

## The Prevalence and Experience of Harassment of People with Mental Health Problems Living in the Community in Iran

Mohammad Arbabi, MD<sup>1</sup>  
Ali-Akbar Nejatiasafa, MD<sup>1</sup>  
Mohammad Reza Mohammadi, MD<sup>1</sup>  
Somayeh Yousefi, BS<sup>1</sup>  
Sara Mahdavian, BS<sup>1</sup>  
Sharzad Izadi, MD<sup>2</sup>  
Kathryn M. Berzins, PhD<sup>3</sup>

1 Psychiatry and Psychology Research Center, Tehran University of Medical Sciences, Tehran, Iran

2 Education and Research Development Center, Imam Khomeini Hospital, Tehran University of Medical Sciences, Tehran, Iran

3 Personal Social Services Research Unit, Division of Psychiatry, University of Manchester, Manchester, UK

### Corresponding author:

Mohammad Arbabi, MD,  
Assistant Professor of Psychiatry,  
Psychiatry and Psychology  
Research Center, Roozbeh  
Hospital, South Kargar Ave.,  
Tehran, 1333795914, Iran.  
Tel: +98-21-55412222,  
Fax: +98-21-55419113,  
Email: arbabi\_m@tums.ac.ir

**Objective:** There have been concerns about people with mental health problems experiencing harassment in the Iranian community. This study measures the prevalence and nature of harassment experienced by individuals with mental health problems and compares them with the general population.

**Methods :** Face to face interviews were conducted by trained interviewers to ascertain experiences of harassment. Interviews were carried out with 112 individuals with mental health problems and with 104 individuals from the general population.

**Results:** Sixty-one per cent of people with mental health problems reported experiencing harassment, nearly ten times more frequently than those in the general population (7%). Among the people with mental health problems, being female, having higher levels of education, or being unemployed were significantly associated with experiencing harassment. The harassment commonly involved verbal abuse, often made reference to individuals' mental health problems and was primarily committed by family members.

**Conclusions:** A significantly higher prevalence of harassment was reported among individuals with mental health problems living in the community than in the general population sample. Mental health professionals should proactively ask their service users about their experiences at home, and educational interventions are recommended, particularly for families of those with mental health problems.

### Key Words:

*Harassment, Mental health, Mentally ill persons*

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One of the aims of the transition from institutional to community care was to encourage normalization, promote integration and increase autonomy increasing people with mental health problems' independence and ability to master their own lives (1). However, a supportive environment is required for people to achieve these goals and to maintain their quality of life (1). In Iran, once patients with mental health problems leave hospital care they attend an out-patient clinic but are largely reliant on family support. This means that the community and home environment are particularly important aspects of these peoples' lives. This research was conducted after concerns were expressed by the community mental health workers who were worried about the reports they received from some outpatients about the negative experiences they had in their families and communities. There has been no previous research into this area in Iran so the prevalence of such problems was unknown particularly in whether people

with mental health problems differ from the general population. Several studies explored similar experiences in other countries, predominantly in the United Kingdom (2). In Scotland, Berzins examined the levels and experiences of harassment of individuals with mental health problems in the community and compared them with those of the general population. Harassment in the community was found to be more than twice as common for individuals with mental health problems (41%) than for those in the general population (15%) (2). Read and Baker's study in England and Wales looked at stigmatization and discrimination against individuals with mental health problems and the results indicated that 50% of the respondents had experienced harassment in both the community and workplace (3). Similarly, research in Northern Ireland reported that 60% of people with mental health illnesses had experienced harassment (4). This study sought to investigate whether there were similar problems facing people with mental health

problems living in Iranian communities and if so, how their experiences were compared to the general population.

### Materials and Methods

This research followed a similar method to Berzins et al (2), using the same definition that states harassment occurs when a person commits an action that may reasonably result in another feeling harassed; it can take a variety of forms, both verbal and physical, have a variety of motives and need not necessarily be repeated; furthermore, the person who committed the harassment does not necessarily need to have acted with intent. This is a broad definition that seeks to focus on the impact of the behavior on the individual rather than classifying specific behaviors as 'harassing'.

#### Participants

One hundred and twelve individuals with mental health problems were interviewed. All lived in the community and attended an outpatient clinic of Roozbeh Hospital for treatment. The general population control group consisted of 104 individuals with a similar distribution of both gender and age to the outpatient sample and none of the individuals in the control group attended mental health services. The control group was selected from patients' caregivers or healthy people who referred for routine medical assessments and did not have psychiatric problems in a general hospital.

