

# Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings

by: Alean Al-Krenawi and John R. Graham

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*Several culturally specific practical considerations should inform social work interventions with ethnic Arab peoples in Arab countries or in Western nations. These include taking into account gender relations, individuals' places in their families and communities, patterns of mental health services use, and, for practice in Western nations, the client's level of acculturation. Such aspects provide the basis for specific guidelines in working with ethnic Arab mental health clients. These include an emphasis on short-term, directive treatment; communication patterns that are passive and informal; patients' understanding of external loci of control and their use of ethnospecific idioms of distress; and, where appropriate, the integration of modern and traditional healing systems.*

**Key words:** Arab ethnic origin; cross-cultural studies; ethnic minority groups; mental health care practice

Ethnic Arab peoples have one of the world's highest rates of population increase. There are 255 million people in 21 Arab countries in North Africa and the Middle East, and they constitute a significant and growing population in such Western countries as Australia (210,000), Canada (80,000), France (2 million), Britain (210,000), and the United States (700,000), as well as Israel (1 million). (Al-Boustani & Farques, 1991; Al-Krenawi & Graham, 1998; UNESCO, 1996). A notable proportion of Arab peoples are Muslim, and Islam is the world's second most practiced religion, with one of the highest increases in the number of practitioners. Today there are an estimated 6 million Muslims in the United States, and nearly 15 percent are people of Arab ethnic origin (*Newsweek*, 1998). Despite Arab peoples' presence in the West and East, there has been little published social work practice research to date related to this population.

Researchers in social work (Al-Krenawi & Graham, 1996a, 1996b, 1997a, 1997b; Al-Krenawi, Graham, & Al-Krenawi, 1997; Lum, 1992; Mass & Al-Krenawi, 1994) and allied disciplines (Al-Issa, 1995; Bilu & Witztum, 1995; Budman, Lipson, & Meleis, 1992) have differentiated among the knowledge and skills necessary to respond to the ethnic and racial diversity of people who may need mental health and social services. The literature provides insight into mental health practice with families of various ethnic origins, among

them African (Franklin, Sarr, Gueye, & Sylla, 1996), African American (Ahia, 1997; Baker, 1994; Kendall, 1996; Logan, 1996), Asian American (Lorenzo, 1988), Chinese (Bentelspacher, DeSilva, Goh, & LaRowe, 1996; Lai, 1995; Pearson, 1996; Pearson & Phillips, 1994; Shek, 1996; Wang, 1994; Xiong et al., 1994), Greek (Madianos, Gefou-Madianou, & Costas, 1993), Italian (Fandetti & Gelfand, 1978), Japanese American (Hsu, Tseng, Ashton, & McDermott, 1983), Korean (Hurh & Kim, 1994), , Latino (De Snyder, Diaz-Perez, Maldonado, & Bautista, 1998), Maori (Chaplow, Chaplow, & Maniapoto, 1993), Native American (Angell, 1997; Trimble, 1990), and Vietnamese (Phan, 1997). However, a great deal remains unknown, because multicultural social work is a heterogeneous and multifaceted phenomenon. Also, many ethnic groups, such as Arab peoples, have not received comparable scrutiny by academic researchers.

Because the topic of social work practice with Arab peoples is complex and because the literature disparate, the present article concentrates on one field of intervention, mental health practice. Future research should analyze other fields such as addictions, child welfare, or gerontology. Presented here is an overview of major practice intervention guidelines resulting from the integration of recent interdisciplinary research (Abudabbeh & Nydell, 1993; Al-Krenawi, 1996; Al-Krenawi & Graham, 1997b, 1997c; Al-Krenawi et al., 1997; Jackson, 1997; Katchadourian, 1974; Qouta, Punamaki, & El-Sarraj, 1995; Savaya & Malkinson, 1997; Timmi, 1995). Although we recognize the diverse aspects of ethnic Arab life, as well as its presence in virtually all countries, the article emphasizes principles of mental health practice that have common and transnational applications. Similarly, the analysis applies to Arab mental health clients of major faith traditions (Christian, Druze, or Islam) living in rural or urban regions, whose communities are immersed in the broadest spectrum of traditional to modern norms and values. Given this journal's readership, particular emphasis is placed on ethnic Arab life in North America, Europe, and other countries with Western-derived cultures (Budman et al., 1992).

The article begins by introducing major aspects of ethnic Arab societies and major processes of acculturation experienced in the West. It then considers several culturally specific practical considerations that should inform social work interventions. These include taking into account gender relations, the individual's place within his or her family and community and patterns of the use of mental health services.

