Al-Krenawi A, Int J Ment Health Psychiatry 2021, 7:1
DOI: 10.37532/ijmhp.2021.7(1).198

International Journal of Mental Health and Psychiatry

Research article A SCITECHNOL JOURNAL

The Effect of the Stigma of Mental Illness and Sense of Coherence on Social Support among Arab Patients in Israel

Al-Krenawi A*

Department of Psychiatry, Ben-Gurion University of the Negev, Israel

***Corresponding author:** Alean Al-Krenawi, Department of Psychiatry, Ben-Gurion University of the Negev, Israel. Tel: 5196916462, E-mail: alean@bgu.ac.il

Received Date: January 11, 2021; **Accepted Date:** January 25, 2021; **Published Date:** February 02, 2021.

Abstract

Background: Patients with mental illness often suffer from self- and social stigma because of their health condition. This stigma might be a barrier to obtaining social support from family members.

Aim: This study examines associations between self- and social stigma, sense of coherence, and family support among individuals with mental illness in Israel's Arab population.

Research Question: How does sense of coherence mediate the relationship between perception of stigma and social support?

Methods: The sample consisted of 120 participants who completed self-questionnaires on self-stigma, social stigma, sense of coherence, and social support.

Results: Positive correlations were found between self-stigma and social stigma. In addition, a mediation model was developed predicated on the fact that high social stigma is associated with a high sense of coherence which in turn is associated with high social support.

Conclusions: The findings suggest that a sense of coherence mediates the relationships between social-stigma and social support among patients with mental illness in Israeli Arab society.

Keywords Stigma; Social Stigma; Self-Stigma; Mental Illness; Sense of Coherence; Social Support

Introduction

Stigma among patients with mental illness

Broad research demonstrates that individuals suffering from mental illness experience stigma relating to their mental health [1,2]. In his pioneering work in conceptualizing stigma, Goffman (1963) defines the term as a significantly "discrediting" attribute that causes an individual to be viewed as "tainted" and "discounted" [3]. The concept of stigma has received substantial theorization. Two distinct levels of mental health-related stigma: (1) social stigma and (2) self-stigma have been discerned [4]. Social stigma, the first level is considered structural; that is, it is an entrenched societal belief that promotes development of a sense of inferiority in the individual and by default affirms the superiority of those who justify the stigma. Significantly, stigma is relationship- and context-specific, residing not in the person but in the social context. Bos, Pryor, Reeder & Stutterheim (2013) maintain that "stigma is dynamically interwoven into the fabric of social interactions" [5]. Corrigan, Watson, and Barr (2006) in their work on self-stigma and mental illness prefer the term "public stigma" to "social stigma" [6].

Self-stigma, the second level occurs when an individual internalizes the sense of inadequacy that is projected from the stigmatizing environment. This paper examines the relationship between social/ public stigma, "Sense of Coherence" (SOC), and social support among individuals with mental illness in the Bedouin population in Israel.

Scholars have identified various labels for undesirable qualities which distinguish between the use of pronouns "I" and "we" and "they" and "us." These are the emotional responses of the stigmatizer and the stigmatized-exhibited through specific behavioral patterns, loss of status, and bias manifested as social responses to the stigmatized individual [7,8]. Such social stigma can lead to disparities in access to fundamental services [9].

While social stigma derives from the expectations of society, self-stigma is rooted in the expectations of an individual toward him/ herself in anticipation of being confronted by stigma emanating from his/her environment [10,11]. "Self-stigma" has been conceptualized as the sense of personal inadequacy an individual experiences in the wake of social stigma although direct social stigmatization is not necessarily a prerequisite for self-stigma. Inculcation of self-stigma and consequent reduction in self-esteem and self-efficacy can operate through indirect awareness of societal stigmatization, potentially affecting behavior [12]. Since internalization of stigma is a highly personal process that depends upon unique personal circumstances, a patient's coping mechanisms can influence the extent to which she is affected by stigma [13].