#### Inclusion criteria

It was felt to be important that interviewees chosen were suffering from enduring mental health problems rather than a single episode like adjustment disorder or mood disorder, single episode type. These individuals with mental health disorders were all experiencing continuing mental health problems and were under continuing treatment of a psychiatrist and other professionals at the outpatient clinic. All were aged between 18 and 65 years.

#### Exclusion criteria

People experiencing dementia, homelessness or substance dependency were excluded as it was felt that these groups had different needs and experiences to the typical outpatient service user.

#### Research instruments

To explore the complex aspects of harassment in a safe environment, a face-to-face interview was used which closely followed the format used by Berzins et al (2003). The interview was semi-structured to collect standard socio-demographic information about the participants before continuing to take details of any incidents of harassment that interviewees described. The same interview was administered to both sample groups to allow direct comparison. This included information about what the experience(s) had consisted

of; where they had occurred; who was committing them; why they were felt to be occurring and the impact they had had on the interviewees.

Again, similar to Berzins et al (2), we recorded harassment that interviewees described both at home and in the wider community but excluded childhood abuse and domestic violence.

#### Procedure

Psychiatric nurses at the outpatient clinic invited people meeting the inclusion criteria to take part in an interview. If informed consent was given, they referred the participants to the research team for an interview. All the outpatient candidates were interviewed in a private room in the clinic of the hospital, an environment familiar to each of them. The general population was recruited from people attending general hospital services who matched the outpatient sample with regards to age and gender. A team of two specially trained interviewers carried out the interviews between January and July 2006, under the supervision of two psychiatrists.

#### Analysis

The data were analyzed using SPSS, Version 11.5 for Windows. Comparisons between subgroups were made using the student t test and the chi square test.

### Results

A total of 216 individuals were recruited: 112 with mental health problems (from 119 outpatients, response rate: 94%) and 104 from the general population (from 116 subjects, response rate 90 %).

#### Socio-demographic characteristics

Table one demonstrates some of the socio-demographic characteristics of the two samples, including gender, age and employment status.

There was one significant difference ( $p=0.006$ ) between the number of individuals in the two groups with respect to employment: 71% (74/104) of the general population were employed or were students, compared to 28% (31/112) of the subjects with mental health problems. Few subjects across the both samples lived alone ; only 3 % ( 3/112) with mental health problems and 4% (4/104) in the general population. The ownership of property was also similar between the samples: 71% (80/112) of the subjects with mental health problems lived in their family-owned house and 74 % ( 77/104) owned their houses in the general population.

Over half of the both samples (71%, 80/112 sample with mental health problems and 60%, 62/104 of the general population sample) had lived in their local area for over twenty years.

#### Prevalence of harassment

Table two describes the overall reported experiences of harassment and demonstrates that harassment was

**Table 1. Socio-demographic characteristics (n, %)**

		People with mental health problems n=112	General population n=104
<b>Gender</b>	Male	51 (46%)	46 (44%)
	Female	61 (54%)	58 (56%)
<b>Age group</b>	<25	31 (28%)	30 (29%)
	25-34	36 (32%)	36 (35%)
	35-44	26 (23%)	23 (22%)
	45-54	13 (11%)	13 (12%)
	55-65	3 (3%)	2 (2%)
	65<	3 (3%)	0
<b>Employment status</b>	Employed / student	31 (28%)	74 (71%)
	Unemployed	81 (72%)	30 (29%)*

\*p<0.005

**Table 2. Summary of the main features of the harassment (n, %)**

		People with mental health problem experiencing harassment (n=68)	General population experiencing harassment (n=7)	
<b>Overall prevalence of harassment*</b>		68(61%)	7(7%)	p<0.001 x <sup>2</sup> =70.28,df=1
<b>Where the harassment occurred</b>	Home	54(79)	4(57)	
	Community / workplace	9(13)	0	p=0.056 x <sup>2</sup> =7.54,df=3
	School	6(8)	3(43)	
<b>Who committed the harassment</b>	Family	51(75)	4(58)	p=0.27 x <sup>2</sup> =3.89,df=3
	Others	17(25)	3(43)	
<b>What the harassment consisted of</b>	Verbal abuse	49(72)	4(57)	
	Other interference	11(15)	3(42)	p=0.17 x <sup>2</sup> =3.51,df=2
	Reference to mental health problems	9(13)	0	
<b>Why the harassment occurred*</b>	Need / inadequacy of the harasser	26(38)	6(86)	
	As victim had mental health problems	25(37)	0	p=0.04 x <sup>2</sup> =6.23,df=2
	Perceived as vulnerable	17(25)	1(14)	

\* p<0.005

significantly higher in the sample of the individuals with mental health problems than in the general population sample (p=0.0001). People with mental health problems were nearly ten times more likely to have experienced harassment than the general population sample: 61% (68/112) of the individuals with mental health problems experienced harassment but only 7% (7/104) of the general population had similar experiences. Figures for the incidence of

harassment are shown broken down further into community, home, workplace and school.

