

A Qualitative Study of the Integration of Arab Muslim Israelis Suffering from Mental Disorders into the Normative Community

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Abstract This study focuses on the process of the integration of Arab Muslim Israelis suffering from mental disorders into the normative community, addressing perspectives of both people with mental disorders and the community. This qualitative-constructivist study seeks to understand the dynamics of face-to-face meetings by highlighting the participants' points of view. The main themes of the findings included stereotypes and prejudices, gender discrimination, and the effect of face-to-face meetings on integration of people with mental disorders (PMD) into the community. The findings support former studies about the integration of PMD into the normative community, but add a unique finding that females suffer from double discrimination: both as women in a conservative society and as PMD. The study findings indicate a perception of lack of self-efficacy of PMD as a key barrier preventing integration into the community, which also prevents community members and counselors from accepting them or treating them as equals. We recommend on a social marketing campaign to be undertaken with the Arab Muslim community to refute stigmas and prejudices, particularly with double gender discrimination suffered by women with mental disorders in the Muslim community and training of community center counselors who have contact with the PMD population.

Keywords Qualitative study · Mental disorder Israeli Arab Muslim · Integrating into normative community

Introduction

A mental disorder is defined as a clinically significant behavioral or psychological pattern that causes suffering and impairs functioning or normal development [1]. The negative impact of mental disorders on patients and their families is considerable. They face three levels of social stigma: *public stigma* [2–5], manifested by fear, banishment, rejection, neglect and punishment of the mentally ill, albeit less today than in the past [6]; *self-stigma* of the mentally ill towards themselves [4, 7, 8]; and *labeling* [5, 9] that leads the mentally ill to avoid social contact. In light of such suffering, many people with mental disorders choose to keep their illness secret from others [10].

The diagnosis of a mental disorder has an impact on the PMD's self-image and usually generates a change in that self-image, depending on whether the person was labeled mentally ill by society or whether the person labeled themselves. Being marked as the member of a stigmatized group does more than designate someone as different [11]. It denotes them as profoundly discredited, devalued, and disgraced [12]. The change of self-image is often defined as "self-stigmatization," [7] which means loss of self-esteem and self-efficacy that occurs when people internalize the public stigma. Most of the studies emphasize that PMD often internalize public stigma and believe they are less valued because of their mental disorders [13, 14], which explains both the drop in their self-esteem [15, 16] and their lower self-efficacy [17]. This might lead PMD to agree with the prejudices and stereotypes attributed to them [13, 14].

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The process of labeling a stigmatized group plays a key role in stigmatization, facilitating the process of considering the stigmatized group as a coherent, distinct entity. The word selected for the group's label can bring attention to the stigma by using the mark or stigmatizing condition in the label [13]. Leaf, Bruce [9] describe "label avoidance" as a stage that develops among PMDs, in which they decide to discontinue their treatment by the mental health services out of fear of being labeled as mentally ill. By doing so they feel as if they are "defending" themselves from the common notion that labels PMD as dangerous, unpredictable people with whom it is difficult to communicate.

Today we know that stereotypes, prejudice and stigma are the most significant barriers to the integration of people with mental disorders into society [18]. These barriers exist within the people themselves [5, 7], their families [19, 20], the community [21, 22] and the media [23, 24].

This article focuses on the minority subgroup in Israeli society of Arab Muslims suffering from mental disorders. The people discussed in this article suffer from balanced mental disorders, which is to say that they were diagnosed by the Israeli National Insurance Institute (NII) as suffering from a mental illness causing more than 40 % disability and live within the community.

Similar to the statistics in the Western world, 25 % of the Arab Muslim population in Israel suffer from mental disorders. The prevailing perception in Arab Muslim society is that mental disorders are caused by lack of religious piety or a curse, and, according to this view, true believers will not suffer from mental illness. Consequently, only faith can cure the sick [25, 26]. This cultural religious view explains Arab Muslim Israelis' aversion to mental health services. Other explanations relate to problems of access both on the cultural and physical levels, including lack of support services within the minority Arab communities [25].

To deal with stigma regarding mental disorders in society, change is needed on two levels: (1) a change of perceptions towards the mentally ill in order to promote their integration into normative society; and (2) the systemic involvement of policymakers to generate broad social change [6, 27]. Amitim is a community rehabilitation program in Israel, whose goal is the social rehabilitation of people suffering from mental disorders ages 18–65 living in Israel with a disability of 40 % or more.¹

¹ In the rehabilitation process, the program emphasizes rehabilitation, community work and public education. The community intervention process offers personal support from program coordinators, volunteers at community centers and within the community, and a support group that focuses on improving skills required for integration (Israel Association of Community Centers website, Amitim program, 2011).

