

Emotional Distress Among First-Time Patients Attending Outpatient Mental Health Clinics in Israel: An Arab-Jewish Comparative Study

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Abstract: *Background:* Few studies have focused specifically on the role of ethnicity in emotional distress and symptoms among first-time psychiatric outpatients. *Methods:* 251 first-time patients, aged 18-72 years, attending three outpatient mental health clinics in Israel, were surveyed. Three methods of case detection were used: a GHQ-12 score (equal or >3), self-reported symptoms (using a checklist) and a psychiatrist's provisional ICD-10 diagnosis. In addition, self-efficacy and perceived social support were measured using standardized self-report questionnaires. Univariate and multivariate analyses compared the two ethnic groups: Israeli Arabs and Israeli Jews. *Results:* Compared to Jewish patients, Israeli Arab patients had a higher "distress caseness" rate based on GHQ-12 score (70.8% versus 41.2%) and a higher rate of psychiatrist-detected ICD-10 stress-related disorders (46.7% versus 23.3%), but a lower rate of self-reported emotional distress (36% versus 54.3%) and symptoms of mood disturbances (38.7% versus 64.7%). The Israeli Arabs also had lower mean scores on measures of self-efficacy (2.0 versus 2.4) and perceived social support from friends (12.2 versus 17.6) and significant others (16.7 versus 20.0). In a parsimonious regression model, the best predictors of emotional distress had low self-efficacy and social support from significant others, and, being Arab, these variables accounted for 27.1%, 7.2% and 8.8%, respectively, of the total variance in GHQ distress scores. *Conclusion:* The results suggest that the detection of emotional distress and symptoms varies markedly by patients' ethnic background. These variations can be predicted by a lower sense of self-efficacy and social support among Israeli Arabs as compared to Israeli Jews.

Introduction

Only a few psychiatric epidemiological studies in Arab countries and published in English have included measures of psychological distress (1-3). Some of those studies included a calibration of the scale used as a screening instrument in a two-stage diagnostic procedure (3). Other studies used the measures solely as an indicator of psychological distress and a proxy for psychopathology (4, 5).

In Israel two studies on psychological distress have been published on the Arab minority: One on the elderly living in the community (6) and a more recent survey on adults aged 21 and above, which was part of the World Health Survey (7). Both

studies used the 12-GHQ (8) to detect distress. In both studies the scores were considerably higher among Israeli Arabs than among the Jews, even with suitable controls entered into the analysis. However, when an ad hoc measure of suspected psychopathology was introduced, a multivariate analysis found no difference in the scores (6). In contrast, Levav et al. (7) found that Israeli Arabs had higher GHQ-12 mean scores and lower self-assessed mental health when compared to Israeli Jews. Arab subjects declared their intention to seek specialized health care only when high distress scores accompanied their depression and anxiety disorders. The question then arises as to whether questionnaire response

style is responsible for the difference between the two population groups and that the score disparities are not a “true” reflection of mental status.

Two illustrations from two different contexts support the case for studying this issue. In the United States, a study of 98 elderly Muslim immigrants found that the respondents were likely to report their mental health and life satisfaction to be poorer than the interviewers perceived (9). In Al-Ain in the United Arab Emirates, a study reported that the SRQ-based “caseness” was eight times higher than the ICD-10 diagnosis, based on the Composite International Diagnostic Interview (10). This suggests a possible tendency to complain or, alternatively, to agree with questionnaire items, particularly when answers are dichotomized (“yes sayers”) (11).

Israel, a multi-ethnic society with an extensive network of public psychiatric settings (12), provides a suitable context for investigating the relationship between cultural variables attributable to ethnic affiliation and the expression of psychological distress in outpatients. Obviously, most or all of these patients defined their psychopathology as requiring psychiatric care, and most or all had overcome the barriers raised by stigma to seeking the help of a psychiatric clinic. The fact that both population groups (Arabs and Jews) are voluntary outpatients, rather than a heterogeneous sample living in the community, makes them, we are entitled to assume, comparable.

The study reported here is a part of a survey on treatment lag among first-time adult psychiatric outpatients. The study objective was to compare the level of expression of psychological distress between Israeli Arabs and Jews, while controlling for confounding factors, e.g., socio-demographic variables. Clinicians’ diagnoses and self-reported mental health problems were registered as clinical outcome variables and measures of self-efficacy and perceived social support as personal psychosocial resources. The rationale for selecting these variables was as follows: 1) socio-demographic factors, such as gender (13, 14) and education (15, 16), have been shown repeatedly to be associated with emotional distress scores; 2) social support acts as a buffer against the effects of an adverse environment (17–22) while encouraging adaptability (23); 3) self-efficacy is a measure of belief in one’s ability to negotiate stressful situations (24–26).