Participants who had experienced harassment across the both sample groups were more likely to have experienced harassment at their own homes: 79% (54/68) of the participants with mental health problems and 57% (4/7) of the participants in the general population (p=0.056).

**Table 3: Socio-demographic characteristics of participants with mental health problems (n,%)**

		Experiencing harassment	Not experiencing harassment	
<b>Sex</b>	Female	44(65)	18(40)	P=0.09, x <sup>2</sup> =6.74,df=1
	Male	25(35)	26(60)	
<b>Age Group</b>	<25	20(29)	11(25)	P=0.24, x <sup>2</sup> =6.64,df=5
	25-34	23(34)	12(28)	
	35-44	15(22)	11(25)	
	45-54	9(14)	4 (9)	
	55-65	0(0)	4(9)	
	65<	1(1)	2(4)	
<b>employment status</b>	employed/student	14(54)	16(37)	P=0.045, x <sup>2</sup> =3.69,df=1
	unemployed	54(80)	28(64)	

**Table 4: Impact of harassment and trying to tackle the problem (n, %)**

		People with mental health problem experiencing harassment (n=68)	General population experiencing harassment (n=7)
<b>To whom was the harassment reported?</b>	No report	28(42)	0
	Family	34(50)	6(86)
	Police	3(4)	1(14)
	Medical and social care staff	3(4)	0
<b>No effect of reporting the harassment</b>		54(79)	3(42)
<b>Solutions attempted to stop the harassment</b>	None	43(63)	4(58)
	Reasoning with the harasser	22(33)	1(14)
	Moving house	3(4)	2(28)
	Adverse effect on mental health	40(60)	2(29)
<b>Impact of the harassment</b>	Anger and annoyance	24(35)	3(42)
	Fear	4(5)	2(29)
	Anger and annoyance	28(41)	3(43)
<b>Most distressing aspect of the harassment?</b>	Stigma of mental health problem	25(37)	0
	Adverse effect on mental health	15(22)	4(57)
<b>What would stop or prevent harassment</b>	Change in public attitude	44(65)	5(72)
	Education in community and schools	16(24)	1(14)
	More effective policing	8(11)	1(14)

\* = p<0.005

**Factors associated with experiencing harassment**

Harassment in the sample of the participants with mental health problems was found to be nearly twice as common for females as for males (p=0.031), no differences were found between genders in the general population. Furthermore, having higher educational status (p=0.0001) and being unemployed (p=0.001) were also shown to have a positive association with experiencing harassment. No significant relationships were found with age, marital status or residential factors.

More than half of the both samples who experienced harassment still experienced it at the time the interview took place. (37/67, 55%, of those with mental health problems in the general population 5/7, 71%)

**The features of the harassment**

Across the both samples, family members were most frequently described as having committed the harassment (subjects with mental health problems 51/68, 75 %, in the general population 4/7, 57%). The

harassment experienced as a result of family predominantly consisted of verbal abuse. Relatives were largely thought to commit harassment as a result of influence from other family members or because of wider negative societal views of mental health problems. The general population also described experiencing harassment by relatives.

In the both samples, verbal abuse was the most common form of harassment (people with mental health problems 49/78, 72%, general population 4/7, 57%). People with mental health problems described verbal abuse containing derogatory references to their mental health forming part of this verbal abuse. Other forms of interference described by outpatients included being physically threatened and even physically abused.

The dominant reason why the subjects with mental health problems felt they were victims of harassment was because they were known to be experiencing mental health problems, or were perceived as vulnerable. The majority of the general population sample felt they had been targeted due to some need of the harasser.

Table 4 demonstrates the impact of the harassment and how people attempted to tackle the problem.

All of the individuals in the general population sample had felt able to report the harassment to somebody, the majority to other family members, whereas nearly half of the outpatient sample had not felt able to report what had happened to anybody. Very few people in the both groups reported their experiences to the police and very few with mental health problems told mental health professionals about their experiences.

Nearly 80% of the outpatients felt that reporting the harassment had made no difference whereas only 42% (n=3) of the general population felt the same. Over half (43/68 63%) of the subjects with mental health problems had taken no action to attempt to stop the harassment. If they did take an action, it was most commonly trying to reason with the harasser although a small number said they had felt necessary to move house.

Nearly two thirds of the interviewees with mental health problems said that the harassment had had a negative impact on their mental health. Anger and annoyance were described most frequently by the general population (3/7, 42%) and second most frequently described by those with mental health problems (23/68, 34%). The most distressing aspect of the experience was the reinforcement of stigma for those with mental health problems as well as the anger they felt at becoming a target.