To deal with the stigma of PMD in society, there must be a change in society's perceptions and positions regarding PMD that will allow it to accept them as equals. The leading strategy to realize this goal is social marketing. This strategy applies the principles of marketing and manufacturing to create, connect and provide value and thereby promote behavior that gives the target audience social benefit [27]. In health-promoting social marketing the emphasis is on effective use of the media in order to reach populations with different cultural characteristics or populations with limited economic resources and relatively low access to existing resources [28, 29]. Participatory social marketing is a theory-based multidisciplinary activity whose goal is to influence the knowledge, positions, beliefs and behaviors of individuals and communities to promote social issues on the individual and societal level, places the community and its needs at the center and builds research-based intervention plans to identify barriers that prevent the target audience from adopting the desirable behavior. Social marketing also addresses both the community and policymakers located upstream [27]. The social marketing approach considers it important to conduct participatory research with different target audiences, especially disempowered target audiences such as PMD in the community. Studies have been conducted worldwide on the integration of people suffering from mental disorders into the community. Likewise, there are social marketing programs that facilitate their integration into the community. However, few studies have addressed the question of the integration of Arab Muslim Israelis suffering from mental disorders. Studies to date have exposed attitudes towards such people in general and the basis for their formation. This study focuses on the process of the integration of Arab Muslim Israelis suffering from mental disorders into the normative community, addressing perspectives of both people with mental disorders and the community. This study adopts a social marketing approach [27], namely the strategy of "in our own voice," which promotes interpersonal relations between the normative community and others, by facilitating face-to-face meetings [30]. The contribution of this study is to analyze the dynamics of such meetings in the particular context of cultural characteristics of a minority group living in Israel.

Objectives

To examine the effectiveness of face-to-face meetings between people suffering from mental disorders (henceforth: PMD) and normative community members among Arab Muslims in Israel, and to locate the barriers that impede their integration into normative society.

Methods

Design

This is a qualitative-constructivist study seeking to understand the dynamics of face-to-face meetings by highlighting the participants' points of view [31]. The face-to-face method is a strategy used with PMDs both as a therapeutic method and as a coping strategy to connect them with normative society. The literature finds that encouraging interpersonal relationships with PMD is an effective strategy for reducing the stigma against them [32–34]. Studies of the face-to-face encounter theory found that usually the effects of personal contact are aimed at people who have the time or willingness to be involved in such activities that reduce stigmas. Corrigan and Penn [32] argued that in order to reduce the effect of stigmas against PMD, there need to be support meetings and public support services offering a wide range of strategies including education and promoting personal relationships between the general public and PMD [32].

In our study, we carried out this strategy in two ways: First, through group activities within the institution itself, aimed at preparing the PMD for the encounter with the normative community. These activities included professionals, who supported and encouraged the interaction. Second, through activities offered to the community at large (swimming, gym). The PMD participate in these activities with normative people outside of the institution.

The target population is Arab Muslims in Israel suffering from mental disorders, with normal self-judgment and a mental disability of over 40 %, normative people, counselors who work with PMD and participants in the Amitim program for the integration of such people into normative society (n = 25). Age range: 18 to 64. Geographic location: Tamra and Shefaram.² The interviews were held from September 2012 to January 2013. Ten personal interviews with people ages 30–52 from the normative population (see Table 1), 10 personal interviews with Arab Muslim PMD, ages 22–58 (see Table 2),³ and five interviews with counselors, ages 24–54, who work in Tamra and Shefaram at the Israel Association of Community Centers (see Table 3).

² Tamra and Shefaram are cities in northern Israel; both ranked third out of ten in the social economic scale as of 2008. Tamra, population (as of December 2010) of 29,268. Shefaram, population of 37,732 (CBS).

³ The participation of members of the normative community who participated in the study in group activities does not necessarily indicate their desire to accept people with mental disorders or integrate them into the community because they were not informed in advance by the community center that people suffering from mental disorders would participate in the activities.

Data Collection

The sampling method was heterogeneous sampling between the subpopulations under study (normative, PMD and counselors) [35]. The Israel Association of Community Centers helped select two community centers that implement the Amitim program in the Arab Muslim community.⁴ Recruitment of participants suffering from mental disorders and counselors was facilitated by community center directors in both cities: the directors gave the researchers lists of potential participants—patients and counselors—and after an initial phone call, a researcher met the potential interviewees personally at the community center to explain the purpose of the study. After the potential interviewees agreed to participate in the study, interview dates were set. A social worker was present to support the PMD and allow for professional intervention if the interviewee exhibited emotional difficulties. It is noteworthy that during the interviews no professional intervention was needed. Participants from the community were recruited by “snowball sampling.”