## Arab Societies

The cultural facets in the context of life in Arab societies were brought by immigrants

who settled in Western nations, although rates of acculturation considerably influence differential patterns of how Arab culture is then transferred to and experienced in the new country. Ethnic Arab societies are highly diverse and consist of heterogeneous systems of social differentiation based on ethnic, linguistic, sectarian, familial, tribal, regional, socioeconomic, and national identities. On one level, therefore, Arab peoples may be perceived as having deep social and class distinctions and as being disunited and politically fragmented, transnationally and within national borders. Ethnic Arab peoples likewise follow more than one faith tradition. Also, Western cultural norms have penetrated much of the Arab world, but their effect has been experienced differently in communities and across societies.

At the same time Arab societies share many attributes, including a common physical and geographic environment and a collective memory of their place and role in history (Barakat, 1993). The Arab world is profoundly transitional, balancing modern phenomena such as oil exploration with traditional structures such as tribal castes. Its economic systems remain largely dependent and underdeveloped, and, as one sociologist has remarked, "Its material and human resources have been harnessed for the benefit of a small segment of the population and on behalf of antagonistic external forces" (p. 26).

In the East and West, Arab societies are often complementary patterns of family structures, patriarchy, primary group relations, spontaneity, and expressiveness. They are also high context, emphasizing the collective over the individual, having a slower pace of societal change, and a greater sense of social stability (Al-Krenawi & Graham, 1996b, 1997a; Barakat, 1993; Hall, 1976). The family, therefore, is important to the homologous interrelationship between the individual and group, as well as between the individual's social and economic status (Barakat). One of the most important parts of its kinship structure is the *hamula*, which includes a number of generations in a patrilineal line that have a common ancestor (Al-Haj, 1987; Al-Krenawi, 1998a). In some ethnic Arab cultures, such as the Bedouin Arab in Egypt, Israel, Jordan, Kuwait, Saudi Arabia, and Syria, several *hamula* together constitute a tribe.

## Family and Gender Constructions

Gender differences in Arab societies tend to remain strong, and the social structure is male dominant. In Libyan society, women are perceived as "physically and mentally weak in comparison to men" (Attir, 1985, p. 121). Ethnic Arab women, particularly in Muslim society, have been viewed as "powerless, subservient, and submissive" (Al-Haj,

1987, p. 103). The male is the leader and highest authority in the household, the economy, and the polity (Al-Krenawi, 1996; Morsy, 1993). In many Arab societies, women's social status is strongly contingent on being married and rearing children, especially boys (Al-Sadawi, 1977, 1995). Arranged marriages are frequent, and women are expected to devote much of their time to caring for their families. It is common for women not to have careers outside the home (Grossbard-Shechtman & Neuman, 1998). Many career women, even those attaining high degrees of success, defer to spouses or families for major decisions (Hoodfar, 1997; Shalhoub-Kevorkian, 1997). Moreover, with Western media and cultural hegemony, Ahmad (cited in Shalhoub-Kevorkian) contended that "the fear of losing an indigenous 'authentic' Islamic-Arab culture is used by society to control women further" (p. 61).

Divorced women in Arab societies suffer emotionally and socially (Tumush, 1989). A divorced woman's prospects for remarrying can be poor; in many Muslim societies, they usually are restricted to becoming the second wife of a married man or the wife of a widower or older man (Al-Krenawi & Graham, 1998; Brhoom, 1987; Hays & Zouari, 1995; Tumush). Mothers are known to endure years of marital problems to avoid the stigma of divorce or the prospect of losing their children (Al-Krenawi & Graham, 1998; Brhoom). This possibility can be particularly severe in Muslim societies, because Islamic tradition holds that fathers have custody over boys after the age of 7 and girls after the age of 9 (Amar, 1984).

## Individual Development in Arab Societies

Arab societies tend to be "father dominant" (patriarchal): The father is the head of the family and is considered a powerful and charismatic figure. He commands respect as the legitimate authority for all matters of the family (El-Islam, 1983). The patriarchal structure extends throughout all levels of society. The father of the nuclear family is subordinate to his own father, who in turn defers to the authority of the head of the clan. All clan heads are subordinate to the head of the tribe or *hamula*. The tribal or clan leader also serves as the spiritual and practical father of the whole group—he represents the collective to the outside world, oversees the rules for the clan or tribe, and guides their actions. In effect, the patriarchal structure creates a complete and autonomous society within a society, functioning as a single unit.

Regardless of whether ethnic Arabs constitute a minority or majority in a particular society, the Arab school system throughout the Middle East and north Africa is strongly representative of Arab culture (Chaleby, 1987b). In many Arab schools, the curriculum is

based largely on rote learning and on remembering facts, rather than on developing individual interpretations and analysis. Conformity, rather than independent thought and creativity, predominate (Chaleby; Geraisy, 1984). The teacher is a strong authority figure, reinforcing society's hierarchical, authoritarian nature, and its insistence on respecting one's elders. Adults are perceived as the source of knowledge, wisdom, and authority (Barakat, 1993; Sharabi, 1975). From early childhood, the individual learns that knowledge and wisdom are passed on by the old to the young and not vice versa (El-Islam, 1989). This viewpoint is expressed in many fables and in sayings such as "Wisdom is found among adults," or "Anyone who is a day older than you in age is a year older than you in understanding."