Methods

Study design

This multi-center, cross-sectional study focused on first-in-lifetime consecutive attendees to psychiatric outpatient clinics during one year. At the pilot stage, the reliability of 20 patients’ self-reports on the onset of their current disorder was tested against the information obtained at intake by a qualified clinician. Other items related to the self administration of the questionnaire in its three languages, Arabic, Hebrew and Russian, were also tested, such as comprehensibility and the time it took to complete. At the second stage, the final version of the self-report questionnaire was administered to a sample consisting of all the consecutive first-time attendees at three mental health outpatient clinics during a 12-month period, December, 2001–November, 2002.

The Clinics. Three psychiatric outpatient settings collaborated in this study. One is located in a general hospital serving an ethnically mixed population (Emek MHC, Afula); the second is an outpatient clinic serving predominantly Arab patients (Mazra MHC, Nazareth); while the third one is the outpatient department of a modern psychiatric hospital that serves mainly Jewish patients (Shalvata MHC, Hod Hasharon). The Institutional Review Board for Human Studies approved the study protocol in each clinic.

The sample. Of a total of 354 apparently first-time attendees, only 251 fulfilled the inclusion criteria: 1) they were seeking help from a psychiatrist for mental health problems for the first time in their life, and 2) they gave written informed consent to their participation in the study. Of the 103 patients not enrolled, 87 were not in fact first-time attendees and 16 refused to be interviewed. The sample was divided by ethnic origin into an Arab ($n=76$) and a Jewish ($n=175$) sub-sample (the latter included seven Russian-born Jewish immigrants) and all comparisons were performed between these two groups.

Procedure. All patients were asked to complete the study questionnaire at an intake session and then return the completed form to their psychiatrist, who then filled in the final page, which contained his provisional psychiatric ICD-10 diagnosis, among other information.

The Questionnaire. The questionnaire consisted of (a) a section on socio-demographic information (gender, age, marital status, years of schooling, employment and religious observance), (b) the GHQ-12 as a measure of emotional distress, and (c) self-reported (rated on a brief checklist) mental or behavioral problems during the previous four weeks (mood disturbances, suicidal thoughts, changes in behavior, emotional distress, phobias, substance abuse, and so on), which were severe enough to seek medical help (patients who confirmed one or more items on the self-report checklist were identified as self-reported cases), and (d) standardized measures of self-efficacy and perceived social support. The time-frame for all measures was the month preceding the survey.

1. *The General Health Questionnaire*, in particular its abridged 12-item version (GHQ-12), has been used extensively world-wide (27), including in Israel and Arab countries (3). It is a valid and reliable measure of current non-specific psychological distress (8, 28). The scale asks whether the respondent has experienced a particular symptom or behavior within the last month. The subjects answer questions, on a 4-point scale, ranging from “much less than usual” (score 0) to “much more than usual” (score 3). In accordance with past research, items scored two or three were regarded as positive and given a score of one. Ratings were summarized across the 12 items to give an individual GHQ score ranging between 0 and 12. Following current practice, an overall score of three or higher was regarded as indicative of a “case” of emotional distress (29, 30).
2. *The General Self-Efficacy Scale* (GSES) measures belief in one’s ability to cope with stressful situations (24). The scale consists of 10 items (e.g., “Usually I am able to control a situation” or “In unexpected situations, I always know how I must behave myself”). Responses are rated on a 4-point Likert-scale ranging from “absolutely not true” (weighted as 1) to “absolutely true” (weighted as 4), where the higher GSES total scores indicate stronger confidence in self-efficacy. Good internal reliability consistency ($\alpha=.92$) and test-retest reliability over six months have been reported (31, 32). This scale

has been applied to physicians and nurses in primary care in Israel (33, 34) as well as to psychiatric inpatients (35).

3. *The Multidimensional Scale of Perceived Social Support* (MSPSS) (36) is a self-report instrument for assessment of emotional help and the level of satisfaction with social support obtained from three sources — family, friends and significant others. The scale comprises 12 items, which refer to people to whom the respondent would turn if he/she had problems in the past month of a personal, health or family nature, as well as financial and employment problems (e.g., “I get the emotional help and support I need from my family” or “I have friends with whom I can share my joys and sorrows,” or “There is a special person who is around when I am in need”). Responses are scored on a 7-point scale from 1 (“completely disagree”) to 7 (“completely agree”). An MSPSS index and three subscales — family, friends and significant others — are computed. MSPSS total scores range from 12 to 84, the higher score indicating greater satisfaction with overall support. The scale has been used among Israeli Arab and Jewish students and found reliable, Cronbach’s $\alpha = 0.94$ (37).