Some of the normative interviewees (Table 4) were first-degree relatives of PMD (father, mother, sibling). It was important for us to recruit relatives from the normative population who were acquainted personally with the interviewees. The study sought to explore several central issues concerning the interviewees from the PMD's families, including the following: First, the extent the family thinks, believes and/or treats its PMD member as able to integrate into the normative community; why they believe that integration is possible; and what they see as the obstacles to the integration the PMD in society. Second, what the family's experience is with normative society: does society behave or treat the family differently if it has a PMD member?; does the family feel it is “punished” for having a child or sibling who is a PMD; how the family interacts with society concerning the PMD—whether it tries to hide the PMD from society or is comfortable being seen in public with that person.

The 25 interviews were conducted in Arabic by an Arabic-speaking researcher. The interviews used three semi-structured protocols adapted to the three target audiences. The protocols consisted of generic questions and questions tailored to each subpopulation (see Table 5). All of the interviews were recorded and transcribed. Each personal interview was transcribed into Arabic and later translated into Hebrew to reinforce credibility.

⁴ The Center for Culture, Youth and Sport, an Israeli government company owned by the Health Ministry.

Table 1 Research population A: members of normative population—demographic data

Interviewee number	Age	Gender	Family status	Profession	Place of residence	Participant in activity	Location of activity
1	46	M	Married	Handyman	Kabul	Physical fitness	Tamra
2	30	M	Married	Nurse	Shefaram	Sport—physical fitness	Shefaram
3	38	F	Married	Nurse	Shefaram	Body sculpt—physical fitness	Shefaram
4	38	F	Married	Sanitation worker	Iblin	Swimming	Shefaram
5	32	F	Single	Kindergarten assistant	Shefaram	Computers	Shefaram
6	22	F	Single	Unemployed	Shefaram	Crafts—sewing	Shefaram
7	32	F	Married	Teacher	Shefaram	Sport—physical fitness	Shefaram
8	42	M	Married	Teacher	Shefaram	Computers	Shefaram
9	52	M	Married	Unemployed	Shefaram	Art—drama	Shefaram
10	42	F	Married	Sanitation worker	Shefaram	Art—drama, jewelry	Shefaram

Table 2 Research population B: PMD—demographic data

Interviewee number	Age	Gender	Family status	Profession (before mental illness)	Place of residence	Participant in activity	Location of activity
1	44	F	Married	Didn't work	Tamra	Computers	Tamra C. C.
2	26	F	Single	Didn't work	Tamra	Physical fitness + hiking	Tamra C. C.
3	22	M	Single	Waiter	Shefaram	Art—drama	Shefaram C. C.
4	57	M	Married	Didn't work	Shefaram	Art—theater	Shefaram C. C.
5	38	F	Divorced	Teacher	Shefaram	Art	Shefaram C. C.
6	38	M	Divorced	Handyman	Shefaram	Art + physical fitness	Shefaram C. C.
7	58	F	Widow	Didn't work	Shefaram	Arabic language class	Shefaram C. C.
8	37	F	Married	Didn't work	Shefaram	Computers	Shefaram C. C.
9	54	F	Married	Teacher	Shefaram	Sports	Shefaram C. C.
10	33	M	Single	Carpenter	Shefaram	Sports	Shefaram C. C.

Data Analysis

Data analysis of the text was conducted using an iterative coding process. A team of two researchers independently coded the transcripts, identifying themes and sub-themes through a modified thematic constant comparative approach [36, 37]; thematic codes were compared within a single interview and between interviews [37]. Two coders separately read and reread transcripts (one in Hebrew and one in Arabic) to identify potential codes, convened to create a common coding system through discussion, and then separately coded text [38]. This process continued until agreement and matching. Qualitative data are presented using direct quotes from the participants to illustrate findings.

Results

Stereotypes and Prejudice

Both normative members of the community and the PMD articulated stereotypes and prejudices for the following reasons: (1) perception of PMD as violent; (2) perception of PMD's lack of self-efficacy; (3) perception of PMD as inferior; and (4) discrimination against PMD and particularly gender discrimination towards female PMD among Arab Muslims.

Perception of PMD as violent—the issue of violence arose in all three groups (counselors, normative community members and PMD). When the PMD spoke about their encounter with the community, seven of the ten



Table 3 Research population C: counselors^a—demographic data

Interviewee number	Age	Gender	Family status	Education	Place of residence	Counselor in activity	Location of activity
1	37	M	Married	High school	Tamra	Physical fitness	Tamra (external)
2	54	M	Married	High school + advanced studies at the Wingate Institute	Tamra	Physical fitness	Tamra (external)
3	26	M	Single	College—physical fitness teacher	Shefaram	Sports	Shefaram (internal)
4	24	F	Single	College—social worker	Shefaram	Support in various classes	Shefaram (internal)
5	26	F	Single	College—social worker	Shefaram	Club director	Shefaram (internal)