## Processes of Acculturation

As social scientists long ago concluded, immigrants invariably experience processes of "adapting" and "adjusting" to life in a new country (Eleftheriadou, 1997; Ng, 1998). Ethnic Arab immigrants to Western countries are known to experience divided loyalties between the ways of the new country and those of the old and the dilemma "of whether to reject or embrace assimilation, secularism, and Western education" (Fares, 1991; Jabbara, 1991, p.43), among other phenomena. This dynamic, in turn, is also influenced by ongoing debates in the new country, society wide, over assimilation of ethnic minority cultures versus a more pluralist and multicultural approach. Lambert and Taylor (1990) argued that in the United States in particular, a "fine line" exists "between retaining one's ethnic identity and being considered" not part of that country. Arab peoples, for their part, are thought to embrace multiculturalism over assimilation with greater intensity than some other ethnic minority cultures (Lambert & Taylor). Although one researcher went so far as to describe some ethnic Arab communities in the West as "a nation in exile rather than as immigrants" (Stockton, 1985, p. 123), it is probably more accurate to emphasize the heterogeneity of acculturation within specific Arab communities and among Arab peoples in general. Indeed, acculturation may differ from one family member to another.

At the same time, nascent research provides provisional evidence that some factors may be associated with Arab peoples' greater acculturation to and life satisfaction in some Western countries. These factors include longer residence in a host country, younger age at immigration, not recently visiting one's Arab country homeland, and being of a Christian religious background (Faragallah, Schumm, & Webb, 1997). Thus, it is essential to emphasize how various Arab cultural values may resonate differently to the Arab social work client, depending in part on level of acculturation and those associative

variables just noted. As for family functioning, it is well known that periods of disharmony are common on and after arrival in a new country and as familial role patterns change (Eldering & Knorth, 1998a, 1998b). In some instances, family satisfaction itself may be associated negatively with acculturation (Faragallah et al.), and family conflicts among Arab social work clients may center on schooling, children going out with friends, and arranged marriages (Eldering & Knorth).

A limited range of findings suggests that in some Arab cultures, males may be better acculturated than females, but for both sexes, acculturation was positively related to better mental health (Ghaffarian, 1987). Research in Belgium revealed that with increasing acculturation, the demand for preventive care among clients of Arab origin decreased, delays for consulting for a curative problem were reduced, and prognoses were improved. But vague complaints (which are, as will be seen, consistent with Arab culture) increased (Van der Stuyft, De Muynck, Schillemans, & Timmerman, 1989).

## Guidelines for Mental Health Practice with Ethnic Arab Clients

Mental health practice with Arab peoples requires several ethnospecific approaches, which are described below and supplemented with brief elaboration.

### Acculturation

Acculturation is a central component in conceiving social work services in the West. In providing social work services to an ethnic Arab family in the West, it is essential to consider the level of acculturation and its differential effect on families. Before a treatment plan is formulated, a detailed history should be taken. In the West this could include length of time outside the country of origin and reasons for and conditions under which emigration occurred. In the West or East, level of social and family support available and degree of religious affiliation are important factors. There is a significant difference, for example, between the ethnic Arab who is here as a student and is struggling with issues of sexuality and a middle-aged man who has left his homeland in turmoil and is suffering from a posttraumatic stress disorder. Thus, an assessment of the client's personal background and level of acculturation will alert the sensitive practitioner to potential cultural conflicts with regard to treatment. It is also imperative clearly to identify culturally appropriate interventions in light of acculturation and with reference to facets discussed in the following guidelines.



## Mental Health Services and Stigmatization

Mental health services can be stigmatizing, particularly for women. Ethnic Arab clients, like those in other non-Western societies, find psychiatric and psychological intervention (Fabreka, 1991) and family and marital therapies (Savaya, 1995) stigmatizing. This is especially true of women. The stigma of mental health services could damage their marital prospects, increase the likelihood of separation or divorce, or, especially among Muslims, be used by a husband or his family as leverage for obtaining a second wife (Al-Krenawi, 1998a; Al-Krenawi et al., 1997; Bazzoui & Al-Issa, 1966; Chaleby, 1987a; Okasha & Lotailf, 1979). Stigma may be avoided or reduced by integrating mental health services into nonstigmatizing frameworks or physical settings, such as general medical clinics (Al-Krenawi, 1996).

## Cultural Expectations

Cultural expectations regarding gender can complicate the helping relationship. Arab men may have difficulty accepting a female social worker's directions. When this problem occurs, it does not arise necessarily from the male client himself but may arise from a male family member in a position of authority such as a father, uncle, older brother, or any older male family member. Of Iranian families, Jalali (1982) wrote "the patriarchal organization of the family is to be acknowledged by addressing fathers first and as the head of the family. The social worker should not attempt to change cultural power hierarchies or role patterns since this will alienate the family" (p. 308).