Stigma–whether social or self-stigma–has been found to produce significant outcomes on three levels: the individual, the familial, and the communal. On the individual level, stigma damages self-esteem [14,15] and hinders coping mechanisms [16]. This can compromise a patient's ability to communicate with others, impede rehabilitation and, in extreme cases, heighten psychotic symptoms. At the familial level, lack of familial support may occur if a patient's family fears his/her illness. This diminishes existing family interactions and impairs its inherent support system [17]. At the communal level, structural stigma is embedded in the customs and modes of action of a wide range of institutions [18].

Sense of Coherence

Aaron Antonovsky (1993) coined the term "Sense of Coherence" (SOC) to describe an individual's ability to understand a given situation and to use his/her resources to cope effectively with it [19,20]. Individuals with high levels of SOC perceive the world as more comprehensive, manageable, and meaningful than do those individuals with low levels of SOC [21]. SOC can be an important predictor of the ability to deal with life's hardships–mental illness, in

SciTechnol

All articles published in International Journal of Mental Health and Psychiatry are the property of SciTechnol and is protected by copyright laws. Copyright © 2021, SciTechnol, All Rights Reserved.

particular. According to Lindstrom and Eriksson (2005), those with strong SOC tend to better select among available resources, thus achieving a higher quality of life than individuals with weak SOC. It has been proposed that strong SOC helps mediate and ameliorate stresses by activating coping strategies. This "salutogenetic" model explains how people deal with stressors such as illness while remaining in reasonably good physical and emotional health in spite of those stressors and environmental "insults." In Antonovsky's (1987) conceptualization, SOC fluctuates throughout an individual's lifespan and is affected by experiences from childhood through the end of life. Greater consistency in an individual's life experiences produces greater likelihood that his/her life will unfold predictably. In this view, success in life is dependent upon one's abilities, knowledge, and stress-management skills- all of which influence SOC.

Mental illness in the Arab population of Israel

The Arab population in Israel, consisting of 1.9 million people is a socio-political minority encompassing approximately 20% of the total population. This demographic consists of Muslims (83%), Christians (9%), and Druze (8%); 66% of Muslims and 34% of Christians are under the age of 25. Most of the Arab population resides in the northern Galilee region, the southern Negev desert, and in Israel's heterogeneous cities. Within the district of Jerusalem, the Arab population is highly concentrated in East Jerusalem. More Arabs live there than any other Israeli locality. Of the city's 252,400 Arab residents, the CBS (2013) reports that in 2006, 239,000 were Muslim and 12,400 were Christian.

From a cultural standpoint, Israel's Arab society is considered to be traditional, patriarchal, and collectivist [22-24]. In such societies the greater good takes precedence over the good of the individual. Furthermore, social stability is high, and the rate of social change is slow [25]. As the youth within this society mature and establish their own nuclear families, they continue to identify with the larger collective [26].

The Bedouin population is a sector of Israel's Arab-Muslim minority that predominantly resides in the Negev (250,000 individuals). A much smaller community of Bedouins is found in the Galilee [27]. Half of the Bedouin population resides in recognized towns while the other half resides in unrecognized villages that lack permanent infrastructure. Although contemporary Bedouin society is experiencing socio-structural change and enhanced educational and social initiatives now obtain, this traditional patriarchal society nevertheless suffers from extreme poverty relative to the rest of the population. It also endures educational disparities, low incomes, unemployment, and shortages in government services that are now necessary for proper social functioning [28].