^a The structure of the meetings with PMD at the community center: there were two kinds of meetings. One was activities outside of the center with PMD and normative people. These activities were advertised and run by external bodies. The center sent the PMD to the activities as “community members” who wanted to take the class: the PMD signed up and participated in the classes without the counselor announcing they were PMD. The other kind of meetings were activities inside the institution and run by it, whose target audience was PMD only. Their main purpose is to empower the PMD and to give them tools to integrate into the community (social skills)

Table 4 Research population A: family members of PMD—demographic data

Interviewee number	Age	Gender	Family status	Family relationship	Profession	Place of residence	Participant in activity	Location of activity
1	38	F	Married	Sister	Nurse	Shefaram	Body sculpt—physical fitness	Shefaram
2	32	F	Married	Sister	Teacher	Shefaram	Sport—physical fitness	Shefaram
3	52	M	Married	Father	Unemployed	Shefaram	Art—drama	Shefaram
4	42	F	Married	Mather	Sanitation worker	Shefaram	Art—drama, jewelry	Shefaram

interviewees focused on the community’s fear of them. This highlighted the self-stigma that supposedly justifies and reinforces the community’s fears of encountering PMD. The PMD interviewed recalled incidents that occurred, especially when their disease was severe.

A mentally ill person is a scary person who does not know what he’s doing, he cannot control his mind. When I was in that state I was very violent... I broke and destroyed everything there was in the house, I hit the car, I hit my brother and sister, and they are both older than me... And I don’t want to tell you that I hit my mother, but I did. That happened (a PMD).

Most of the interviewees from the normative community, including the relatives of the PMD (eight interviewees), overcame their fear of the PMD following the encounter with them, where they learned that PMD are not necessarily violent. “For instance, on the matter of violence, they can’t hurt, they are not violent, they have good hearts, they are harmless,” (community member). One of

the reasons for their success is the presence of the counselor in the face-to-face encounters, providing them with a sense of security: “If a threatening situation arises, the counselor will take care of it” (community member). Perception of PMD as lacking self-efficacy—The perception that PMD lack self-efficacy was expressed by most of the interviewees in all three subpopulations and touched upon three aspects of self-efficacy: (1) the perception of PMD as lacking social skills; (2) the perception of PMD as physically “defective”; (3) the perception of PMD as not responsible for themselves or others.

The counselors (two interviewees), most of the interviewed members of the community (nine interviewees), all of the family members of PMD (four interviewees) and half of the PMD (five interviewees) view PMD as lacking social skills. According to the interviewees, in their interactions with the community, PMD speak, behave and interact in a way that makes the community avoid them. They claim that the reason is that mental disorders change the social behavior of PMD:

Table 5 Selected focus group questions from the moderator's guide

Perceptions and attitudes

Emotional

Were you afraid of meeting community members at the community center? If so, what were you afraid of? In what situations?

Did your first meeting with members of the community during the group activity allay your concerns about the meeting?

Do you think there are situations in which the community is afraid of meeting PMD?

Cognitive

How do you think members of the community perceive PMD?

How would you like people to perceive PMD?

Did your perception of meetings with the community change after the meetings at the community center began? If so, could you explain how?

Perception of norms

How do you perceive how other members of your community perceive PMD?

Do you have friends from the community who are not PMD? Can you tell me about them?

Needs

Do PMD have different physical abilities than “normal” people? If so, what?

Do PMD have different social-communicative abilities than “normal” people? If so, what?

Change of positions following encounter

Do you think the meeting with community members changed the attitudes of participants in the group activities towards PMD? If so, how?

In what other ways can PMD be integrated into the community?

... At first I lived at home. People were always coming and going (visitors). After I moved to the hostel (she means after the community found out she was a PMD)... visitors stopped coming to the house (PMD).

I think in their extended isolation, especially the chronic patients, they lost many communication skills, their interpersonal skills, and that makes it very difficult for them. Sometimes they behave normally, sometimes their behavior is not normal,” (counselor).”... I feel that people with mental disorders talk differently, not like us (normative people). It's also different in terms of the conversation topics. Sometimes they speak strangely, they also have strange requests...” (community member). “PMD are very sensitive, every little thing insults them. They express what they are holding inside (counselor).

... They are different (PMD)... Because they maintain a distance from society... Their mental condition... They like to be alone (community member).

On the other hand, a smaller number of counselors (two interviewees), one interviewee from the community and less than half of the PMD (four interviewees), viewed PMD as having the same level of communication skills as normative members of the community:

They have the same abilities... Of course they have the same abilities... There's no problem, (PMD).

“... Just like a normative person, if they don't know you and you approach them for the first time to talk to them, some of them scream, some speak in a low voice and some don't modify the way they talk to the situation they're in. PMD also sometimes don't know how to behave in social situations, but not because they are PMD” (community member). On the one hand, most of the families consider their PMD member as having limited efficacy, both in their social and communicative efficacy and in their physical efficacy, which has an impact on the PMD's social image and inhibits their integration into the normative community. On the other hand, the family does see the potential for the integration of the PMD in society, as long as society recognizes and accepts their disability. The following quote illustrates this point (by a relative of a PMD): “There is a difference between the way you treat a PMD and a person who does not have a mental disorder. Society must recognize his disability and accept it.”

