

Psychological Factors Associated with Emotional Distress among Palestinian Arabs from East Jerusalem Accessing Psychiatric Care in Israel

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ABSTRACT

Background: The Palestinian population residing in East Jerusalem is characterized by high rates of poverty and unemployment and is subject to discrimination in various forms, including infrastructure of mental health services. Little is known about the help seeking needs and practices of East Jerusalem residents.

Method: We examined socio-demographic and clinical characteristics of a consecutive sample Palestinian residents from East Jerusalem (N=50) who accessed a specially assigned psychiatric clinic in Israel. In addition, we examined the psychological factors associated with emotional distress among these service-users upon entry to care. Participants completed a survey in Arabic that included a socio-demographic questionnaire and measures assessing emotional distress, perceived exposure to discrimination and social support, and mental health stigma.

Results: Participants reported high levels of emotional distress. Female gender, low socioeconomic status, higher perceived exposure to discrimination and higher perceived social support were associated with increased emotional distress.

Conclusions: Findings add to the scarce body of knowledge on specific mental health characteristics of East Jerusalem Palestinian residents.

INTRODUCTION

Mental health disparities are defined as unequal health status and service utilization usually favoring members of advantaged over disadvantaged groups in society. Social advantage or disadvantage refers to the relatively favorable or unfavorable social, economic or political conditions that some groups systematically experience based on their relative position in social hierarchies (1-4). Studies in many Western countries have documented differences in mental health between advantaged and disadvantaged ethnic groups (2, 5, 6). For example, studies showed higher rates of depression and emotional distress, and lower rates of mental health service utilization among Arab-Israelis than among their Jewish counterparts. Those findings, at least in part, have been imputed to social causation factors, e.g., adversity and stress (7, 8), arising from the disadvantaged social status of the Arab minority (9, 10).

Other studies have documented ethnic differences in mental health care and service utilization (11, 12). In Israel, for instance, a larger proportion of Arab-Israelis remain untreated for mental health problems as compared with Jewish-Israelis. Experiences of group-based discrimination, arising from lower social status and intergroup conflict, may translate into cultural mistrust toward the medical establishment and thus operate as a barrier to access care for people with mental health problems (13). Additional barriers to seeking care include structural factors, e.g., financial considerations (cost of treatment), and limited availability and accessibility of linguistically and culturally appropriate care (11, 14, 15). Service-user-based factors have also been identified as a source for barriers to seek

care and include negative attitudes toward mental health treatment (16-20). Despite the importance of the topic, little is known about the mental health needs and service utilization of Palestinian Arab residents of East Jerusalem.

THE CASE OF PALESTINIAN RESIDENTS IN EAST JERUSALEM

Following the 1967 war, Israel annexed approximately 70 sq. km. (known as neighborhoods of East Jerusalem) to the municipal boundaries of West Jerusalem. At the end of 2014, Jerusalem's population (including the Eastern and Western parts) was comprised of 815,310 residents: 515,160 of them Jews and others (63%), and 300,200 Palestinians (37%). East Jerusalem, at the time, was populated by 293,000 Arab residents, most of whom were Muslims (21). Palestinians in East Jerusalem, unlike Palestinian Arabs living in other parts of Israel, hold resident status. A majority of this population identifies with the Palestinian Authority and considers itself part of the Palestinian society (22). Their legal status is ambiguous: As permanent residents they have the right to vote in municipal elections (though they largely abstain), but are not entitled to participate in the general elections to the Knesset (Israeli Parliament). They are permitted to live and work in Israel, without the necessity of special permits, and alongside civil obligations such as payment of city taxes, they are entitled to social benefits, including health care under the Israeli National Insurance Law (23).

The Palestinian population residing in East Jerusalem is characterized by higher rates of poverty and unemployment compared to their Jewish counterparts who live in the Western part of the city. In 2013, approximately 75% of all East Jerusalem residents were living below the poverty line, as compared with approximately 22% of all residents in Israel (21). They suffer discrimination in various forms, including lower expenditure of public funds for educational, health, and social services (24). Approximately half of East Jerusalem Arab students, compared to 7% of the Jewish students in Jerusalem, do not complete high school. Among residents of East Jerusalem, 34% completed elementary school, 32% graduated high school, 11% completed some college, and 23% had a college degree (21). Arab residents of East Jerusalem also suffer from limited access to economic resources and lower sanitary conditions (22, 25).