An opposite-gender client relationship is complicated and may be impractical. But even when a positive connection is established and the client settles into the professional helping process, he or she might soon open up and get attached, which leads to conflict or confusion. Every attempt should be made to educate the client about the appropriateness of the attachment, and reassurance should be offered that the relationship is protected by professional standards. Likewise, a female-male social worker-client dyad is best responded to with such culturally appropriate techniques as referring to the client as "my sister," maintaining minimal eye contact and appropriate physical distances between client and worker, and integrating the family in many, if not all, stages of treatment (Al-Krenawi, 1996).

Cultural differences between the traditional Arab societies and Western society also are expressed in the nature of interpersonal contacts. For the Arab client it is very difficult to accept the formal distance between worker and client that is the norm in modern helping

situations, and it may be that the worker will have to bend principles. For the ethnic Arab, it is more important to build a relationship than to solve a problem. Relationships are built through the Arab conception of trust. Once clients trust the social workers, a helping alliance can be developed and maintained (Durst, 1994).

In situations where the client and social worker are of the same gender, the social worker should take into consideration the client's need for expressions of intimacy and occasionally relax the formality that is the norm in Western helping. Conversely, when the social worker and client are not of the same gender, the former should maintain even greater distance than normal, for fear of invoking sexual impropriety (Mass & Al-Krenawi, 1994). Minimal eye contact may occur as a result (Al-Bostani, 1988; Rizvi, 1989) and should not be interpreted as client resistance to treatment.

## **Interventions and Context**

Contrary to a Western therapeutic emphasis on the individual, all interventions with Arab clients need to be couched in the context of the family, extended family, community, or tribal background.

Modern talking therapy is an extension of the development of individualism, nurtured by the liberal political climate of democracy (Monte, 1995). It presents the individual as an independent entity whose needs, rights, opinions, and values must be respected. Not surprisingly, "self-realization" has been an important therapeutic and epistemological goal for decades (Fromm, 1941, 1946; Pedersen, Fukuyama, & Heath, 1989).

As several scholars have pointed out, one of the most important dimensions of intracultural differences is whether a culture is individualist or collectivist (Georgas, 1989). In individualist cultures in the West, during the course of development individuals undergo an important psychological separation from their parents, and as an integral part of this process, they form a unique and autonomous identity (Erikson, 1963; Mahler, 1968). A similar process of personal development does not occur in the same way in collectivist cultures in Africa, Asia, South America, or the Middle East (Sue & Sue, 1990). Nor does it among Arab peoples, where the group or family identity remains the focus and the individual remains embedded in the collective identity (Hofstede, 1986).

Individuals' interests unite with those of their group of allegiance, and the general good supersedes the personal. Individual problems draw the members of the group in common pursuit of solutions. Individuals in trouble do not choose, in isolation from others, among alternative courses of action. The importance of the group is reinforced in



daily interactions. Rather than adopting Euro-American ideals of conjugal isolation and withdrawal from the extended family, Arab social structures are dominated by daily interaction with near and extended kin (Holmes-Eber, 1997).

Individuals can be perceived only through the group to which they belong (Barakat, 1993). Whereas a Western individual may internalize social rules and rely on internally derived guilt to amend inappropriate behaviors, an Arab individual is more likely to be sanctioned by external-oriented shame, stemming from the attitudes of others (Gorkin, Masalha, & Yatziv, 1984). The mingling of the individual and the group, and the acceptance of the sociocultural norms and values of that group, have certain advantages at the psychological level. The group gives the individual protection and security, a feeling of belonging and identity, as well as emotional and practical support during crises (Barakat). A drawback is the diminished sense of "self." The fate of an individual with ambitions or desires that do not fit in with the ambitions or values of the collective, is likely to be isolation or even ostracism (Chaleby, 1987b). Thus, a social worker needs to incorporate people, other than just the identified patient or client, in both the construction and resolution of problems, and also, where relevant in the actual processes of helping.

## **Family Involvement**

The family's involvement in individual mental health helping is considerable, and often makes the social worker's work more complicated. The family unit is sacred among Arab peoples, who are raised to depend on it as a continual source of support. Extended family members are highly valued as well. They are expected to be involved and are consulted in times of crisis. When a family member is sick, the restoration of health is of concern to all other members. As pointed out by Meleis and La Fever (1984), although Arabs "value privacy and guard it vehemently . . . their personal privacy within the family is virtually non-existent . . . Decisions regarding health care are made by the family group and are not the responsibility of the individual" (p. 76). In some cases the family will intervene on behalf of the identified patient, although they too lack in trust, whereas they expect much. For example, they might try to control the interview by answering the questions directed at the client while they withhold information that may be perceived as embarrassing. The family members' involvement easily can be experienced as arrogance, verging on insult, when they act as authorities on matters that pertain to the social worker's area of expertise.