In line with the global processes of modernization, the role of the Arab family as a source of primal support in times of crisis has diminished [29]. This can be assumed to induce psychological stress—particularly because Arab society is a society in transition [30]. Such lack of social support significantly impacts individuals coping with mental illness and its specific stigmas. In Islam, mental illness is regarded as a test from God or a sign of divine punishment which corresponds to a sin committed against the Creator [31]. There are many hadiths containing the words of Mohammad that deal with the mental state of all humans. Since Islam is seen as a source of solace [32] overcoming mental illness is perceived as an act requiring a sustained increase of faith. From the perspective of Islam, recovery hinges on afflicted individuals strengthening their devotion to God [33,34] and enduring their travails steadfastly until relief occurs. Due to this presumed link between mental illness and supernatural phenomena, the role of the patient within the family is of crucial significance. Unfortunately, social support is particularly deficient when the patient happens to be the head of a family. Damage to the main breadwinner's status is likely to result in social and economic distress, further isolating the patient and making it even more difficult to recover or return to normal functioning [35,36]. Although various studies point to stigmatization as a major impediment to requesting treatment services [37], very few of the available stigma-reducing strategies are effective for those seeking help.

Only 3% of Arabs suffering with mental illness avail themselves of psychiatric services−which is miniscule compared to the mentally-ill population in Israel who do utilize these services [38]. Ambivalent attitudes toward mental health providers, limited mental health services in the Arab sector, and a lack of demand for mental health employment contribute to this high differential [39].

Aims

The present study examines the associations between self- and social stigma, Sense of Coherence, and family support among people with mental illness in Israel's Arab population.

Method

Study population and procedure

The study population included 122 patients with mental illness, 59% of whom were males over the age of 18. Within that group, 10% were between 18-25 y/o, 21% were between 25-35 y/o, 37% were between 35-45 y/o and 32% were above 45 y/o. Regarding marital status, about 43% were single, 33% were married and the rest were either separated (15%) or widowed (6%). The educational distribution indicates that 25% of respondents finished elementary school, 31% finished junior high school, 32% finished high school and 9% completed higher education. Most participants (85%) were not employed due to the constraints of their disability. The majority of the respondents in the sample were treated in mental health clinics.

Patients were recruited with the help of clinic staff after the researchers made an initial contact with program directors at community mental health centers. An informational meeting was held with the staff to inform them of the nature of the study and how they were to interact with patients. For example, after reviewing the questionnaire, the staff was trained in conducting a preliminary interview in order to obtain the consent and willingness of patients to participate in the study. Aware of the delicate subject matter, the researchers distributed the questionnaires with empathetic inquiry into participants' mental state before, during, and after filling out the questionnaires. Participants who could read and write filled in the answers by themselves. For those patients who were illiterate, the staff asked the participants the questions and filled in the respondents' answers as they sat alongside them. No one received compensation for participation, although small gifts were handed out by the researchers as traditional tokens of appreciation.

Measures

Self-stigma was measured using the Self-Stigma of Mental Illness Scale. The measure included 40 items on a Likert scale in order to quantify awareness of existing stereotypes, agreement with stereotypes, applying stereotypes, and injury to self-esteem. The reliability of the indices in the present study was high: 0.78, 0.82, 0.85, and 0.91, respectively.

Social stigma was examined using the multidisciplinary scale, which examines how psychiatric patients are perceived by society. The 27-item scale references nine social stereotypes: guilt, anger, compassion, willingness to help, readiness, fear, avoidance, exclusion, and necessity for treatment. In previous studies the reliability of this scale has been found to be high- 0.76-0.88. In the current study, reliability was $\alpha = 0.8$.

Social support was measured using a perceived social support questionnaire [40] that measures individual perception of his or her potential sources of support. The questionnaire includes 40 statements examining four components: sense of belonging ($\alpha = 0.87$), consulting and sharing with another ($\alpha = 0.75$), material support ($\alpha = 0.77$), and support for self-worth ($\alpha = 0.84$).

Sense of Coherence was measured using the Sense of Coherence Scale [41]. The scale includes 13 items which assess four aspects of Sense of Coherence: general perception of self, stressors, health condition and health behavior [42]. The reliability of the scale ranges between 0.7 and 0.95. Reliability in the current study was 0.7. A high score translates into a higher Sense of Coherence.