Studies have also documented higher rates of exposure to community and political violence among Palestinian youth compared with the rates found among youth from other countries in the world (26). Ongoing community and political violence are associated with higher levels of posttraumatic stress disorder (PTSD) (27, 28) and depres-

sion (28, 29). An epidemiological study conducted among a stratified multi-stage cluster random sample of Palestinians residing in East Jerusalem documented relatively high prevalence rates of PTSD (men, 16.1%; women, 19.7 %). The rates of major depression among residents of East Jerusalem were 16.1 % for men and 27.6 % for women (30). Exposure to community and political violence were significantly associated with increased risk to develop mental health problems among Palestinians in this region (30). In addition, socio-demographic characteristics such as older age, lower socioeconomic status, female gender and loss of interpersonal support were related to higher reports of emotional distress (30, 31).

Little is known about the mental health service utilization of East Jerusalem residents. According to Physicians for Human Rights organization, about 10,000 children live in East Jerusalem without health insurance (32). State mental health services designated to provide services to the Arab sector in Jerusalem, as of 2014, consisted of three mental health clinics: two, for minors and adults, that have been active since 2012, and one for adults only that has been active since 1988 (32). The staff in all three clinics is multidisciplinary and include five psychiatrists (including residents), two licensed psychologists and five school psychology interns, and four social workers. The number of Arabic speaking providers is variable though it is indicated that a majority are native Arabic speakers (32). During the year 2013, 490 minors and 961 adults sought services in these clinics (32). Data on the number of private practitioners providing services to the population in East Jerusalem, as well as their training is missing.

Studies of Arab populations in the Middle East, including Israel, have found low levels of willingness to seek formal help (33). As part of the collectivist values that characterize the Arab community in East Jerusalem, family members are commonly perceived as the main source of help to cope with mental health concerns. The success or failure of a family member effects the entire extended family (34, 35). In a study among Palestinian adolescents, almost half of the adolescents sought informal help (from family members, friends and religious leaders, etc.) following exposure to community violence, while only 1.9% of the youth sought only formal help (36).

In this study, we examined the socio-demographic characteristics of a consecutive sample of adult service users seeking mental health care in a psychiatric clinic in Jerusalem, as well as the socio-demographic and psychological factors associated with emotional distress among members of this population.

METHOD

PARTICIPANTS AND SETTING

A consecutive sample of $N=50$ adult service users who are residents of East Jerusalem and presented for a first-ever or a renewed episode of care in a psychiatric clinic between November 2014 and June 2015 participated in the study. During this time period $N=88$ patients contacted the clinic for new episode of care (response rate 56%; most prevalent reasons for declining to participate were fear of being exposed, concerns about confidentiality, and lack of time to complete the measures). Access to care did not necessitate medical referral and is provided at no cost under the Israel National Health Insurance Law. The participating clinic is located in a psychiatric hospital in the western side of Jerusalem.

PROCEDURE

All patients who presented for a new episode of care in the clinic during the time of the study were invited to participate by the treating psychiatrist. Informed consent was obtained from all patients who agreed to participate. Participants completed a set of questionnaires in Arabic upon accessing care. These were handed out by the administrative personnel. Assigned clinic personnel, who was a native Arabic speaker also read the questions to service users who were not literate ($n=2$, 4%) or were not able to read the survey due to vision problems ($n=4$, 8%). The study was approved by the Institutional Ethics Committee of the Jerusalem Mental Health Center, and data collection was in compliance with human subject protocol.

MEASURES

Socio-demographic and clinical history questionnaire.

It included socio-demographic information: age, gender, education, income (below average, average, above average of national mean income); perceived socio-economic status (rated on a scale ranging from 1-worst status to 10- best status); employment status (employed/unemployed); country of birth, marital status, religion and degree of religiosity (secular, traditional, religious); and social security financial support. In addition, it included questions about emotional problems and help seeking practices in the past. Participants were also asked about how they arrived at the clinic, how long it took them and if they had difficulty finding the clinic.