In addition, most of the interviewees mentioned the PMD's lack of physical efficacy (seven interviewees). The PMD claimed that the disorder negatively impacted their physical ability, weakening them. They claim the reason for the weakness is the disorder itself as well as the drug therapy they receive for it.

Seven PMD interviewees claimed that their disease has a detrimental effect on their physical ability and makes them weak and powerless. They claim the reason for their

weakness is the illness itself, as well as the medications they take:

In terms of ability, I think that PMD have less physical strength than other people (a PMD).

Everything is different and let me give you an example based on personal experience. When I got out of the mental hospital I couldn't do anything. Before I went in I could pick up anything... I was strong... After the treatment I lost my strength. Now I am not strong enough to pick up anything or to do anything physical (a PMD).

It's because of the meds. The meds make us weaker... we can't move a glass (PMD).

The families of PMD all claimed there was a difference between the PMD's physical abilities and those of members of the community:

I feel they are weaker people. Their bodies are thin... You can tell they are weak (mother of a PMD).

On the other hand, a minority of interviewees from the community (two interviewees) said that in terms of physical ability there was no difference between PMD and other people in the community. In one interview with a normative person, the concept was suggested that the physical ability of PMD compared to normative people changes depending on the degree of their mental disability: the greater the mental disability, the weaker the person is physically:

It depends on the case... For example, there are some people who have mental problems and take medicine. the medicine might affect them in terms of being able to pick things up. And there are people that have normal abilities like everybody else (community member).

Discrimination Against PMD in the Community

Discrimination against PMD in the community is expressed in several ways: (1) the difficulty of PMD to find partners; (2) loss of employment as a result of mental disturbance; (3) the double discrimination of female PMD in the Arab community.

The difficulty of PMD in finding life partners: Most of the PMD interviewees (6 out of 10) mentioned the difficulty of finding a partner. They said because of their mental disorders, they could not find anyone who would agree to marry them:

I want to get engaged or married... But I can't find a girl who would agree to marry me (PMD).

Some also mentioned the difficulty of maintaining a marriage that began before the person was revealed as a PMD:

A while ago I went to propose to a girl, she agreed and so did her parents. After some time they changed their mind and both the girl and her parents said they did not want to proceed and did not want me to marry her. I asked why and they never gave me an answer. But I'm sure they said 'This guy is crazy. He lives on medicine' (PMD).

A woman from the community shared a personal experience she had before taking the class with PMD: she refused a marriage proposal because she was afraid the person proposing to her was a PMD, even though he never said so. Shortly thereafter, her suspicions were confirmed and she found out that he was in fact PMD.

The man who proposed to me and I refused to marry him I don't know, even though at the beginning I wasn't sure he had a mental disorder (woman from the community).

When the interviewee was asked whether the encounter in the class affected her perception of marrying a PMD, she answered that whereas before the joint encounters she would have definitely refused to marry a PMD, if she had to decide today she would decide depending on how serious the problem was:

It depends on the case... His problem. How I would deal with it (woman from the community).

Furthermore, a mental disorder in the family makes it significantly more difficult for family members who are not PMD to find partners. A PMD interviewee shared a personal anecdote about his family:

My father married off his sisters outside of the family (clan) and that is why he wanted to get me out of the house so that he could marry them outside of the clan (PMD).

A mental disorder means loss of employment: All of the PMD interviewees who held jobs before being diagnosed (six interviewees) lost their jobs after they were exposed as PMD. All of the interviewees emphasized that their workplaces and jobs mean a lot to PMD: they feel active, effective and contributing to their society and feel that they have the same abilities as normative people.

The following are the words of a PMD who worked in carpentry until he was diagnosed. He is currently unemployed:

I wish they would let me work, send me to work, it calms me down. People won't give me a job, (PMD).

This is what a PMD said who worked as a teacher until she was diagnosed. Now she is employed in a workplace for PMD in a job not within her professional field:

... On days when I don't go to work I feel strong emotional distress. For instance, on Saturday we don't work, I prefer to sleep all day, I wait for a work day to go to work, and when I do have work, I forget my troubles, (PMD).

Gender Discrimination

The interviews indicate that female PMD in the Arab Muslim population suffer from double discrimination: both as women in a conservative society and as PMD. Most of the female PMD interviewed (five out of six) stated specifically that they suffered from physical or verbal abuse because of being women with mental disorders. The male PMD interviewed spoke of being perceived as "inferior" and "weird" but, unlike the women, did not mention physical abuse.