For the entire sample, internal reliability as measured by Cronbach’s α coefficient was consistently very satisfactory: GHQ-12, 0.85 (0.81 for Arabs and 0.85 for Jews); GSES, 0.92 (0.93 for Arabs and 0.91 for Jews); and for the different MSPSS subscales, 0.83–0.92 (0.86 for Arabs and 0.92 for Jews).

Data analysis

Univariate and multivariate analyses were performed to examine the emotional distress experienced by the two ethnic groups. Chi-square statistics were employed to test the significance of differences in proportions. Two-tailed t -tests and Mann-Whitney two sample (non-matched) tests were used to define the significance of differences in means and standard deviations (SD) for normally and non-parametrically distributed scores, respectively. Multiple regression analyses were made, with GHQ-12 mean score as the dependent variable and ethnic affiliation (Arabs/Jews) as the variable under test. We

controlled for potential confounders, which showed significant between-group differences at a $p < 0.05$ level in a univariate analysis. The confounders included gender, years of education, marital status (married/unmarried), religious observance (religious/secular), ICD-10 diagnostic category (stress-related/other disorders), self-efficacy, and perceived

total social support from family, friends, and significant others. Backward stepwise selection was performed on each model, removing variables with $p > 0.05$ in order to find the most parsimonious model for the prediction of psychological distress. All statistical analyses were performed using the SPSS-12.0 software package.

Table 1. Arab and Jewish Patients by Socio-Demographic Characteristics

Characteristic		Arabs (N=75)	Jews (N=176)	Significance test
Gender, n (%)	Male	45 (60.0)	101 (57.4)	$\chi^2=7.09$, $df=1$, $p < 0.01$
	Female	30 (40.0)	75 (42.6)	
Age, yrs., mean \pm SD, Range		35.8 \pm 11.1 18-72	37.3 \pm 13.3 18-70	$t_{1,251}=0.64$, $p=0.52$
Schooling, yrs., mean \pm SD Range		9.5 \pm 2.2 4-16	12.3 \pm 2.5 5-18	$t_{1,241}=8.08$ $p < 0.001$
Marital status, n (%)	Single/divorced/widowed	26 (37.1)	100 (57.1)	$\chi^2=8.01$, $df=1$, $p < 0.005$
	Married	44 (62.9)	75 (42.9)	
Employment, n (%)	Full-time	5 (6.7)	59 (33.7)	$\chi^2=56.94$, $df=3$, $p < 0.001$
	Part-time	10 (13.3)	34 (19.4)	
	Unemployed	42 (56.0)	49 (28.0)	
	Other (student, housewife, etc.)	18 (24.0)	33 (18.9)	
Religious observance	Religious	71 (94.7)	60 (34.1)	$\chi^2=80.65$, $df=1$, $p < 0.001$
	Secular	4 (5.3)	116 (65.9)	

Table 2. Arab and Jewish Patients by Clinicians' Diagnoses, Patients' Self-Reported Mental Health Problems, and Distress Scores

	Arabs (n=75)			Jews (n=176)			z-value [†]	t-value [‡]
	N	%	GHQ Mean \pm SD	N	%	GHQ Mean \pm SD		
Clinical diagnoses (ICD-10)								
Organic & substance use disorders	7	9.3	3.6 \pm 0.5	3	1.7	3.7 \pm 0.1	2.83**	0.46
Schizophrenia	4	5.3	3.7 \pm 0.8	4	2.3	3.2 \pm 1.4	1.26	0.69
Mood disorders	2	2.7	3.0 \pm 0.8	20	11.4	3.1 \pm 0.4	2.23*	0.46
Stress-related disorders	35	46.7	3.4 \pm 0.7	41	23.3	2.8 \pm 0.7	3.69***	4.13***
Personality disorders	11	14.7	3.8 \pm 0.5	11	6.3	2.7 \pm 0.8	2.16*	3.81***
Diagnosis pending	16	21.3	3.3 \pm 0.7	97	55.1	3.0 \pm 0.8	4.92***	1.19
Self-reported problems [#]								
	N=75			N=173				
Alcohol abuse	4	5.4	3.7 \pm 0.7	19	11.1	3.5 \pm 0.8	1.41	0.51
Mood disturbances	29	38.7	3.6 \pm 0.5	112	64.7	3.1 \pm 0.7	3.81***	3.60***
Suicide ideation	38	50.7	3.4 \pm 0.6	70	40.5	3.3 \pm 0.7	1.49	1.31
Behavior problems	32	42.7	3.7 \pm 0.6	56	32.4	3.3 \pm 0.6	1.56	2.46*
Emotional distress	27	36.0	3.4 \pm 0.5	94	54.3	3.1 \pm 0.7	2.65**	1.96*
Phobias	25	33.3	3.5 \pm 0.7	63	36.6	3.2 \pm 0.7	0.47	2.00*