The General Health Questionnaire (GHQ-12) (37). This 12-item scale is a well-documented screening measure for common psychiatric disorders and assesses

symptoms in the last month. It has been subject of tests in many countries (38), including a study conducted also among Arabs in Israel (39). The 12 items are rated on a 4-point Likert scale. The final score was computed as the sum of all items, with higher scores indicating higher emotional distress. The overall internal consistency for the scale in this study was good (Cronbach's $\alpha = .88$).

Mental health care stigma (40). This 9-item scale is a modified version of the "Orientations to Seeking Professional Help Scale" (41), which is commonly used to assess respondents' attitudes toward mental health services. The specific items used were selected from a study conducted in Israel that included Arab respondents aimed at assessing attitudes and barriers toward seeking help (40, 42). Items included statements about explicit willingness to seek mental health treatment (e.g., "I will feel uncomfortable going to mental health treatment because of what people will think of me"), attitudes toward mental health treatment (e.g., "I would prefer to turn to a friend than to mental health treatment, even for an emotional problem"); and perception of the benefits of mental health treatment (e.g., "someone who has a healthy logic does not need mental health treatment"). Participants were asked to rate the degree to which they thought that the statement is true on a 5-point scale, ranging from not true at all (1) to very true (5). Final score was the sum score for all items with higher scores indicating higher negative attitudes toward seeking care. The internal consistency of the scale in this study was good (Cronbach's $\alpha = .77$).

Social distance from mental illness (40). This 8-item scale is an adaptation of the Social Distance Scale (43). The specific items employed were selected from a study conducted in Israel that included Arab respondents aimed at assessing stigma toward mental health (38). Items included statements about explicit willingness to have different levels of contact with persons with mental illness (i.e., sitting next to the person in a bus, neighbor, employment, friendship, and driving your children to school). Service users were asked to rate the degree to which they are willing to have contact on a 5-point scale, ranging from definitely willing (1) to definitely unwilling (5). The final score was computed as the mean of all items with higher scores representing greater desire to distance oneself from persons with mental illness. The internal consistency of the scale in this study was good (Cronbach's $\alpha = .93$).

Everyday Discrimination Scale (44). This 9-item self-report measure assesses the frequency of experiences of routine, minor acts of discrimination (e.g., "You are treated with less respect than other people," "You are

called names or insulted”). Participants were asked to rate their experiences on a 5-point scale, ranging from never (1) to almost every day (5). Final score included mean score for all items with a higher score indicating higher perceived exposure to discrimination. The internal consistency of the scale in this study was good (Cronbach’s $\alpha = .82$).

Multidimensional Scale of Perceived Social Support questionnaire (MSPSS) (45). This 12-item self-report measure describes three different subscales of social support, each consisting of four items: Family Support: e.g., “My family really tries to help me”; Friend Support: e.g., “I have friends with whom I can share my joys and sorrows”; and Significant Other Support: e.g., “There is a special person who is around when I am in need.” Respondents use a 7-point Likert-type scale (1 - very strongly disagree to 7 - very strongly agree) with each item. In this study we used a total score for social support calculated as mean score for all items, with higher scores indicated higher level of perceived social support. The internal consistency of the scale in this study was good (Cronbach’s $\alpha = .90$).

STATISTICAL ANALYSIS

Analyses were performed using the SPSS version 20.0 (SPSS Inc., Chicago, IL). Hierarchical linear regression was computed to examine the contribution of psychological factors, above the effects of socio-demographic variables on emotional distress. Emotional distress was entered as the dependent variable, while independent variables included socio-demographic variables (gender, age, years of education and perceived socioeconomic status) in the first block, and perceived social support, perceived exposure to discrimination, social distance from persons with mental illness and mental health care stigma in the second block.

