrive, on their first visit, they have already been to a religious figure and got some medicine to get Satan out'.

Self-help

Self-help techniques were mentioned in all focus groups with primary care patients as the single most effective technique. Nevertheless, this technique was most often viewed as synonymous with religious practices as is clearly depicted in the following statement:

> A person has to trust only himself. No neighbor is going to help. No brother is going to help. Only you to yourself. You and God. You are sitting with yourself and thinking. I have to take care of myself because there are people who will glow at my sorrow.

In addition to religious self-help techniques, respondents also mentioned the importance of staying active physically and mentally and the ability to distance oneself from the situation: 'When I am depressed and want to get out of it, I keep myself busy', said a patient. Physicians hardly discussed any of the self-help techniques as a potential source of support.

Other informal sources of support. Self-help groups, herbal medicine, positive thinking and information gathering received only very limited attention in focus group interviews. Hence, these may not reflect common alternatives in this population.

Discussion

The present study evaluated attitudes toward informal mental health help-seeking attitudes among Israeli Arab primary care patients and primary care providers. This study is particularly timely given the high prevalence of mental illness among Israeli Arabs in general and Israeli Arab women in particular (Kaplan et al., 2010), coupled with documented low rates of formal mental health service use in this population (Ayalon et al., 2011; Levav et al., 2007). Previous alternatives discussed in the literature include the family system and religious beliefs and practices (Savaya, 1998). Although these alternatives emerged in the present study as well, their contribution is viewed more ambivalently in the present study.

In interpreting the findings, it is important to take into account the gender divide of our data sources, which limits our interpretation of the findings. Despite our attempts to obtain samples of maximum variations, our samples of providers consist solely of men, whereas all patients interviewed in this study are women. This sampling frame is a true reflection of the Arab society, in which highly educated women who capture prestigious positions are still the exception, and not the norm (Oplatka & Lapidot, 2012). Consistently, Arab women are more likely to report mental illness than men (Kaplan et al., 2010) and are more likely to receive help from male physicians (Gross & Bramley-Grinberg, 2000). Values of masculinity have shown to serve as a barrier for mental health service use (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Potentially, these values which are likely more prevalent in the patriarch Arab society serve as a barrier to discussing issues concerning mental illness by Israeli Arab men in the present study. Although this was not the focus of the present study, the gender divide could serve as a barrier to

mental health service use among Arab women who are most likely to have men physicians as their providers. The fact that providers were younger and more educated than patients in the present study could serve as an additional barrier to service use and explain the more traditional views reported by patients compared with providers.

Past research has largely acknowledged social and intergenerational solidarity as assets to the Arab community in Israel (Khalaila & Litwin, 2011). Nonetheless, this study shows that the extended family, neighbors and society at large are often ineffective in alleviating one's mental illness. This was attributed both to their inadequacy to support individuals with mental health needs as well as to the fact that society at large might even be a cause of one's mental illness, rather than a source of support. Although close family members and friends were viewed somewhat more favorably as potential sources of support, disclosure of personal information about mental illness was seen as having negative emotional ramifications on other family members as well as a potential source of aggravation of mental illness.

Of note is the description of multiple negative life events as potential sources of mental illness. Some of these life events are uniquely related to the lives of the Arab community in Israel, such as the high levels of murder and crime in this community as well as the lack of an adequate infrastructure for leisure time activities and social interactions. For instance, although the Arab population in Israel constitutes about 21% of the population (Israel Central Bureau of Statistics, 2013), one out of three Israelis killed in car accidents is an Arab (Kubovich, 2014). Similarly, the murder rates are significantly higher in this population (Kubovich, 2014), the poverty rate is higher, infant mortality is higher and the average lifespan is lower than that in the Jewish population (Myers-JDC-Brookdale Institute, 2012). These dry statistics are clearly reflected in respondents' accounts as reasons for their mental distress.

Not only was the social structure perceived as an ineffective source of support, but it was also viewed as a source of mental distress due to modernization processes that have taken place in society. Reportedly, social and intergenerational solidarity have deteriorated and are often replaced by loneliness and loss of social values. Past research has found loneliness to be an independent risk for depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006). This empirical finding is supported by respondents' observations of the increasing rates of loneliness along with the increasing rates of mental distress in this population.

Although religiosity and particularly the inner belief in God and the praying to God were identified as effective sources of coping by the women who were interviewed in this study, none of the physicians identified these as potentially helpful practices. This again is an indication of the modernization processes experienced by the Arab society. Most Israeli Arab primary care providers obtained their training in Israel (studying at Jewish universities) or in Europe. Hence, they are well accustomed to more modern notions concerning mental illness and tend to use the bio-psychosocial model to address it. Their attitudes toward religion and secularity might differ from primary care patients. Primary care patients, in contrast, largely hold onto their religious values and may not be as familiar with the bio-psychosocial model (Al-Krenawi & Graham, 1999). This discrepancy could become a barrier to mental health service use for patients who do not see the role of religiosity in the same way as their providers.

Another interesting finding was the distinction between private religiosity and public religiosity through the use of religious mediators. Whereas all primary care patients raved about the important role of private religiosity in their lives, public religiosity was viewed more ambivalently. This too could potentially be a sign of transition from a traditional society to a more modern one, which has to reinvent its coping mechanisms at times of distress.

Finally, similar to worldwide trends concerning self-help activities, primary care patients and to a lesser degree primary care providers mentioned the engagement in activities and the disengagement from stressful life events as potential effective coping mechanisms. Interestingly, primary care patients made a strong connection between self-help mechanisms and religiosity, seeing the two as interconnected or even synonymous.

The present study has several limitations that should be acknowledged. First, as already noted, we ended up interviewing women as primary care patients and men as primary care providers. Although this division reflects the gender distribution of mental health users and providers in this population, it limits the information provided by these groups. Second, the findings are based on a relatively small number of focus groups. The small number of groups does not allow for testing differences across different religious subgroups within the Arab community, but does allow identifying potentially important themes, using an in-depth perspective. Nevertheless, the reliance on two sources of information and the highly diverse samples of primary care patients and providers are strengths of this study. The findings suggest that the Arab population in Israel might be lacking informal sources of support at times of mental health needs. The lack of effective alternative means to cope with mental illness might even put Israeli Arab women at a risk for heightened levels of mental illness. This can be partially explained by the modernization processes that have taken place in this society.

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Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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