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ABSTRACT

Individuals in Arabian cultures, as in any other culture, are forced into different life experiences and therefore, deliberately and inadvertently, develop many different and unique cultural values and perspectives. When practicing therapy, these differences must be taken into account before maximum success can be achieved. This paper concentrates on exactly this premise. Based on personal practice, anthropological studies, psychosocial research, and personal observations, themes central to four major shared social and psychological characteristics including: religious orientation; communal values; sex taboos; and authority-obedience orientation have been identified. The role of such dimensions in facilitating or hindering treatment effectiveness as it pertains to identifying target behavior, selecting treatment techniques, and identifying treatment goals and prognosis criteria is analyzed. Illustrative case studies and research findings are included. (Contains 51 references.) (Author/JDM)

Cultural Perspectives On Mental Health Practice in Arab Countries

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Abstract:

Individuals in Arabian cultures, as in any other culture, are forced into different life experiences, and, therefore, deliberately and inadvertently, develop many different and unique cultural values and perspectives. When we practice therapy, these differences must be taken into account before maximum success in therapy can be achieved. This presentation concentrates on exactly this premise. Based on personal practice, anthropological studies, psychosocial research, and personal observations, themes central to four major shared social and psychological characteristics including *religious orientation*; *communal values*; *sex taboos*; and *authority-obedience orientation* have been identified. The role of such dimensions in facilitating or hindering treatment effectiveness as pertain to: *identifying target behavior*; selecting *treatment techniques*; and *identifying treatment goals and prognosis criteria* have been analyzed. Illustrative case studies and research findings have been cited in support of our assumptions.

The concept of *culture* has undergone a variety of definitions, most emphasizing it as a shared feature of human groups. One traditional way, which we will be following here, is to deal with this concept as a construct that incorporates the values, beliefs, and behavioral patterns of a people who have lived together in a particular geographic area for a sustained period of time, i.e., at least three or four generations (e.g., Johnson, 1990; Wehrly, 1995). In short, and as Berry (2000, p. 393) put it, culture is a shared way of life among a group of people.

Mental health specialists have just recently been involved in making conscious efforts to incorporate cultural factors into their treatment strategies. The current state of affair in research and practice in psychotherapy and counseling seems to focus on how and in what way culturally

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determined behavioral patterns may influence the psychological treatment processes. In the last two decades, these *culturally oriented approaches* of psychological treatments have been enriched by many scholarly writings addressing the topic of cross- cultural and multicultural factors in professional practice (e.g., El-Dawla, 2001; El-Islam, 2001; Fish, 1995; Ghubash, 2001; Ibrahim, 2001; Jilek, 2001; Jenkins, 1985; Kiesler, 1966; Sue, 1981).

The culturally oriented approaches of treatment often operate under an acceptable assumption that individuals in any culture are forced into psycho-socially different experiences. Therefore, individuals in any culture, intentionally and unintentionally, develop many different and unique culturally determined behavior patterns and perspectives. To be alert to those factors can be of great value for mental health practice in Arabian countries.

Why Is Culture Beneficial for Mental Health Practice?

The benefits of information about the role of cultural factors in mental health practice are numerous. Johnson (1991), for example, cited proof that the role or function of culture in therapy provides the therapist with a framework to better comprehend the systems of relationships involved in multicultural practice. Additionally, awareness of cultural patterns plays an important role in determining the relevancy and effectiveness of any therapeutic relationship. Also, the inability to offer culturally relevant treatment is seen by Sue and Zane (1987, p. 45) as the single most important reason ethnic minorities are inadequately served. Further, well gathered knowledge of culture, will alert mental health practitioners to possible problems of credibility.

The Need for Mental Health Services in Arabian Cultures

Literature on the need for mental health services, and in what way these services should be presented in Arabian cultures is almost absent. One basic goal of this presentation is to present an overview of some major empirical psychological, psychiatric, and anthropological research done in Arab countries (e.g., Egypt, Saudi Arabia, Kuwait, and Libya), to identify the need for

mental health services in that culture. By and large, psychopathological patterns emerged in Arabian cultures are similar to those usually noted in the West. However, large proportions of mental health problems in Arabian countries receive inadequate psychological care. Further, we aimed to investigate the sensitive role of cultural patterns for providers of mental health services for Arabs.