... My mother tells people not to talk to me... she's sick... don't go near her... and my brother can't stand anything I do... my father can't stand anything I do... and I get beaten up all the time... (a PMD).

When my daughter-in-law visits our home... my husband starts pointing at me and tells my daughter-in-law, 'look at her (indicating his wife), she's crazy'... that's how he talks to me (a PMD)

The interviews with the PMDs indicate that gender has an impact both on willingness and ability to integrate into the community. Most of the male interviewees (three out of four) had difficulty integrating in the community and expressed an unwillingness to integrate: "I don't feel good being with people (the community), they make fun of me" (a PMD). "I prefer to be with elderly people... like us who have mental problems" (a PMD). Compared to the male PMD, the female PMD (four out of six interviewees) showed a higher rate of integration and more of an interest in integrating in the community:

Wonderful people come to the classes and I talk about myself. I get along with everyone, young and old, with the young people I'm young and with the old people I'm old and with the elderly I'm elderly. I can get along with everybody, it's not hard for me (PMD).

Despite the female PMDs' tendency to cope better with their illnesses, they suffer from social and cultural discrimination.

The Effect of the Face-to-Face Meetings on the Acceptance of PMD

Most of the interviewees in the three groups (PMD, community members and counselors) claimed that the meetings at the community centers had a positive impact.

... Today I am in touch with them more because of the group. I know more about why they are the way they are, I got to know their families. I think these meetings are important for integrating them into the community (counselor).

Most of the community members (nine interviewees including family members of PMD) considered the meetings significant for integrating the PMD into the community, because they gave the PMD tools for integrating and helped them gain self-confidence:

It gives them self-confidence... They can do things that normal people do, it helps them overcome their problems... that they are not worthless... (community member).

Most of the community members (six interviewees without PMD relatives and one father of a PMD) saw the meetings as critical for transforming their perceptions and attitudes towards the PMD.

... Certainly, the meeting changed my perception of PMD... At first I didn't know and didn't see PMD... But when I met them... I saw that they aren't violent, I mean not every PMD has to be removed from the community. On the contrary, they can be integrated (community member).

One community member, the father of a PMD participating in the program, stressed the contribution of the meetings to the process of integrating PMD into the community, but claimed that the significance of the meetings also depends on how they are run: "Yes, the meeting is important, it makes the person feel like he is part of the community... But sometimes the meetings make them (the PMD) feel as if they are sick..."

However, the findings indicate that the interaction between the PMD and normative community members remains confined to the group activities and does not continue after the meetings. They report that even family members of do not want to be seen together in public:

Even my brother, I told him once, let's go out, let's go have a barbecue outside. He said... you're sick and you have to stay home (a PMD).

One of the reasons community members avoid interacting with PMD outside the group activities is that this is perceived as detrimental to social standing. Some even felt

that spending time with PMD in the context of the activities was detrimental to their social standing:

Sometimes I talk to myself and say, why should I go to a place like that, which is beneath me and has people like that? (community member).

The interviews with PMD indicate that gender has an impact both on willingness and ability to integrate into the community. Most of the male interviewees (three out of four) claimed that the activities did not increase their willingness to integrate in the community, because of their fear of being labeled (label avoidance).

I don't feel comfortable being with people [in the community], they'll make fun of me (a PMD).

I prefer to be with old people... like us who have mental problems (a PMD).

Compared to the male PMD, the female PMD (four out of six interviewees) showed more of an interest in integrating into the community:

Wonderful people come to the activities and let me talk about myself. I get along with everyone, the young people and the old; with the young people I'm young and with the old people I'm old. (a PMD).

Discussion

The study examined three groups: (a) PMD (in the 18–64 age group); (b) normative community members; (c) counselors of PMD. The data analysis revealed findings that support studies in the literature about the integration of PMD into the normative community, along with unique findings about PMD among Arab Muslims in Israel. Like most of the studies [39, 40], in the present study, stigmas were found to be the main barrier to the integration of PMD into the community. This is expressed on three levels, according to the interviews. (1) *Public stigma*: the interviewees in this study noted that the Arab community maintains a social stigma [2–5] that sees PMD as violent and socially inferior. Therefore, community members (who are not relatives of PMD) do not express a desire to have contact with a PMD beyond the activities at the center. (2) *Self-stigma* [4, 7, 8]: in most of the interviews, the PMD spoke about themselves as threatening. (3) *Label avoidance* [5, 9]: in the interviews with male PMD, they said they preferred to avoid contact with the community.