These cultural constructions of family can best be used by social workers' willingness to tolerate the enmeshment so characteristic of Arab families, by educating themselves

regarding Arab family values so that they can in turn sensitively educate the family about the necessary requirement for a workable helping relationship. Practitioners working with an Arab individual by necessity will come into contact with the family and need to reconsider what might otherwise be seen as an Arab family's overinvolvement, overprotection, blatant codependency, or enmeshment. These characteristics, in fact, may well be highly appropriate in a culture where any less involvement would be considered neglect if not abandonment.

If the cultural gap is too great, involving a cultural consultant (Budman et al., 1992)—a member of the culture who can mediate between the family and the practitioners—might be advisable. The chosen consultant may be affiliated with the mental health agency, a different agency, or may be a member of the community, but in all instances, he or she would have to be deemed suitable by the family. The consultant, in turn, "translates for the staff the symbolic meanings of behaviour and action, and clarifies cultural properties, can be invaluable to treatment planning, and a key factor in staff acceptance of the patient" (Meleis & La Fever, 1984, p. 85).

## **Client Communication**

Arab clients' communications are restrained, formal, and impersonal. Clients' idioms of distress might rely on a complex system of metaphors and proverbs. Arab clients may use a variety of ethnospecific idioms of distress. They may describe a depression as "a dark life," or their fear by saying "my heart fell down." Likewise, proverbs are often used. One client, for example, described an inability to confront personal problems as "my eye is blind and my hand is short" (Al-Krenawi, 1998a). Client communication also may appear to be indirect, circular, and nonspecific (Al-Krenawi, in press).

Arab communication styles are formal, impersonal, and restrained, rather than candid, personal, and expressive. It is also difficult for an Arab client to divulge personal problems and feelings to someone outside of the family or community. To do so is to be seen as weak, disloyal, or both (Al-Issa, 1990). Thus, several techniques commonly used in Western cultures have limited application to Arab clients. Self-disclosure, client affect, and self-exploration are often difficult, particularly if they are perceived as risking damage to family honor. These difficulties should not be construed as client resistance.

Arab clients also interpret the social worker's messages according to their own cultural codes, which may be different from those of the worker (Sharp, 1994). Not surprisingly then miscommunication between the client and a social worker unfamiliar with the client's culture can occur (Al-Krenawi, Maoz, & Reicher, 1994; Eisenbruch, 1991).

Difficulties in communicating and deciphering the client's verbal and nonverbal messages can lead to errant assessments, because of the existence of culture-bound symptoms and syndromes (Al-Krenawi & Graham, 1997c; Bilu & Witztum, 1995) and the choice of approaches and techniques of practice that may be unsuitable for the client's cultural perceptions. This is one of the reasons for early termination of treatment or nonuse of mental health services (Al-Krenawi, 1999a; Al-Krenawi & Graham, 1996b, 1997c; Savaya, 1998; Sue & Zane, 1987).

## **Length of Treatment**

Treatment is most successful when it is short term and directive. A social worker who maintains too rigid a time frame could be perceived as being cold or unreasonable. In Arab societies helping has a more explanatory and instructional character. Arab clients expect social workers to be like teachers, to explain conditions and supply information concerning problems. Preference for the instructional-explanatory model for treating Arab clients is linked to the society's child-rearing methods, the instructional methods used in its schools, and its hierarchical structure. Children learn to receive advice and assistance from those more senior in age and status and repeat these patterns throughout their lives. The process of child development rests on guidance from the father, the mother, and other adults in the nuclear and extended families and even in the clan. This guidance is usually expressed in the form of "do's" and "don'ts" and assertions that "this is right" and "that is wrong," with little explanation or justification. Such a process may inhibit children from coping independently with their problems or from learning experientially (Hatab & Makki, 1978). Rather, the child tends to learn to obey by means of punishment and reward.

Arab clients and their families place a great deal of responsibility on mental health practitioners to provide solutions to problems with little or no input from the client. The Arab client generally will view social workers as genuine figures of authority and conform to what is advised or prescribed—at least on the surface—because disagreement is equated with confrontation, which is considered rude. The mental health provider can expect the Arab client to remain passive during the assessment interview and the helping process in general.

Not surprisingly then, clients expect social workers to explain the nature of their problems and to supply solutions, rather than trying to discover solutions for them. Thus, helping should be direct and clear, with concrete targets. It should provide guidance, advice, direction, explanations, and instructions. In addition, social workers should

develop techniques to encourage trust and openness between client and practitioner. Behavioral and cognitive therapies are obviously more suited than psychodynamic approaches.

## **Issues of Temporality**

Temporal issues need to be constructed differently for ethnic Arab people than for people in Western nations. Social workers should be aware of the Arab concept of time and help prevent this from becoming a barrier to effective service.