All interviewees who experienced harassment in the both samples were asked what they thought would help to stop or prevent harassment of people with mental health problems from occurring in the first place. The responses were very similar between the two groups. The most common response was 'change in public attitudes' towards mental health problems, followed by education at schools and the wider community; and 9%

of those with mental health problems felt that more responsive policing would help.

## Discussion

This study showed that in Iran, individuals with mental health problems are nearly ten times more likely to experience harassment than the general population. In this respect, the study supports the earlier findings of Read and Baker, Kelly and McKenna, and Berzins (2-4). This study followed a similar methodology of Berzins but found a greater difference between the sample of people with mental health problems and the general population.

Iran is a different society compare to the United Kingdom, with very few people living alone as most people live within a family unit, this was not the case in the Berzins study where the majority of the subjects lived alone and targeted by people in their community, particularly neighbors and younger people (2). In this Iranian study, the fact that the majority of the harassment came from the family seems to indicate that living in family units does not necessarily offer protection from such negative experiences, but can instead make such people a target within their own family. It may be hypothesized that people with mental health problems are not seen as making a contribution to the household either due to their inability to be employed and earn a salary, or to make a satisfactory contribution to activities at home such as cooking or household tasks. In the Iranian sample, women were particularly vulnerable to harassment, a finding contrary to Berzins who detected no gender differences (2). Traditionally, women in the Iranian culture leave home less frequently than men so they are likely to have more contact time with their family members and it may also be that more is expected of them at home. It seems that being a woman with mental health problems living within a family home can be viewed as a predictor that harassment inside home is more likely to occur.

The correlation with higher educational level and experiencing harassment may be caused by higher expectations placed on the more educated persons with mental health problems to be employed and their economic inactivity less tolerated due to the potentially higher loss of earnings. Over a quarter of the Iranian outpatients were employed which is greater than the Berzins sample, this may be as people with mental health problems are less excluded from the labor market in developing countries than they are in the UK, where factors such as stigma and the Welfare Benefits system can make it difficult for people to re-enter employment after experiencing mental illness. In the Iranian sample, it seems that being employed offers some protection against negative experiences at home in those with mental illnesses. This may be due to the fact that those who are employed spend less time with other family members at home. Furthermore, what could be viewed as the 'normalising' aspects of employment, such as providing a weekly structure and

self-worth, in addition to employment, allow the patient to make a financial contribution to his/her family. In this respect, these findings add support to the idea that people with mental health problems are supported to enter employment interventions.

The fact that family members were cited as responsible for the majority of harassing behaviors within this sample, may additionally be related to high levels of expressed emotion) within the family (5). Much of the harassment consisted of verbal abuse, particularly making reference to peoples' illnesses. This is similar to the findings of both Read and Baker and Berzins and may be an extension of high levels of expressed emotion where family members are openly hostile and critical of the person with mental health problems (2, 3). A study by Mottaghipour reported highly expressed emotions in 60% of the families of Iranians with schizophrenia and this was found to be a risk factor for higher rates of relapse (6). In this study, the almost identical percentage (61%) of people with mental health problems experiencing harassment could be hypothesized to also leave people with mental health problems more vulnerable to relapse. This study supports the previous studies of harassment in that people with mental health problems who had experienced harassment felt it had a detrimental affect on their mental health.

The harassment was largely felt to occur because of general societal misunderstanding of mental illness leading to stigma and hostility. This research supports the development of anti-stigma work with the wider population but particularly with the families of people with mental health problems. Mottaghipour found that families had strong concerns surrounding the stigma of having a relative with mental health problems and this, plus a finding that many family members had low levels of education, should be taken into consideration when developing educational interventions with families (6). Further research is recommended into the development and evaluation of such interventions. Berzins found that 30% of people with mental health problems who had experienced harassment had moved house, as a result, this is not a viable option for many people in Iran as the majority of people live with other relatives in a family home. This adds further support to the need for interventions with families (2).

Although 61% of people with mental health problems had experienced harassment, 42% did not report it to anyone at all and very few told mental health professionals about their problems. It is recommended that awareness rising of this problem be carried out with mental health professionals who must be able to offer appropriate support when necessary. It is recommended that people with mental health problems in Iran and similar cultures should routinely be questioned about their experiences at home during clinical interviews and assessments to ensure that if there are problems, support can be provided and solutions can be sought.

There were some limitations in this study: First, the

instrument was made by researchers and it needs more assessment on its validation and reliability and second, the reports of harassments by the patients were subjective. Future studies can better answer questions about harassment in psychiatric patients by using standardized instruments and designing quantitative projects to observe and assess harassment .

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