All questionnaires were translated from English into Arabic by professionals and then back translated into English as a check upon the accuracy of the translation.

Data analysis

Data were entered and analyzed using SPSS Version 24. Descriptive statistics were produced for demographic data using frequencies for nominal variables while means and standard deviations were calculated for numerical variables. A Pearson correlation was used to examine relationships among variables. In addition, multiple linear regressions were used to assess how stigma and Sense of Coherence are related to social support. Finally, a mediation analysis was conducted using the PROCESS SPSS macro in order to assess how Sense of Coherence impacts the relationship between stigma and social support. We did not assume that Sense of Coherence would affect the correlation between these two variables. The mediation model (as opposed to a moderation model) best revealed the mechanism by which Sense of Coherence, stigma and social support are related. The significance level was set at 5%.

Variable	**N**	**%**
Sex		
· Males	72	59.02
· Females	50	40.98
Age		
· 18-25	13	10.74
· 25-35	25	20.66
· 35-45	45	37.19
· 45+	38	31.4
Marital status		
· Single	53	44.17
· Married	41	34.17
· Separated	19	15.83
· Widow	7	5.83
Children		
· Yes	53	46.09
· No	62	53.91
Education		
· Elementary	30	25.42
· Junior High	40	33.9
· High School	38	32.2
· Academic	10	8.47
Employment		
· Employed	18	15.13
· Unemployed	101	84.87
Years since diagnosis		
· 1-5	29	24.58
· 6-10	30	25.42
· 11-15	25	21.19
· 16+	34	28.81
Treatment		
· Untreated	2	1.67
· Traditional customs	7	5.83
· Mental health clinic	70	58.33
· Traditional customs + mental health clinic	41	34.17

Table 1: Demographic characteristics of participants in the study

Results

Table 2 shows the descriptive statistics of the main variables in the study. Self-stigma was found to be positively correlated with social stigma; meaning that patients with high self-stigma also suffered from high social stigma. In addition, social stigma was found to be positively related to Sense of Coherence. Patients who suffered from high social stigma also had a high Sense of Coherence. Finally, Sense of Coherence was found to be positively associated with social

support, meaning that patients who received high social support also had a high Sense of Coherence.

	M (SD)	1	2	3
1. Self-stigma	2.78 (0.61)			
2. Social stigma	3.02 (0.62)	.23*		
3. Sense of coherence	3.13 (0.55)	0.03	.44**	
4. Social support	2.42 (0.48)	0.08	0.09	.27**

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

Table 2: Means, standard deviations and Pearson correlations between main study variables

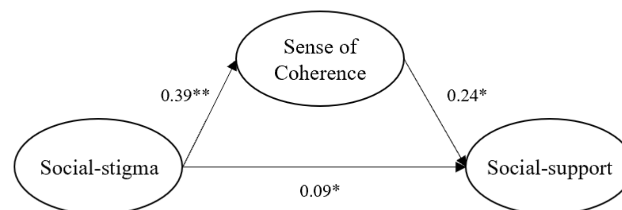
Table 3 shows the results of the multiple regression assessing relationships between self-stigma, social stigma, and Sense of Coherence on social support after controlling for sex, age, education and duration of illness. Independent variables explained 12% of the variance in social support (F(7,101) = 2.91, p<.05). As shown in Table 3, SOC was positively correlated to social support, meaning that individuals with high SOC also had high social support.