Differences in temporal perceptions can produce challenges in working with ethnic Arab families. In a clinical or hospital setting in particular, families may have difficulty with limited visiting hours, which may have to be extended. Ethnic Arab people's notions of time are more fluid and not as structured or determined as they are in the West. Ethnic Arab peoples, as a result, may not be very time bound. In Arabic languages, there are no clear distinctions among various forms of past and future. As Patai (1973, cited in Kulwicki, 1996, p. 195) explained, "it is almost as if the past were one huge undifferentiated entity, within which time distinctions are immaterial and hence not noticed and which, almost imperceptibly, merges into the present and continues into the future" (p. 70). Psychologically speaking this view can be viewed as advantageous in that it fosters flexibility in one's adaptation to life circumstances, with an ability for prompt readiness when facing the unforeseen. It is a disadvantage, however, when the culture in which one lives requires a time-sensitive attitude.

Thus, making and keeping appointments at fixed times or starting and ending sessions promptly might be a source of difficulty. Short-term helping may also be preferred to long term. Arab clients may not show up for appointments at a precise time, and the exact duration of a session may need to be more fluid than in a Western context (Sue & Sue, 1990).

Social workers should reconsider what would constitute intrusion to helping or on the privacy of the client based on the client's expectations and not on Western standards. Social workers would do well to clearly establish early on what the rules are regarding appointment times, lateness, and missed sessions. This will be part of the social worker's role as an educator in the process of treatment, the social worker's role, expertise, and goals.

## **Views of Mental Health Services**

Clients of ethnic Arab origin have a negative view of mental health services and may tend to mistrust and underuse them. Although there are some exceptions, based on level of education and degree of acculturation, it can be safely assumed that most ethnic Arab people view mental health services in a negative light, and consequently use of mental health services is limited. Ethnic Arab peoples, particularly in Arab countries, do not distinguish among psychiatrists, psychologists, or other professionals in the mental health field. All tend to be viewed suspiciously as researchers or as doctors who discard religious values and fail to see these values as a genuine source of solace and healing. In such a context, it may be difficult to establish trust. There is no inherent notion that the social worker-client relationship could include a sincere emotional connection that involves mutuality, let alone the idea that such a relationship has a central helping and healing value. These need to be included, explicitly, in any treatment process.

A cultural gap leading to mistrust is a given when a non-Arab mental health provider comes into contact with an ethnic Arab client (Al-Krenawi, 1999a, 1999b). Therefore, social workers' first task is to educate themselves about the religious, cultural, and national background of the client. Aside from the individual background, an understanding of topics such as the Arab view of health and medicine, including mental health, the Arab family system, Arabs peoples' opinions of Western society, Americans' view of ethnic Arab people, and ethnic Arabs' use of traditional healing systems might assist the practitioners in better understanding ethnic Arab clients.

## **Somatization of Affective Disorders**

Ethnic Arab clients often view affective disorders as having somatic origins. Therefore, they expect mental health treatment to be similar to physical or medical treatment in its timeliness and in its lack of demand for client contribution.

As explained by Kulwicki (1996), "Arab-American clients often expect doctors to make medical decisions without the need for the collection of a medical history and without consultation with the client. In cases where clients are asked to participate in decision making about their medical regimen, they may lose trust in the medical experts and discontinue treatment" (p. 201). The client might wait to be questioned by the social worker, may not complain much about emotional distress, but might do so for physical ailments. Because their psychological symptoms often are experienced and interpreted physically rather than emotionally, Arab clients frequently expect to be "cured" of symptoms without having to divulge many aspects of their personal lives, much as they

would when seeking a physician's help for physical ailments. Indeed, it is frequently a physician who makes the referral. If the client follows through with the recommendation, it is either with much ambivalence or as a desperate attempt to restore health, neither of which may be conducive to establishing a long-term positive connection. Therefore, it is important that the practitioner stay very close to the here and now and be prepared for the possibility of short-term work.

Depression and somatization are so intertwined in Arab culture that it is almost impossible to separate them in two distinct categories, as is done in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Indeed, as cross-cultural studies of depression so far have indicated,

The *experience* and *expression* of depression varies across ethnocultural boundaries. Reviewers concur that feelings of guilt, self-deprecation, suicidal ideas, and feelings of despair are often rare or absent among non-European populations, whereas somatic and quasi-somatic symptoms, including disturbances of sleep, appetite, energy, body sensation, and motor functioning, are more common. (Marsella, Sartorius, Jablensky, & Fenton, 1985, p. 306)

The expression of conflict, whether internal or external, and the expression of negative feelings are not well accepted in the Arab culture. The anxious self-absorption that often accompanies a depressed mood is viewed negatively as "thinking too much," which is in turn viewed as a narcissistic preoccupation. Physical symptoms, however, are accepted as legitimate and morally acceptable expressions of pain. Even the way the language is used lends itself to a confusion of psyche and soma, as depressive symptoms are depicted in physical imagery, especially involving the chest and abdomen. For example, as pointed out by Bazzoui (1970), "the average Iraqi patient describes his depression as a sense of oppression in the chest, a feeling of being hemmed in, or in other cases, a hunger for air. On being asked if he feels sad, downcast or depressed, one is struck in many cases by the unawareness of the patient of his mood" (p. 196).