[#] More than one problem could be reported. [†] Mann-Whitney two sample (non-matched) test: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

[‡] Two-tailed t-test: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Results

Characteristics of the groups. Table 1 shows that the two ethnic groups differed substantially in most sociodemographic characteristics studied. The Arab group was more male ($\chi^2=7.09$, $df=1$, $p<0.01$), less educated ($\chi^2=59.17$, $df=3$, $p<0.001$), more unemployed ($\chi^2=56.94$, $df=3$, $p<0.001$) and more religious ($\chi^2=80.65$, $df=1$, $p<0.001$). The groups were similar on average age ($t=0.64$, $p=0.52$). There were statistically significantly more single/divorced/widowed subjects in the Jewish group, and more married subjects in the Arab group ($\chi^2=8.01$, $df=1$, $p<0.005$).

GHQ-12 emotional distress detection. Overall, Arabs scored significantly higher than Jews on the GHQ-12 (3.5 ± 0.6 vs. 3.0 ± 0.7 ; $t=5.17$, $p<0.001$). This was also the case when the GHQ-12 individual items were analyzed: on 9 of the 12 GHQ-12 items Arabs scored higher than Jews. Using a mean GHQ-12 score of 3 as cut-off point to distinguish cases of distress (3 and higher) from non-cases, we found 70.8% cases of distress in the Arab group versus 41.2% in the Jewish group (Man-Whitney two sample (non-matched) tests: z -value=4.32, $p<0.0001$).

Psychiatrist's Diagnosis. Table 2 presents the clinicians' ICD-10-based diagnoses and patient's self-reported problems (complaints) and their relation to GHQ-12 distress scores. The clinicians' intake diagnoses were available for 78.7% Arab and for 44.9% Jewish subjects. According to the psychiatrists' diagnoses, stress-related disorders was the most frequent ICD-10 diagnostic category in both groups (Arabs: 46.7%, Jews: 23.3%), while the least frequent categories were mood disorders among the Arab patients (1.7%), and organic/substance use disorders among the Jews (3.8%).

Compared to Jewish patients, Israeli-Arab patients had a higher rate of psychiatrist-detected ICD-10 stress-related disorders (46.7% versus 23.3%), of organic/substance use disorders (9.3% versus 1.7%) and of personality disorders (14.7% versus 6.3%), but a lower rate of mood disorders (2.7% versus 11.4%; $\chi^2=20.26$, $df=4$, $p<0.01$). No significant difference in the detection rate for schizophrenia was found (2.3% versus 5.3%).

Patients from both groups who were clinically diagnosed with organic/substance use disorders,

schizophrenia and mood disorders did not differ on their mean GHQ-12 distress scores. Arabs with diagnoses of stress-related and, in particular, personality disorders, scored significantly higher distress scores than their Jewish counterparts (3.4 ± 0.7 versus 2.8 ± 0.7 , $t=4.13$ and 3.8 ± 0.5 versus 2.7 ± 0.8 , $t=3.81$, both $p<0.001$, respectively).

Self-Reported Problems (complaints). According to the self-report checklist of complaints, the most frequent problems for these applicants for outpatient care were mood disturbances for the Jews and suicidal ideation for the Arabs (64.7% and 50%, respectively), while the least reported problem was alcohol abuse for both groups (11.1% and 5.4%, respectively). The groups did not significantly differ in their self-reported rates of alcohol/drug use, behavioral problems or suicidal ideation. There were significant differences with regard to mood disturbances and experienced emotional distress, which were higher among Jews than among Arabs (64.7% versus 38.7%; $z=3.79$, $p<0.001$, and 54.3% versus 36%, $z=4.15$, $p<0.001$, respectively).