	B	Std. Error	Beta	t	p
Sex (Males)	-0.011	0.088	-0.012	-0.125	0.901
Age	-0.042	0.053	-0.088	-0.793	0.43
Eeducation	-0.026	0.05	-0.054	-0.532	0.596
Duration of illness	-0.027	0.043	-0.067	-0.62	0.537
Self-Stigma	0.089	0.076	0.119	1.167	0.246
Social Stigma	0.095	0.088	0.122	1.083	0.282
SOC	0.154	0.089	0.19	1.723	0.042

Table 3: Regression coefficients predicting social support

To assess how Sense of Coherence mediates the relationship between stigma and social support, we conducted a mediation analysis. First, it was found that social stigma is positively related to Sense of Coherence (B = 0.39, se=0.07, p< .001, 95%CI [0.24,0.54]). In addition, after controlling for social support, a positive association was found between SOC and social support (B = 0.24, se = 0.08, p<. 05, 95%CI [0.07,0.41]). Finally, a significant indirect effect was found between social stigma and social support through SOC (B = 0.09, se = 0.04, p<.05, 95% CI [0.03,0.21]). We see that high social stigma is associated with high SOC, which in turn is associated with high social support (see Figure 1).

In a similar mediation model that relates self-stigma to social support through SOC, no significant indirect effect was found (B = 0.01, se = 0.03, p<.05, 95%CI [-0.03,0.05]).



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

Figure 1: Mediation model: social stigma and social support thorough Sense of Coherence

Discussion

The current study examines the association between self-stigma and social stigma, Sense of Coherence, and social support for individuals with mental illness in Israel's Arab population. Several important findings were obtained. First, self-stigma was found to be positively correlated to social stigma, meaning that patients with high self-stigma also suffer from high social stigma. This finding is in line with previous studies that show that individuals with mental illness suffer from both self-stigma and social stigma. These two forms of stigma are highly correlated as patients tend to internalize stigmas regarding mental illness from the social cues ambient in their society. These results are consistent with previous studies that found that negative social attitudes toward mental illness affect patients who are mentally ill and who in turn expect to experience constrained responses to their condition from members of their society. The expectations of such patients often contribute to their demoralization and a diminished sense of self-worth. Just as stigma affects self-efficacy and self-image, self-perception is influenced by the socio-cultural background from which social stigma originates. This, in turn, can lead to the formation and amplification of self-stigma. In other words, the very expectation of discriminatory treatment can prompt a stigma-related response from a person with mental illness.

When exploring this outcome from a cultural perspective, it is crucial to understand the religious elements in Arab society that amplify the implications of self-perception. Traditionally, Arab society is characterized by a strong collectivist ethos that is salient and enduring even today. In the current case, it appears that the traditional collective character of Israel's Arab society heightens the relationship between personal stigma and social stigma with regard to mental illness. Societal values and norms influence individual perceptions and life choices, which then form the basis for an individual's perception of his/her own mental health [43]. The present study confirms this association among patients with mental illness in the Arab population in Israel.

In addition, social stigma was found to be positively related to Sense of Coherence. Patients with mental illness who suffer from high social stigma also have high SOC. Counterintuitively, social stigma does not diminish SOC. Rather, it amplifies it. Moreover, Sense of Coherence is positively associated with social support, meaning that patients who have a high SOC also experience high social support. The mediation model supports the notion that Sense of Coherence mediates the relationship between stigma and social support. It is important to understanding how this occurs: high Sense of Coherence generates greater support from family members. SOC is crucial to developing enhanced social support for patients with mental illness in

Arab society in Israel. This is confirmed by Braun-Lewensohn and Sagy who note that in traditional religious societies, a Sense of Coherence produces elements of help and support. This is highly relevant to Bedouins, who maintain the highest level of traditional values among all Arabs in Israel [44].

Implications

Social stigma and self-stigma are powerful structural, relational, and personal phenomena which are only heightened among the vulnerable population of mentally ill. This article presents innovative research that explores the links between social/public stigma, self-stigma, and Sense of Coherence (SOC) among the mentally ill Bedouin population in Israel. This group is particularly at risk in light of the social, educational, and financial challenges that Bedouins in Israel faces.

As a broad topic, stigma has received a great deal of research attention since Goffman's seminal work [45]. SOC, too, has been amply discussed in the scholarship – including its links to experiences of stigma among people with mental illness [46-48]. That said, the literature has overlooked the possible mediating effect of Sense of Coherence upon stigma and social support.