The study findings indicate a perception of lack of self-efficacy of PMD is a key barrier preventing integration into the community, which also prevents community members and counselors from accepting them or treating them as

equals. The societal perception of PMD as people who are inferior in their physical and social skills to normative community members has also been found in other studies [4, 19, 41]. The interviews also found that all three interview groups see the medication the mental patients receive as the main reason for skill impairment. These findings are backed by findings in other studies according to which PMD are unable to live independent lives or work at normative jobs because of their medication [21, 41]. Furthermore, the aversion some of the interviewees in this study expressed to pharmaceutical therapy is consistent with cultural attitudes of the Arab Muslim population, which prefers alternative (nonclinical) treatments of mental disorders, such as natural medicine, Koran therapy, exorcising demons from the body [25] and overall avoidance of medications that impair functioning and efficacy.

Aside from the prejudices and stereotypes discussed above and which are supported by other studies, the interviewees also discussed the importance of the encounter between PMD and community members. The interviews indicate that interviewees from all three groups perceive the meetings as important for the integration of the PMD into the community. The interviews also indicate that the interaction led to some changes in community members' attitudes towards PMD. The interviews reinforce the claim by Corrigan and Penn [32] that in order to reduce the effects of stigmas towards PMD, it is important to run support groups and offer public support services with a wide variety of strategies, including education, to foster contact between the general public and PMD [32]. However, the research findings indicate that the interaction between the PMD and the community is limited to the group activities. This raises the question of the impact of the setting on the nature of the encounter. There is a need for further studies to examine the impact of face-to-face meetings at larger community events.

The research indicates that gender differences have an impact on PMD's ability to integrate into the community. The findings indicate that women in the Arab Muslim population are more willing and able to integrate into the community. This finding is consistent with the findings of previous studies that found that women have a greater ability to recover than men, especially from serious mental disorders [42]. However, the findings of the present study indicate that the Arab Muslim community obstructs female PMD, undermines their ability to integrate in the community and discriminates against them. Consequently, discrimination against female mental patients in the Arab Muslim population is twofold: gender discrimination—for being a woman, and discrimination for being a PMD. This finding is consistent with the findings of previous studies that indicate that the social status of female mental patients is worse than that of men of equal psychiatric status [43].

Limitations of the Study

This qualitative research provides an in-depth view of the perceptions and interactions both of PMD and the people who surround them. Since we did not use a representative sample, the findings cannot be applied to the entire population of PMD living in the Arab Muslim community in Israel.

One of the limitations was the difficulty of recruiting PMD for the study for various reasons. The social workers were particularly concerned about the exposure of the PMD to the interviews. The social workers were the ones who decided who would be interviewed and mediated between the researchers and the PMD, so there are PMD who were not chosen, and this may have created a “choice bias.” Furthermore, we encountered fears the PMD’s fears of being interviewed. Most of these fears were allayed when the PMD met the interviewer, but there were some who refused the initial encounter.

Conclusions

We recommend on a social marketing campaign to be undertaken with the Arab Muslim community to refute stigmas and prejudices. There is a particular need to confront the issue of the double gender discrimination suffered by women with mental disorders in the Muslim community. In addition, community center counselors who have contact with this population should be trained. According to the findings, not all of the professionals were skilled and some were prejudiced themselves. In order for them to serve as community change agents, the counselors need to be given tools and long-term professional support.

Compliance with Ethical Standards

Ethical Approval Application was made to the Faculty of Social Welfare and Health Sciences Ethics Committee for research with human subjects at Haifa University and full ethical approval (No. 207/12) was granted.