Although the Jews reported mood disturbances and emotional distress more frequently than the Arabs did, Arabs reporting these conditions scored higher on the GHQ-12 than their Jewish counterparts (3.6 ± 0.5 versus 3.1 ± 0.7 , $t=3.60$, $p<0.001$ and 3.4 ± 0.5 versus 3.1 ± 0.7 , $t=1.96$, $p<0.05$).

Other Psychosocial Measures. Table 3 shows that Jewish subjects scored higher than Arabs with regard to feelings of self-efficacy ($t=3.89$, $p<0.001$), the total level of perceived social support ($t=3.74$, $p<0.001$), support from friends ($t=4.76$, $p<0.001$) and from significant others ($t=3.04$, $p<0.01$). No between-group differences were found in perceived family support ($t=1.62$, $p>0.10$).

Predictors of Psychological Distress. Table 4 presents a summary of the multiple regression analysis used here to examine the relationship between emotional distress, as summarized by the GHQ-12 mean score (the dependent variable), and ethnic affiliation (Arabs/Jews), while controlling for other independent variables. In a reduced version of the initial model, which included eight independent variables (ethnic group, gender, years of education, marital status, religious observance, ICD-10 diagnostic

Table 3. Arab and Jewish Outpatients by Self-Efficacy and Perceived Social Support from Family, Friends, and Significant Others (means±SD scores)

Measure	N	Arabs	N	Jews	t-test (df) ^a
GSES ^b	68	2.0±0.6	153	2.4±0.7	t (1,219)=3.89***
MSPSS, ^c total score	64	46.4±20.3	149	57.4±18.4	t (1,211)=3.74***
Family support	72	18.0±7.8	165	19.8±7.5	t (1,235)=1.62
Friends support	68	12.2±7.9	159	17.6±7.7	t (1,225)=4.76***
Significant others support	68	16.7±7.7	155	20.0±6.9	t (1,221)=3.04**

^a Two-tailed t-tests: * p<.05; ** p<.01; *** p<.001 ^b General Self-Efficacy Scale ^c Multidimensional Scale of Perceived Social Support

Table 4. Parsimonious Model for Predicting GHQ Distress Scores from Demographic, Clinical and Psychosocial Variables

Independent variables		Standardized estimation (β)	t-value (β=0)	Probability level	Total % Variance accounted for
Predictor variables	Self-efficacy	-.458	8.47	.001	27.1
	Ethnic group (Arab/Jewish)	.233	3.56	.001	8.8
	Social support (total score)	-.136	2.50	.013	7.2
	Religious observance (religious/secular)	-.128	2.03	.044	0.7
Variables removed	Education (years)	.002	.039	.969	-
	Diagnosis (stress-related/other)	.042	.790	.430	-
	Marital status (married/unmarried)	.050	.923	.357	-
	Gender	-.087	-1.628	.105	-

R²=0.33; Adjusted R²=0.32; F_{4,251}=30.83, p<0.0001

category, self-efficacy, and social support aggregated from family, friends, and significant others), only four variables were associated with a higher likelihood of psychological distress. Of these four, three — low sense of self-efficacy, ethnicity (being Arab), and insufficient social support — accounted for 27.1%, 8.8%, and 7.2% of the total variance in the GHQ-12 distress scores (R²=0.33; Adjusted R²=0.32; F_{4,251}=30.83, p<0.0001). Although significant, the contribution of religious observance (religious/secular) to this model was negligible (0.7% of the variance).

Discussion

This study reported here showed that, compared to their Israeli-Jewish counterparts, Israeli-Arabs, seeking help for the first time in their lives for mental health problems from psychiatric outpatient clinics, had significantly higher emotional distress as measured by the GHQ-12 scores and a higher rate of psychiatrist-detected ICD-10 stress-related disorders. However, they reported a lower rate of emotional

distress and symptoms of mood disturbances as a reason for seeking healthcare. Moreover, they apparently have significantly less psychosocial resources to cope with stress, such as feelings of self-efficacy and social support from friends and significant others. The multiple regression analysis confirmed the association of emotional distress with ethnic affiliation (being Arab) and low feelings of self-efficacy and total social support.