The surprising finding of the current research is that Sense of Coherence is partially positively associated with social stigma among mentally ill Arabs in Israel. This intriguing result suggests a productive direction for future research. It is important to test whether this association holds among other populations that experience stigma due to mental illness. The study's finding that high Sense of Coherence leads to increased support from family members has salient clinical implications. The family unit, traditional bedrock of Arab society has experienced significant and rather precipitous downfall. This has resulted in a loosening of its support structure and an erosion of family strength – with a concomitant loss in familial ability to act as a buffer for vulnerable members: patients with mental illness. Significantly, family-oriented treatment has been found to be the modality of choice in the population under study. Family-oriented treatment is also highly utilized throughout the Israeli Arab population that contain family members who suffer from mental illness. Langeland et al. discuss the claim that Western psychotherapies overly emphasize negative events in patients' histories and overlook the development of coping resources. Such an assessment aligns with research on the Arab population. Arab society places emphasis upon present-oriented treatment [49]. The current study indicates that treatment planning for individuals with mental illness and their families might benefit from greater focus on the development of such coping skills within the broader context of SOC .

Limitations

The current study has several limitations. First, the sample size is relatively small and was obtained using the convenient method of sampling. Therefore, it cannot be said that this sample is truly representative of all cases of mental illness in Arab society in Israel. Second, as participants in this study suffer from cognitive deterioration, the reliability of the data is limited. While these limitations may inhibit generalization of these results, the study, nevertheless, represents an important first step in determining directions for future research on self- and social stigma as they relate to Sense of Coherence and family support. A more comprehensive study might use a moderating model to investigate the effect of SOC on buffering social stigma.

Conclusions

Mental health practitioners need to consider the impact of personal and social stigma when working with Arab clients. For example, treatment strategies that consider Arab culture and religion, as well as gender differences, may greatly increase their effectiveness. Additionally, mental health practitioners should be aware that many of their Arab clients use traditional healing systems. Practitioners may need to identify intervention strategies in traditional healing that are less stigmatizing than those in modern Westernized mental health paradigms and possibly incorporate them into their treatment. Promotion of culturally-religiously appropriate psychiatric services in Arab communities should enable achievement of effective mental health outcomes.

Funding

The authors have no funding to disclose.

Compliance with Ethical Standards

All Procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Conflicts of Interest

The authors declare that they have no conflict of interest.

Informed Consent

Informed consent was obtained from all individual adult participants included in the study.

References

1. Corrigan PW, Druss BG, Perlick DA (2014) The impact of mental illness stigma on seeking and participating in mental health care. Psychol Sci Public Interest 15: 37-70.
2. Henderson C, Evans-Lacko S, Thornicroft G (2013) Mental illness stigma, help seeking, and public health programs. Am J Public Health 103: 777-780.
3. Goffman E (1963) Stigma: Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice Hall.
4. Ahmedani B (2011) Mental health stigma: Society, individuals and the profession. J Soc Work Values Ethics 8: 1-16.
5. Bos A, Pryor J, Reeder G, Stutterheim S (2013) Stigma: Advances in Theory and Research, Int J Soc Welf 35: 1-9.
6. Corrigan PW, Barr L, Watson AC (2006) The self- stigma of mental illness: Implications for self-esteem and self-efficacy. J Soc Clin Psychol 25: 875-884.
7. Peluso ÉTP, Blay SL (2011) Public stigma and schizophrenia in São Paulo city. Brazilian Journal of Psychiatry 33: 130-136.
8. Link BG, Phelan JC (2013) "Labeling and stigma" in Handbook of the Sociology of Mental Health, Springer Netherlands 525-541.
9. Gray JA (2002) Stigma in psychiatry. J R Soc Med 95: 72-76.