RESULTS

SOCIO-DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF THE SAMPLE

Slightly over half of the sample were males ($n=28$, 56%) and half reported being married ($n=26$, 52%). Participants’ ages ranged from 19 to 59, with an average of 35.6 years old ($SD=11.0$). The majority of service users who participated in the study were Muslims ($n=47$, 94%) the remaining three were Christians. With regard to religiosity, 60% of the sample reported being traditional, 36% were religious and 4% were secular. Participants

reported an average of 10.6 years of education ($SD=3.5$), and average of 4.2 on the socioeconomic status scale that ranges between 0-10 ($SD=1.7$). Seventy-four percent of the sample were unemployed ($n=47$; $n=12$, 24% searching for a job; $n=14$, 28% not working and not searching for a job; $n=11$, 22% housewives), the remaining reported working full time ($n=7$, 14%) or part-time ($n=6$, 12%). The majority of the sample reported below average income ($n=41$, 82%), 16% reported average income ($n=8$), and only one participant reported above average income. Almost half of the sample reported receiving social security financial aid ($n=23$, 46%).

Eighty percent ($n=40$) of participants reported previously seeking help due to emotional distress. Half of the sample reported seeking help from family, friends or neighbors ($n=25$), 20% reported seeking help from professional mental health services (psychologists and psychiatrists, $n=10$), and 18% reported seeking help from their general medical doctor ($n=9$). The majority of participants were returning service users ($n=37$, 74%) and 62% of participants reported currently using psychotropic medications ($n=31$). Participants reported diverse emotional problems that prompted them to seek care, including: sleeping problems ($n=28$, 56%), mood problems ($n=27$, 54%), bad thoughts ($n=26$, 52%), stress ($n=26$, 52%), fears ($n=23$, 46%), anger ($n=18$, 36%), behavioral change ($n=16$, 32%), and drinking problems ($n=1$, 2%).

Approximately half of participants reported arriving to the clinic by public transportation ($n=27$, 54%), 20% by private car ($n=10$), 14% walked to the clinic ($n=7$) and 12% arrived by taxi ($n=6$). Time to arrive to the clinic ranged from 10 to 120 minutes, with an average of 48 minutes ($SD=24.0$). Most of the participants reported having no trouble finding the clinic ($n=41$, 82%).

Participants reported higher levels of emotional distress ($Mean= 30.6$ $SD=7.7$) relative to a community representative sample of Arabs in Israel (10). Mean scores on the measures assessing perceived social support ($M= 3.3$ $SD=1.3$); perceived exposure to discrimination ($M= 2.1$ $SD=0.9$); mental health care stigma ($M= 2.8$ $SD=0.8$) and social distance from persons with mental illness ($M= 2.7$ $SD=1.1$) were in the mid-range of the scales.

THE ASSOCIATION BETWEEN PERCEIVED SOCIAL SUPPORT, PERCEIVED DISCRIMINATION, SOCIAL DISTANCE, CARE STIGMA AND EMOTIONAL DISTRESS

Hierarchical linear regression analysis using emotional distress as the outcome measure, and gender, age, years of education, socioeconomic status, perceived social

support, perceived discrimination, social distance from persons with mental illness and mental health care stigma as predictors was significant, predicting 53.4% of the variance (see Table 1). Perceived exposure to discrimination was significantly related to service users' report of emotional distress, such that higher reports of perception of discrimination were associated with higher reports of emotional distress (*partial r* = .34, *p* <.05). Additionally, perceived social support was significantly related to service users' reports of emotional distress, such that higher perceived social support was associated with higher reports of emotional distress (*partial r* = .41, *p* <.01). Social distance from persons with mental illness and mental health care stigma were not significantly associated with emotional distress. Of the demographic characteristics, females reported higher emotional distress than males (*partial r* = .32, *p* <.05), and socioeconomic status was negatively associated with emotional distress (*partial r* = -.33, *p* <.05).

Table 1. Hierarchical Multiple Regression Analysis Examining Socio-Demographic and Clinical Predictors of Emotional Distress among Service Users (N=50)

Model	B	SE B	β	Partial r
Block 1				
(Constant)	31.12	7.19		
Gender ¹	4.66	2.04	.30*	.32
Age	.03	.11	.05	.05
Years of education	-.17	.32	-.08	-.08
Socioeconomic status	-1.54	.67	-.35*	-.33
Block 2				
Perceived social support	2.44	.86	.41**	.41
Perceived exposure to discrimination	2.42	1.05	.29*	.34
Mental health care stigma	.87	1.32	.09	.10
Social distance from persons with mental illness	-.13	.87	-.02	-.02

Note. R² = .10, F(7,228) = 3.59**.