References

- Sadock BJ, Sadoc VA. Kaplan and Sadock’s synopsis of psychiatry: behavioral sciences/clinical psychiatry. Philadelphia, PA: Wolter Kluwer/Lippincott Williams & Wilkins, cop.; 2007.
- Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophr Bull.* 2004; 30(3):481–91.
- Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry.* 2002;1(1):16–20.
- Pattyn E, Verhaeghe M, Sercu C, Bracke P. Public stigma and self-stigma: differential association with attitudes toward formal and informal help seeking. *Psychiatr Serv.* 2014;65(2):232–8.
- Ben-Zeev D, Young MA, Corrigan PW. DSM-V and the stigma of mental illness. *J Ment Health.* 2010;19(4):318–27.
- Hinshaw SP. The mark of shame: stigma of mental illness and an agenda for change. New York: Oxford University Press; 2009.
- Gallo KM. First person account: self-stigmatization. *Schizophr Bull.* 1994;20(2):407–10.
- Corrigan PW, Rao D. On the self-stigma of mental illness: stages, disclosure, and strategies for change. *Can J Psychiatry.* 2012;57(8): 464–9.
- Leaf PJ, Bruce ML, Tischler GL, Holzer CE 3rd. The relationship between demographic factors and attitudes toward mental health services. *J Community Psychol.* 1987;15(2):275–84.
- Stefan S. Hollow promises: employment discrimination against people with mental disabilities. 1st ed. Washington: American Psychological Association (APA); 2002.
- Thompson TL, Seibold DR. Stigma management in normal-stigmatized interactions: test of the disclosure hypothesis and a model of stigma acceptance. *Hum Commun Res.* 1978;4(3): 231–42.
- Goffman E. Stigma: notes on the management of spoiled identity. Englewood Cliffs: Prentice-Hall; 1963.
- Link BG. Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. *Am Sociol Rev.* 1987;52(1):96–112.
- Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol.* 2001;27(1):363–85.
- Corrigan PW, Faber D, Rashid F, Leary M. The construct validity of empowerment among consumers of mental health services. *Schizophr Res.* 1999;38(1):77–84.
- Rosenberg M. Society and the adolescent self image. Princeton: Princeton University Press; 1965.
- Bandura A. Regulation of cognitive processes through perceived self-efficacy. *Dev Psychol.* 1989;25:729–35.
- Corrigan PW. On the stigma of mental illness: practical strategies for research and social change. Washington: American Psychological Association; 2005.
- Link BG, Struening EL, Rahav M, Phelan JC, Nuttbrock L. On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *J Health Soc Behav.* 1997;38(2):177–90.
- Dixon L, McFarlane WR, Lefley H, Lucksted A, Cohen M, Falloon I, et al. Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatr Serv.* 2001; 52(7):903–10.
- Corrigan PW. Mental health stigma as social attribution: implications for research methods and attitude change. *Clin Psychol Sci Pract.* 2000;7(1):48–67.
- Penn DL, Martin J. The stigma of severe mental illness: some potential solutions for a recalcitrant problem. *Psychiatr Q.* 1998; 69(3):235–47.
- Wahl OF. Media madness: public images of mental illness. New Brunswick: Rutgers University Press; 1995.
- Pirkis J, Francis C. Mental illness in the news and the information media—a critical review. Australia: Hunter Institute of Mental; 2012. <http://www.mindframe-media.info/home/resource-downloads/other-resources-and-reports/?a=6322>.
- Shalateh M. Findings of focus groups of patients and their families. Jerusalem: Department of Disabilities and Rehabilitation and Joint Israel; 2010.
- Struch N, Shereshevsky Y, Naon D, Daniel D, Fischman N. People with severe mental disorders in Israel: an integrated view of the service systems. Jerusalem: Myers-JDC-Brookdale Institute; 2009.
- Kotler P, Lee NR. Social marketing: influencing behaviors for good. Thousand Oaks: Sage; 2008.

28. Bradley T, Thorson E, Bothner V, Allen T. When the target audience is hostile to the behavior change: a case study in strategy development in social marketing. *Soc Mark Q.* 2000;6(3):35–8.
29. Hastings GB, Stead M, Whitehead M, Lowry R, MacFadyen L, McVey D, et al. Using the media to tackle the health divide: future directions. *Soc Mark Q.* 1998;4(3):42–67.
30. Pettigrew TF, Tropp LR. Does intergroup contact reduce prejudice: recent meta-analytic findings. In: Oskamp S, editor. *Reducing prejudice and discrimination: the Claremont symposium on applied social psychology.* Mahwah: Lawrence Erlbaum Associates Inc; 2000. p. 93–114.
31. Denzin NK, Lincoln YS. *Handbook of qualitative research.* Thousand Oaks: Sage; 2000.
32. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. *Am Psychol.* 1999;54(9):765–76.
33. Pinfold V, Toulmin H, Thornicroft G, Huxley P, Farmer P, Graham T. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *Br J Psychiatry.* 2003;182(4):342–6.
34. Wolff G, Pathare S, Craig T, Leff J. Public education for community care. A new approach. *Br J Psychiatry.* 1996;168(4):441–7.
35. Ulin PR, Robinson ET, Tolley EE. *Qualitative methods in public health: a field guide for applied research.* San Francisco: Jossey-Bass; 2005.
36. Bernard HR, Ryan GW. *Analyzing qualitative data: systematic approaches.* Los Angeles: Sage; 2010.
37. Boeije H. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Qual Quant.* 2002;36:391–409.
38. MacQueen KM, McLellan E, Kay K, Milstein B. Codebook development for team-based qualitative analysis. *Field Methods.* 1998;10(2):31–6.
39. Crisp AH, Gelder MG, Rix S, Meltzer HI, Rowlands OJ. Stigmatisation of people with mental illnesses. *Br J Psychiatry.* 2000;177:4–7.
40. Crisp A, Gelder M, Goddard E, Meltzer H. Stigmatization of people with mental illness: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry.* 2005;4(2):106–13.
41. Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *Am J Public Health.* 1999;89(9):1328–33.
42. Ulla-Karin S. *Recovery from severe mental illness, a gender perspective.* Stockholm: Stockholm University; 2009.
43. Stuart H. Mental illness and employment discrimination. *Curr Opin Psychiatry.* 2006;19(5):522–6.

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