10. Hansson L, Wenz E, Bjorkman T, Lundberg B (2009) Are stigma experiences among persons with mental illness related to perceptions of self-esteem, empowerment, and sense of coherence?. J Psychiatr Ment Health Nurs 16: 516-522.
11. Weller BE, Faulkner M, Doyle O, Daniel SS, Goldston DB (2015) Impact of patients' psychiatric hospitalization on caregivers: A systematic review. Psychiatric Services 66: 527-535.
12. Corrigan P W, Lurie BD, Goldman HH, Slopen N, Medasani K, et al. (2005) How adolescents perceive the stigma of mental illness and alcohol abuse. Psychiatric Services 56: 544-550.
13. Manstead AS, Hewstone ME, Fiske ST, Hogg MA, Reis HT, et al. (1995) The Blackwell encyclopedia of social psychology. Blackwell Reference/Blackwell Publishers.
14. Corrigan PW, Markowitz FE, Watson AC (2004) Structural levels of mental illness stigma and discrimination. Schizophrenia Bulletin 30: 481-491.
15. Talebi M, Matheson K, Anisman H (2016) The stigma of seeking help for mental health issues: Mediating roles of support and coping and the moderating role of symptom profile. J Appl Soc Psychol 46: 470-482.
16. Reinecke J, Llic M, Bohner G, Rottgers H, Beblo T, et al. (2012) Protecting self-esteem from stigma: A test of different strategies for coping with the stigma of mental illness. Int J Soc Psychiatry 58: 246-57.
17. Chien WT, Yeung FK, Chan AH(2014) Perceived stigma of patients with severe mental illness in Hong Kong: Relationships with patients' psychosocial conditions and attitudes of family caregivers and health professionals. Admin Pol Ment Health 41: 237-251.
18. Watson AC, Corrigan P, Larson JE, Sells M (2007) Self-stigma in people with mental illness. Schizophrenia Bulletin 33: 1312-1318.
19. Antonovsky A (1987) Unrevealing the Mystery of Health: How People Manage Stress and Stay Well. Jossey-Bass, San Francisco, CA.
20. Eriksson M, Lindström B (2007) Antonovsky's sense of coherence scale and its relation with quality of life: a systematic review. Journal of Epidemiology & Community Health 61: 938-944.
21. Super S, Wagemakers MAE, Picavet HSJ, Verkooijen KT, Koelen MA (2016) Strengthening sense of coherence: opportunities for theory building in health promotion. Health Promotion International 31: 869–878.
22. Al-Haj M (1989) Social research on family lifestyles among Arabs in Israel. Journal of Comparative Family Studies 20: 175-195.
23. Dwairy M (2006) Counselling and Psychotherapy with Arabs and Muslims: A culturally sensitive approach. New York: Teachers College Press. Columbia University.
24. Kandel I, Moad M, Vardi G, Press J, Merrick J (2004) The Arab community in Israel coping with intellectual and developmental disability. Sci World J 4: 324-332.
25. Al-Krenawi A, Graham J, Al-Gharaibih F (2011) The impact of intellectual disability, caregiver burden, family functioning, marital quality, and sense of coherence. Disability and Society 26: 139-150.
26. Al-Krenawi A, Graham JR, Slonim-Nevo V (2002) Mental health aspects of Arab-Israeli adolescents from polygamous versus monogamous families. J Soc Psychol 142: 446-460.
27. Daoud N, Braun-Lewensohn O, Eriksson M, Sagy S (2014) Sense of coherence and depressive symptoms among low-income Bedouin women in the Negev, Israel. J Ment Health 23: 307-311.
28. Marx E, Meir A (2005) Land, towns and planning: The Negev Bedouin and the State of Israel. In Geography Research Forum 25: 43-61.
29. Azaiza F (2008) The perception and utilization of social support in times of cultural change: The case of Arabs in Israel. Int J Soc Welf 17: 198-203.
30. Ayalon L, Karkabi K, Bleichman I, Fleischmann S, Goldfracht M (2015) Between modern and traditional values: Informal mental health help-seeking attitudes according to Israeli Arab women, primary care patients, and their providers. Int J Soc Psychiatry 61:383-393.
31. Aloud N (2004) Factors affecting attitudes toward seeking and using formal mental health and psychological services among the Arab-Muslim population. Doctoral dissertation, The Ohio State University.
32. Amri S, Bemak F (2013) Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust. Journal of Muslim Mental Health 7: 43-63.
33. Al-Krenawi A (2005) Mental health practice in Arab countries. Current Opinion in Psychiatry 18: 560-564.
34. Gayle K, McCann RA, Charbonneau AM, Webb M (2011) Struggling and enduring with God, religious support, and recovery from severe mental illness. J Clin Psychol 67: 1161-1176.
35. Al-Krenawi A, Graham JR, Kanat-Maymon Y (2009) Analysis of trauma exposure, symptomatology and functioning in Jewish Israeli and Palestinian adolescents. The British Journal of Psychiatry 195: 427-432.
36. Haj-Yehia A, Bialer M (1989) Structure–pharmacokinetic relationships in a series of valpromide derivatives with antiepileptic activity. Pharm Res 6: 683-689.
37. Eisenberg D, Downs MF, Golberstein E, Zivin K (2009) Stigma and help seeking for mental health among college students. Medical Care Research and Review 66: 522-541.
38. Al-Krenawi A, Graham JR (2000) Culturally sensitive social work practice with Arab clients in mental health settings. Health & Social Work 25: 9-22.
39. Al-Krenawi A, Graham JR (2011) Mental health help seeking among Arabs in Israel. Mental Health, Religion, & Culture 14: 157-167.
40. Sarason IG, Levine HM, Basham RB, Sarason BR (1983) Assessing social support: The social support questionnaire. J Pers Soc Psychol 44: 127-139.
41. Antonovsky A (1993) The structure and properties of the Sense of Coherence Scale. Social Science and Medicine 36: 725-733.
42. Pallant JF, Lae L (2002) Sense of coherence, well-being, coping and personality factors: further evaluation of the sense of coherence scale. Personality and individual differences 33: 39-48.