For both groups, Jews and Arabs, the rate of detection by the GHQ-12 was higher than for the other two detection methods used. However, there were significant cultural differences in the detection of distress by the patients themselves and by their psychiatrists. The GHQ-12 detection rate was in agreement with the psychiatrists' diagnoses, but not with patients' identification of emotional distress and disturbance. These results suggest a significant difference between the ethnic groups according to which of the three methods of case detection is used. Israeli Arabs seem to be prone to complain less than Jews of emotional distress, which, however, both psychiatrist and GHQ-12 detect. This clear discrepancy may

be explained by culturally shared health beliefs, whereby in Arab culture emotional symptoms (fears, worries, low spirits) are attributed to weakness of personality or weakness of religious faith (38). Depressed people can readily accept and internalize this notion and so not self-report emotional problems.

How to interpret these findings?

One possible explanation is that Israeli Arabs, who are usually more distant from services, may need to be feeling higher distress than Jews before they will seek psychiatric care. Another explanation is that minority status and associated lower socioeconomic status may be responsible for the higher levels of distress found among Arab applicants, independent of their help-seeking attitudes and behavior. Another factor making application more likely to the formal service system, in particular long-term care services, is the change in the availability and capacity of the Arab informal support system to address these increasing needs (39).

Specific health belief systems may also influence the way patients interact with a psychiatrist. Culture makes the Arab patient-doctor relationship triangular rather than diadically-linear, as there is three-way communication between patient doctor and family(OK) Although some degree of personal independence is allowed, interpersonal concern, interdependence and minimal "social distances" are the norm in Arab families. For example, the doctor is not expected to encourage adolescents to achieve full, Western-type independence from their parents. Not only is this culturally undesirable, but there are also no socio-economic provisions for adolescents to live away from their families. Arab doctors encourage this interdependent group ego. The Arab family runs the affairs of its healthy and unhealthy members alike. The decision to seek the help of professionals or traditional healers is one made by the family (38).

The psychosocial resources scores (self-efficacy and social support) confirm that the finding of higher emotional distress among Arabs compared to Jews is not an artifact. Stress theory suggests that social and emotional support may serve as a major resource for coping with stressful situations (40). Members of minority groups may suffer not only from the distress inherent in their status, but also

from alienation and lack of social support (41). Although the Arab population in Israel is currently undergoing a modernization process, it is still dominated by traditional values and ideology. Israeli Arabs generally maintain their separateness by exhibiting low motivation towards integration into Israeli society, even in academic settings (42). Traditional networks of social support do not provide a sufficient buffer against distress (43). These findings are in line with other recent studies on how minority groups deal with the negative effects of stress (44). Arab students, for example, turn to partners and best friends as the primary sources of social support in emotionally stressful situations, rather than to members of the family of origin. In this way partners and friends help bridge the gap between tradition and modernization. Reflecting this situation, our findings show that the Arab attendees who seek help from formal psychiatric services report insufficient social support from friends and significant others, while reporting a level of social support from family no different from that of the Jewish patients.

Reverse causality, namely the likelihood that a low perception of social support results from current psychopathology, cannot be ruled out. However, this seems unlikely because a diagnosis of stress-related disorder was removed from the regression model as non-statistically significant, whereas low social support was found to be a markedly significant predictor of distress.

Clinical implications

The presented data may help in identifying difficulties to detection of common symptoms of anxiety and depression comprising emotional distress among members of the ethnic minority first attending mental health clinics in Israel. The clinical implication of the findings of this study is that it may be possible to improve psychiatrist detection of emotional distress and mood disturbances among Arab patients by the physician relying on GHQ-12 scores rather than on the patient's complaints or subjective sense of health.

Study Limitations

First, as a matter of convenience the Israeli-Jewish group included several Russian-born Jewish immi-

grants, who might differ from Israel-born Jews with regards to psychopathology and psychosocial resources. Second, the methodology did not allow psychiatrists not to know their patient's responses to the GHQ-12, although it was believed that they have made their diagnosis independently. The psychiatrist reading the patient section of the questionnaire would have had the effect increasing, not decreasing, the agreement between patient self-report and psychiatrist detection. Third, there was no "gold standard" such as the Composite International Diagnostic Interview (45) to confirm the diagnoses. Likewise, the GHQ-12 and self-report items were based on Western conceptualizations of emotional distress. Finally, although we did not test diagnostic agreement between the Israeli Jewish and Arab clinicians who participated in the study, we suggest that there is satisfactory concordance between diagnoses made by them, as they are all products of the Israeli medical training system (46).

Conclusions

The results of this study suggest that the ethnic background of patients brings about substantial variation in the rates of detection of emotional distress and symptoms. This variation can be predicted by lower senses of self-efficacy and social support among Israeli Arabs as compared to Israeli Jews.

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