In the West, when treating depression as described in the DSM-IV, the practitioner looks for mood symptoms such as depressed mood or loss of interest in most activities; physical symptoms such as fatigue, insomnia, changes in appetite; and cognitive symptoms such as excessive guilt, feelings of worthlessness, and preoccupation with death. The literature on affective and somatic disorders in Arab countries seems to lack mood symptoms for both depressed and manic or hypomanic clients (Al-Issa, 1995; El-Islam, 1989, 1994). That is, when the client is asked if he feels sad or elated, he generally answers "no" or perhaps "I don't know." Similarly, a lack of cognitive symptoms



has been noted, especially those associated with guilt and loss of self-esteem. So, whereas a client may feel incapacitated by psychomotor retardation, extreme fatigue, and other physical symptoms, he will not interpret these as mood related, which would be a typical interpretation in Western nations.

Arab culture condemns suicide, and clients may not divulge suicidal feelings easily. Dubovsky (1983), working in Saudi Arabia as a psychiatrist, discovered that "if asked directly if they are having thoughts of killing themselves, most depressed patients reply that they are good people and would never entertain such thoughts. If, however, potentially suicidal patients are asked if they wish that God would let them die, they usually will reply in the affirmative" (p. 1457).

Special considerations are needed for work with the somatic client. These clients may be passively dependent on the mental health professional. They may seek a cure, usually of a medicinal kind, and may be reluctant to discuss their personal concerns or difficulties. Behind this resistance often lies a fear of embarrassment or of shaming the family. As Racy (1980) discovered while working with Arab Muslim women in Saudi Arabia, "much effort is required to break through the barriers of somatization and passivity in order to get any specific picture of that particular patient's life . . . when such effort is successful, one frequently is able to discover . . . feelings of loneliness on separation from parents and siblings . . . fatigue from prolonged child-rearing, and conflicts with in-laws" (p. 214). He suggested that the practitioner may effectively use a client's passivity as well as the authority placed in the social worker to engage the client in her own treatment, such as having her keep a diary or perform certain tasks or assign an exercise regimen.

## **Role of Religion in Interventions**

Religion is an important context in which problems are constructed and resolved. Consideration must be given to the role of religion in Arab societies, whether Islamic, Druze, or Christian. Social workers should be aware of how religion relates to topics often raised by clients such as spirits, sorcery, and the devil. Adherents to most Arab religions could believe that an illness is divine punishment (Nasr, 1966).

In many Arab communities, people believed to be mentally ill may be viewed as not quite human and not quite angelic but are associated with the supernatural. In Denny's (1985) words "they are feared by humans, for they are associated with the spooky and uncanny dimensions of life" (p. 93). This is to suggest that mental illness is regarded with some respect and fear of God. Social workers also should appreciate how a religious outlook

could cultivate a conservative approach to family problems, marital problems, family matters, and the education of children. Thus, religious concepts may often be explicitly incorporated in the helping process.

## Concept of Psychosocial Problems

The Arab clients' concept of their psychiatric or psychosocial problems may be that the origin of them is biomedical, human, or supernatural. Particular emphasis often is placed on an external locus of control. Ethnic Arab clients tend not to see the origins of illnesses from a biomedical point of view but rather as resting with an external locus of control (Al-Issa, 1995; Al-Krenawi & Graham, 1997b, 1997c; Chaleby, 1987b). For example, physical or mental sickness or family or marital problems could result from several external causes. These include the intervention of supernatural elements such as spirits or the participation of other people with the supernatural through such avenues as the evil eye or sorcery (Al-Krenawi, 1999b; Al-Krenawi, Graham, & Maoz, 1996; El-Islam, 1982; Morsy, 1993; Sanua, 1979; West, 1987). Druze, as a different example, believe in the transmigration of souls and could conceptualize a mental illness as punishment from a previous life (Daie, Witztum, Mark, & Rabinowitz, 1992). Among Arab religions angels are believed to exist and to be important helpers of God. Denny (1985) explained:

Although most of the great angels are good creatures of God, one is evil. That is Satan, who was cast out of heaven after he refused God's command to bow down to Adam . . . The angels, which have no sex, are made of light, whereas humans are created from clay . . . In addition to the angels are the supernatural beings, created of fire, known as *jinn* . . . the invisible beings that possess poets, filling them with special awareness and power in speech. One who is possessed by a *jinni* is rendered *majnun*, meaning insane (p. 93).

Research on Arab clients indicates no correlation between clients' educational level and their perception of the problem or mental illness as caused by supernatural forces (Al-Krenawi, 1999a; El-Islam & Abu-Dagga, 1992; Khalifa, 1989).