CONCEPTUAL ISSUES RELATED TO ARABIAN CULTURE

At least four major modal personality and behavioral patterns that are relevant for better understanding of Arab patients can be hypothesized as follows:

(1) Religious orientation

(2) Orientation toward others, kinship, and communal attachments

(3) Attitudes, relationships, and dealing with sex subjects and opposite sex, and

(4) Attitudes, relationships, and dealing with authority figures.

Examining the role of each of these characteristics in practice is in order.

1. Religious Orientation:

Culture has strong impact not only on the beliefs we hold about the supernatural powers and the religion we adopt but also on the way we allow these beliefs and religious faith to impact our daily practices, the way we think, and styles of communication with others including therapeutic relationships.

Generally Arabs are religious. Islam is the major adopted religion in all Arab countries. Arabs' domestic world of relations is deeply affected by Islam in both its great and little traditions. Q'uraan (the *Islamic Holly Book)*, and a prayer rug is almost in every Muslim house. As in other cultures, there are, of course, those who do not ordinarily keep a strict religious practices but those individuals follow orthodox

practices during periods of religious celebration, such as in the fasting month of Ramadan (Altorki, 1986).

The strong religious orientation of Arabs deserves the attention of any mental health practitioner in Arabian countries. Because religion has such a pervasive influence, the practitioner with a working knowledge of Islamic values and assumptions can capitalize on such part of awareness. It is unfortunate that the training curricula of mental health practitioners in most departments of psychology in its imitation of the Western training methods downplay or ignore the importance of religion as a strong force in dealing with mental health problems in such part of the world.

In practice, it is easy for any practitioner to identify the vital roles of religion in the treatment process starting from identifying the chief complaints through to the choice of effective treatment techniques.

For example, pathological behaviors such as depression, obsession of cleanliness, interpersonal disorders and/or other types of mood alterations are either colored by rigid religious knowledge, or attributed to factors of religious and supernatural nature such as spirits, evil eye, or envy (*hasad).*

For examle, the clinical picture of obsessive- compulsive disorder (OCD) in Arabic patients is found in Egypt and Saudi Arabia to be colored by Islamic religious elements (Ibrahim, 2000; Okasha, et al. 1994). Research (Okasha et al, 1994) found that the most commonly occurring compulsions were repeating rituals, cleaning and washing, and contamination: symptoms that clearly reflect the alertness and attachment of Arabs with religion.

Also, similar religious picture colors expressing depression. Research showed that Arabs expressed their depression with more shame than guilt as compared with

individuals in the West. Therefore, Psychiatrists argue that one should consider shame a clinical symptom of depression if widely expressed by an Arabic patient. Suicide rates are very low in most research among depressed patients in Arabian countries, and are the lowest ever during the fasting month of Ramadan. This may suggest, at least in part, that religion has a preventive and shielding effect on expressing depression in Islamic cultures.

Because of their strong religious orientation, Arab patients seek professional mental health providers only after they have sought the help of traditional and religious types of healing (Dwairy, 1998; El-Islam, 1982; Okasha, 1977).

Some therapists may mistakenly call for, and may adopt, strong religious tones in their therapeutic practices. Hence, they color their treatment practices with strong tones of religious knowledge by using Q'uraanic verses, the prophet Mohamed sayings (*ahadeeth*), and theological interpretations (*fiqh.*) Although this strategy can, at times, be effective, it may be seen less credible especially by the patient who has already sought help with religious healers. It may be more effective to avoid religious arguments altogether and to reframe the client's problem on a *medicalized* ground. This approach is found to be an effective recognized treatment policy with non Anglo – American ethnic minorities in the US (Sue, Zane, 1987), and can positively influence Arab patients, as well.

2. Orientation toward Others, Kinship, and Communal Attachments:

Sociability is much more important in Arab cultures than in the West (Melikian, 1977; Sharabi & Ani, 1977). Children are reinforced early in life to accept constant togetherness. They are raised to regard wishing to be left alone as odd or bad. Pleasing others, social conformity, and approval seeking are expected to be the socially

accepted norm under this type of atmosphere. Social anxiety which is found to be among the most common disorders among Arab students may, at least partially, be related to this factor (Ibrahim, 1991). Chaleby (1987) found that social anxiety constituted 13 percent of the neurotic disorders in the clinical population compared to two percent in the West.