*p < .05. **p < .01.

¹male=1, female=2.

DISCUSSION

In this study we examined psychological factors associated with emotional distress among Palestinian residents from East Jerusalem who sought mental health care in a community mental health clinic in Israel. Service users reported high levels of emotional distress at entry to care. These rates were similar to those reported among a comparable sample of Jewish service users at community mental health clinics in Israel (12). Similar to other studies we found that female gender and lower socioeconomic status were associated with increased emotional distress

(30, 31). This association can be understood in the context of the social determinants of health and the role of social factors characterizing disadvantaged groups (e.g., gender, SES) in increasing the risk to develop emotional problems (2, 7, 46).

Our findings highlight the role of perceived exposure to discrimination in contributing to increased levels of emotional distress. This study is consistent with similar findings in studies among disadvantaged groups (47, 48). Discrimination on a basis of different dimensions of identity (e.g., ethnicity, religion, mental health status etc.) can harm psychological well-being by making it hard to find a good job or place to live, undermining learning in educational settings, or depriving people of adequate health care (48). Perceived discrimination implies something about one's place in society and thus can have consequences for well-being that go beyond the consequences of the negative treatment itself (49).

In addition, our findings highlight the role of social support in the management of emotional distress. Social support and social relationships are usually conceptualized and measured as two major components (50, 51): (a) structural, which is the structure of social ties (e.g., marital status, group membership), and (b) functional, which is the support that is actually provided by the social structure. Functional support refers to both received social support (e.g., social interactions) and the more subjective perceived social support (e.g., beliefs and perceptions of support availability) (52). A large body of research has consistently found that social support serves as a protective factor against the development of emotional problems in the general population and among those who were exposed to traumatic events (47, 53, 54). For example, in a meta-analysis examining predictors of PTSD in adults in the general population, perceived social support was among the strongest predictors of PTSD diagnosis and symptoms (53).

Our findings that increased emotional distress was associated with higher social support are thus surprising. This unexpected finding may be due to the fact that the study included active service users at initial stages of treatment. Possibly, those who are recognized as having higher emotional distress in the community receive higher levels of social support from their relatives and friends. This hypothesis is supported by sociological studies documenting the high collectivist values that characterize the Palestinian community which stress the importance of social cohesion and support (34). Studies showing that only a minority of the Palestinian

population actually seek formal mental health care (3, 35, 36) suggests that non-formal mental health support that include familial and community resources is more frequently used by persons in need. It is likely that these individuals first receive care from their family and friends and thus by the time they reach the mental health clinic they are actually reporting higher levels of social support that they received as a result of their deteriorating mental health status. Indeed, more than half of the participants in our sample reported seeking help from friends, family or neighbors before accessing specialized care. The correlational nature of the current study precludes our ability to determine the cause and effect relationship between social support and emotional distress. Future studies among community dwelling adults may shed more light on these findings.

Despite the documented role of care stigma and mental health stigma to accessing care (55, 56), in the current study these variables were not significantly associated with emotional distress. It is possible that this is due to the fact that the study was conducted among those who actually accessed care and that these variables would be more influential among those in need in the community.

The study has several limitations. First, participants included a relatively small sample size. Second, the survey included self-report measures which may be subject to social desirability bias. Future studies should examine a larger representative sample of East Jerusalem patients as well as include mental health assessment using a structured diagnostic interview (gold standard for psychiatric assessment), and in-depth interviews in order to further understand the connection between social support and emotional distress documented in this study.

The Palestinians in East Jerusalem reside under unique political circumstances. They are formally residents of Israel, yet the vast majority of the members of this population identifies with the Palestinian Authority. As part of their rights they are entitled to receive free mental health care from psychiatric centers in Israel, yet the services offered are limited and their cultural adaptability is yet to be evaluated. Their mental health needs and barriers to care should be studied in order to improve identification of mental health concerns and improve care. Actions to bridge mental health gap through improved availability, accessibility and appropriateness of the services including efforts to work with local religious leaders, would facilitate access to the benefits derived from evidence-based mental health treatments in both primary care and/or in specialized services.

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