Social workers should appreciate the etiology of the problem or illness from the perspectives of the clients, their families, and the society to which they belong. Their explanatory model, derived from their cultural and religious realities is, in this sense, an informal theory. The social worker's knowledge and skills are based on a formal theory (Al-Krenawi, 1998b). The practitioner could bridge the gap between formal and informal

theories, as the informal theories have strong resonance with clients and their families. Such bridging could include using clients' idioms of distress in the intervention process (Bilu & Witztum, 1995), and it also could include incorporating traditional healing with the modern helping process and incorporating the clients' perceptions of etiologies.

## **Ethnic Arab Clients' Use of Mental Health Services**

Clients often use mental health services and traditional healing concurrently or in succession. Informal systems in ethnic Arab societies should be regarded as complementary to modern mental health systems rather than competitors. Indeed, Arab clients have developed a strategy of dual use, in which modern and traditional biomedical systems are consulted concurrently or in succession (Al-Krenawi & Graham, 1996a, 1996b, 1997c). The choice between the modern mental health services and the traditional systems is not left entirely to the client (El-Islam, 1994). Usually family members accompany the client in the process of seeking help and determine the pathway to care for or with the client. The professional literature indicates that Arab clients often make use of informal systems before turning to modern mental health treatment. Therefore, traditional healing can be integrated readily into a helping process with clients of various cultural backgrounds (for example, by adopting some of the religious-cultural rituals of Arab societies).

Traditional healers tend to treat spiritual-mental aspects, whereas workers from biomedical health systems may be more closely linked to somatic aspects, expressed by physical disorders. Arab traditional healers include, but are not limited to, *al-fataha* or female fortune tellers; the *khatib* or *hajjab*, male healers who produce amulets that are worn on the body to ward off evil spirits; the *Dervish*, male or female healers who treat mental illness using a variety of religious and cultural rituals; and *moalj belkoran*, male Koranic healers who use Islamic scripture as a basis of warding off evil spirits (Al-Issa, 1990; Al-Krenawi & Graham, 1996a, 1996b; El-Islam, 1982; Gorkin & Othman, 1994). Thus, where appropriate, practitioners could integrate activities of traditional healers into modern helping or validate their use by clients and their families (Al-Krenawi & Graham, 1999a, 1996a, 1996b).

## **Traditional Healers**

Mental health practitioners can learn much from traditional healers, particularly with respect to working with families. They could also collaborate effectively with traditional healers in Arab communities. Traditional healers are part of the client's culture. Healer

and client share a common worldview that stresses the importance of their joint origin and helps them understand the problem, its sources, and the best ways of relating to it. The element of worldview is an important factor in the traditional system's efficacy (Torrey, 1986).

In traditional healing systems, the healer is active, and the client is passive. The healer directs, advises, guides, gives instructions, and suggests practical courses of treatment, such as rituals, incense burning, or visiting saints' tombs (Al-Krenawi & Graham, 1996a; El-Islam, 1982). The client sees the traditional healer as a figure of authority and charisma and also as a supportive and understanding father figure. Traditional healers often develop good relations with the client, which reinforces the client's belief in the healer's supernatural powers (Al-Krenawi & Graham, 1996a, 1997b, 1997c; El-Islam, 1982).

The traditional healer engages the help of the client's family as partners in the processes of treatment and healing, as spokespeople for the client. The healer can engage the family's help effectively in seeing that instructions are carried out and in reporting back on the client's condition (Al-Krenawi & Graham, 1997c). Traditional healers are particularly skilled in identifying and using the dominant figure in the client's family, enlisting that person's help in bringing about change in the client and in mobilizing the family and community to this end. Such methods are not widely used in modern mental health systems, which often are characterized by detachment and by the lack of cooperation between the social worker and the client's family (Al-Krenawi & Graham, 1999b).

## Conclusion

In summary, as a growing body of interdisciplinary research shows, there are several important facets of mental health practice with Arab clients. These include taking into account gender relations, the individuals' place in their families and communities, patterns of mental health services use, and, for practice in the West, the clients' level of acculturation. Such aspects provide the basis for specific guidelines in working with Arab mental health clients: an emphasis on short-term, directive treatment; communication patterns that are passive and informal; patients' understanding of external loci of control and their use of ethnospecific idioms of distress; and, where appropriate, the integration of modern and traditional healing systems.

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## About the Authors

**Alean Al-Krenawi, PhD**, is senior lecturer, Department of Social Work, Ben Gurion University of the Negev, Beer-Sheva 84105 Israel, e-mail: [alean@bgumail.bgu.ac.il](mailto:alean@bgumail.bgu.ac.il).

**John R. Graham, PhD**, is associate professor, Faculty of Social Work, University of Calgary, Calgary T2N 1N4, Canada. Send correspondence to A. Al-Krenawi, Department of Social Work, Ben Gurion University of the Negev, Beer-Sheva 84105 Israel.

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