Arabs show their concern for others in many unique positive and/or negative ways. For example,, research has shown that in Saudi Arabia, an Arabian culture which encourages strong family ties and kinship, respondents avoided expressing feelings of hostility or aggression toward others. Instead, feelings of hostility are disguised by niceties of behavior *(mujamala)* and conformity (*musayara*). *Musayara* means to get along with others' attitudes, wishes, and expectations through conformity and hiding one's real feelings, thoughts, and attitudes (Dwairy, 1998, p. 83).

Also, one of the main concerns of the Arabian individual is to maintain amiable relationships with others *(mawadda)*. The person exercises extreme caution not to hurt the feelings of others or their dignity even when he or she wants to refuse or reject unreasonable requests of others. Refusal of un realistic demands from other is usually practiced in subtle indirect way including avoidance, too much apology and subtle body language (such as avoidance of eye contact or irrelevant smiling).

It is very important for the mental health practitioners to be aware of these characteristics when they are involved in treating interpersonal and social interaction difficulties including stressed relationships between husbands and wives, parents and children, superiors and employees.

Some behavioral therapeutic techniques such as training for assertiveness, confrontation, refusal responses, and anger-expression should be practiced wisely and

carefully. If the basic goal of treatment is to get the client to believe that treatment is realistic and rational, then it would not enhance the therapist's credibility to encourage an Arab to be aggressive toward others such as spouses, superiors, friends, and community.

Clinical examples encountered during our practice provided ample evidence of the potential for productive family participation in the treatment process. The traditional strong kinship feelings of obligation toward others in the family can be of positive value. Family oriented behavioral modalities of treatment can play a major and positive role in solving both psychological and social problems among Arab patients. Involvement of husbands and parents can particularly enhance the credibility of behavioral approaches of treatment and would find a fertile environment in Arab countries. This is due to the traditional strong feelings of obligation toward others in the family.

The family support does serve an important function in lessening the negative effects of stress and social isolation caused by both mental and emotional disorders. Mental health practitioners will find it helpful to sometimes get extended family members to intervene in solving some marital conflicts and assist in facilitating treatment for children and cases of depression due to divorce, separation, or grief.

It may be argued here that cognitive - behavior therapy techniques such as imagery relaxation can be deliberately formulated to benefit from the strong affiliation tendencies among our Arabian patients. For example, social situations connected with images of affiliation and family gatherings were well received by our patients and judged as soothing, effective and deeply relaxing.

3. Dealing with Opposite Sex, and Sex Subjects:

Subjects of sex in the family are forbidden ones. Expressing sex is coupled by silence, secrecy, and shyness (*a'yb*) even among married Arabs. In more conservative Arabian countries such as Saudi Arabia, women cover their faces with veils in public places and during shopping. Unmarried girls still, although less strictly so, observe the veil especially outside the house The woman is not even called by her first name; she is called instead as the mother (*umm*) of the first born son *(umm Ahmed,* for example). If her first born is a daughter and not a son, she still should be called by her first available son. Husbands do not mention the names of their wives in public, they refer to them as my people (*aljamaa*). Al- Torki (1986) has found that along the Arabian Gulf countries (Saudi Arabia, Kuwait, Quatar, etc.), visual and physical contact between men and women is strictly controlled by the degree of kinship.

Even in countries such as Egypt, where women enjoy the most favorable condition as compared to other Arabian countries, sex relations are restricted. Public expression of love even between wives and husbands, except for highly educated and Westernized individuals, is not accepted. In fact, chances for marriage can be ruined for unmarried women if seen with a friend male outside her family.

Hakky and Brizzolera (1985) showed that Arab females kept males (friends or not) very far away, which should be considered by the male therapist when dealing with female patients and vice versa. It is more appropriate to maintain a larger personal space zones with opposite sex during treatment sessions. The use of touching as a reinforcement technique may be better avoided or at best practiced very cautiously. It is also desirable to have a male and female therapists sharing treatment sessions with couples who seek sex therapy.

In brief, it is expected from the health practitioners to deal with sex problems very cautiously. Techniques of treating sex difficulties should be realistic and congruent with Arab value system.