43. Lai SHH (2016) Value Orientation as a Moderator on Self-stigma in People with Mental Illness. Univers J Psychol 4: 132-138.
44. Braun-Lewensohn O, Sagy S (2011) Salutogenesis and culture: Personal and community sense of coherence among adolescents belonging to three different cultural groups. Int Rev Psychiatry.
45. Goffman E (2009) Stigma: Notes on the management of spoiled identity. Simon & Schuster.
46. Griffiths CA (2009) Sense of Coherence and Mental Health Rehabilitation. Clin Rehabil 23: 72-78.
47. Świtaj P, Grygiel P, Chrostek A, Nowak I, Wciórka J, et al. (2017) The relationship between internalized stigma and quality of life among people with mental illness: are self-esteem and sense of coherence sequential mediators?. Qual Life Res 26: 2471-2478.
48. Świtaj P, Anczewska M, Chrostek A, Grygiel P, Prot-Klinger K, et al. (2013) The sense of coherence as a predictor of the scope and impact of stigma experiences among people with mental illness. Psychiatry Res 249-251.
49. Langeland E, Wahl A, Kristoffersen K, Hanestad BR (2007) Promoting coping: Salutogenesis among people with mental health problems. Issues in Mental Health Nursing 28: 275-295.
50. Central Bureau of Statistics of Israel (2013).
51. Dudley JR (2000) Confronting stigma within the services system. Social Work 45: 449.
52. Feldman DB, Crandall CS (2007) Dimensions of mental illness stigma: What about mental illness causes social rejection?. J Soc Clin Psychol 26: 137-154.
53. Jones EE (1984) Social stigma: The psychology of marked relationships. WH Freeman.