Involvement in American oriented sex therapy techniques such as those used by Johnson and Johnson can be embarrassing and painful for both the therapist and the partners involved in the treatment. This is not to mean, however, that therapists should not discuss sex problems or to avoid the common behavioral techniques used in such cases. In cultures where sex education is restricted and sexual knowledge is avoided, sex therapy is vital, useful, and can be effective. A major effort, though, should be made by mental health practitioners to have their clients initiate expressing their problems in this regard.

4. Dealing with Authority Figures:

Both research and casual observations agree that relationships with authority figures in Arabian cultures are vital (Ibrahim, 1982, 1985; Melikian, 1977). Such relationships form a major part of the interpersonal relationships system in Arab countries. Arabs show deep respect and obedience to authority values more than Western cultures.

One major implication of authority orientation is an external locus of control (Phares, 1979); that is the belief to be dominated by outer forces and circumstances. Arab children as well as adults are guided by strict external rules. External authority such as parents and teachers are the agents that ensure fulfillment of the societal norms (Dwairy, 1998, p. 29).

Therapeutically speaking, externals vs. internals are more likely to seek structured and direct types of treatment. Therefore, the more structured and the more directive the therapy is the better. This conclusion is, indeed, consistent with results extracted from other views of health specialists (e.g., Badri, 1979; Cheleby, 1992; West & Al-Kaisi, 1985) who do also agree that structured types of mental health intervention such as behavior therapy, cognitive therapy, chemotherapy, hypnotherapy may prove more effective than those based on nondirective techniques, humanistic client- centered therapy, and psychoanalysis. Chaleby (1992) has found that many Arab mental health specialists, for example, chose cognitive therapy, as the preferred modality of

psychological treatment because of its clarity and suitability to the Arabian culture mainly due to its directive role. Some research is badly needed in this part of the world to test the validity of this result.

Identifying of such factors, however, was based on our and others' research and many years of personal and mental health experience with Arabs in Michigan and the Middle East. In the meantime, many assumptions underlying our thinking of these dimensions, integrate with ideas derived from several anthropological, sociological, psychiatric, and psychological notions and research done in Arab countries. The implications of these characteristics in terms of enhancing the role of mental health specialists in providing effective psychological service, and in determining the credibility of his/her psychological approach was discussed. In the authors' opinion, the limited numbers of the mental health providers in Arab countries can achieve a lot of credibility and effectiveness if they integrate their practices with such special cultural patterns characterizing Arabian patients. In fact, the argument that direct treatment approaches (e.g., behavior therapy, cognitive therapy, chemotherapy), compared to other psychoanalytical and/or indirect treatment approaches, are more appropriate for treating Arab clients is acceptable one , because of their compatibility with the cultural values indicated above.

Cultural Considerations in the Treatment Process

Kiesler (1966), almost four decades ago, examined the assumptions underlying practice and research in psychotherapy. He observed that researchers often seem to operate under a "myth of uniformity;" that is the assumption of homogeneity of social groups to respond in the same manner with respect to psychological treatment techniques formulated by most major psychotherapy theories (e.g., psychoanalysis, behavior therapy.) He warned against this assumption, and advised practitioners to take, the differences between social groups, into consideration before maximum success in therapy can be achieved.

One of the basic goals of this presentation is to adopt the same warning and to take into account the cultural differences in Arabian countries to promote effectiveness and credibility in the treatment process. We propose the role of cultural patterns along three stages inherent in the treatment process: (1) identifying target problems, (2) choice of treatment technique (s), and (3) treatment goals.

(1) Identifying Target Problems:

The practitioner who is not aware of the Arabian individual's cultural belief system may find himself *targeting* minor or irrelevant *behavioral problem*. Hence she/he may loose her/his effectiveness and sacrifices her/his credibility. Clients as well known among researchers in the field of psychotherapy and mental health practice conceptualize their problems in a manner consistent and congruent with their culturally built belief system.

Take, for example, the veil function in conservative Arabian cultures such as in some Arabian countries. Veiling for such religious and conservative groups is a social norm. Men and women view it alike as a religious duty. For some, unveiling exposes the woman to "men's eyes." According to Imam al-Ghazali, a famous Muslim scholar, philosopher, and sufi, the eye is undoubtedly an erogenous zone in the Muslim reality. It is accordingly usable to give a sexual pleasure. A man can do as much damage to a woman's honor with his eyes. As if he were to seize hold of her with his hands (quoted in Al-Torki, 1986, pp. 96-97). Therefore, the mental health practitioner who is not alert to this fact may find himself targeting wrong problems with his female patients. A husband of one of the female patients reported a new hired psychiatrist to the administration in a large Arab hospital because he (the psychiatrist) insisted on having the patient uncover her face and remove her veil. As a result the patient was assigned to a new therapist, and shortly after that she prematurely terminated her treatment. Perhaps the doctor in this situation based on his educational background and training in treatment modalities

(primarily developed for Anglo-Americans), assumed that he has to have some eye contact, and to watch the patient's facial expression during the session. He probably aimed to facilitate communication, and consequently to achieve an effective treatment relationship. However, he was trapped in targeting a problem that was seen by his patient as minor and incongruent with her problems. It is instructive, therapeutically, to view social norms including veiling and related religious practices as an expression of privacy. To avoid hinging on this and similar types of privacy, we should be able to create culturally and in the same time therapeutically forms of more appropriate patient-therapist relationships.

(2) Treatment Techniques:

The treatment process will negatively suffer if the practitioner requires from the client to practice some *treatment technique* that are culturally unacceptable. A typical case is as follows:

An American lady therapist in Detroit, who was dealing with an Arab married female client, informed the writer that her client detached herself from the treatment process and almost dropped out of treatment. The therapist felt that her patient should develop more assertive role with her husband who was judged by the therapist as restrictive to the patient. The therapist embarked on teaching the patient some assertive and anger-expression techniques. Obviously, the therapist in this case conceptualized in different terms from that accepted by Arab culture in terms of husband-wife relationships. Among Arabs expression of anger is usually avoided particularly toward the husband. When the therapist was alerted by the author of this fact, she changed her treatment methodology, and adopted instead, a different approach based on involving the husband in couple therapy sessions. Within this framework, the patient began to express her need more securely. Even the husband, who was initially cynical and antagonistic toward the treatment sessions, became more cooperative and started to help his wife develop some social and athletic outings. The treatment process from now on developed to more positive

channels. Couple therapy from now on has been adopted as the more effective and accepted modality of treatment for helping this patient to express her needs to her husband.

Similarly, some patterns of behavior among Arabs may be seen as unacceptable and unhealthy if looked at it from a Western viewpoint, but are accepted and seen as healthy and normal from the Arabian individuals. Take, as another example, guilt and shyness: the therapist who would respond strongly to this pattern in Arabic individuals and treat them as pathological would be out of sync. Many Arab people see shyness as a virtuous behavior. In Arab language the word 'hayyaa,' is used as synonymous to shyness and is perceived as a decent, and well-accepted behavioral pattern.

(3) Goals of Treatment:

The credibility will also suffer if *goals of treatment* conceptualized by the mental health specialist are not consistent with those interwoven in the culturally accepted values of the client. If treatment goals of the therapist for his patient are different from those of the patient, the treatment credibility will suffer. Indeed, many patients may prematurely terminate treatment altogether because of the uncomfortable feeling and the embarrassment caused by formulating different goals. This is explained in the following example:

A Saudi female 35 years-old college graduate married to a successful and highly educated man who recently got promoted to a distinguished governmental position. She has a number of complaints including anxiety, feelings of inadequacy, boredom, and weight gaining. She was seen by a psychiatrist before. As indicated by her record, the goal of previous treatment as formulated by her previous psychiatrist was help her gain insight into the deep underlying dynamics concerning her relationship with her husband. The patient described her previous treatment experience as uncomfortable and irrelevant to solving her problems. When I encouraged the patient express her own complaints, a mutual agreement was reached about the

main targets and goals of therapy. That was the beginning of a successful acceptance of treatment through applying behavioral therapy techniques including relaxation, building social interaction skills, and managed behavioral marital therapy. She is now enjoying a new job, maintains a good and positive relationship with her husband and children. She has also, completed her MA; a goal that was hindered before because of her anxiety, lacking social skills, and inability to manage her time in a more effective way.

Attuning to the patients' concerns is of course one of the basic skills that mental health therapists should be well trained for achieving it. If psychotherapists and mental health practitioners are keen to process any positive changes in their patients, they should be able, in brief, to listen carefully to their patients, and give ample time to formulate mutually accepted treatment goals.

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