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CROSS-CULTURAL PSYCHOTHERAPY WITH INDIGENOUS PEOPLES:

The Bedouin Arab Case

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ALEAN AL-KRENAWI

Indigenous peoples throughout the world are facing cultural deterioration and many communities are threatened by extinction. Such populations share a history of colonization that has deprived them of the right to self-determination, to their own land, and to their own resources (Weaver 1998, 1999). Like other indigenous populations, the Negev's Bedouin Arabs are experiencing an array of social, economic, educational, welfare, and physical and mental health problems (Mokuau and Matsuoka 1995) as they undergo a rapid, dramatic process of modernization. As a result, they live in a dialectic between globalization and localization. On one hand, attempts are made to protect indigenous culture and religious belief systems, while on the other, the pervasive forces of modernization as well as exposure to Western values tend to dislocate these systems. Many Bedouin Arabs perceive their situation as a struggle between a dominant and minority culture. This becomes clear in therapy sessions when, at some level, references are made to these conflicts as one cannot avoid being part of intercultural dynamics (Al-Krenawi 1998a).

Cross-cultural therapy is defined as any encounter that involves individuals from two different races, cultures, genders, generations, life stages, sexual orientations, or religious backgrounds (Al-Krenawi 2000a; Al-Krenawi and Graham 2002). These variables influence the mode by which the therapist approaches the client's problem. Scholars have offered three major recommendations to ease the process of cross-cultural encounters in therapy. These

include: (a) an understanding of worldview (values, beliefs, and assumptions) and its impact on identity, philosophy, and mode of interaction with the world, including but not limited to problem solving, conflict resolution, and decision making (Al-Krenawi 1998a; Sue and Sue 1990); (b) knowledge of specific cultures and culture-specific verbal and nonverbal skills to facilitate the particular encounter (Sue and Zane 1987); (c) research on various processes and outcome variables including racial similarity/dissimilarity, client expectations, a match between therapist and client, therapist credibility, and attractiveness (Sue and Zane 1987).

All professional assistance is value-laden (Bergin 1991; Beutler and Bergan 1991; Strupp 1978). Controversy regarding the role of the therapists' values and their impact on process and outcome in therapy has raged for decades (Patterson 1989). Some argue that there is a distinction between the theory to which therapists subscribe and the personal values they hold (Beck, Rush, Shaw, and Emery 1979), while others consider this perspective impractical and confusing (Cirillo and Wapner 1986). Most agree that practitioners cannot advocate a value position that is free of their personal assumptions or interpretations (Frank 1973; Strong 1968).

Beutler and Bergan suggest that research on value similarity and therapy/therapist efficacy during the last two decades points to two conclusions: (a) value convergence between therapist-client beliefs and attitudes is directly related to positive outcome, and (b) a "complex pattern of similarity and dissimilarity between client and therapist values is conducive to enhancing the strength of this convergence" (1991, 18). This implies that for a positive outcome in therapy, therapist and client cognitive and cultural schemas must have certain points of convergence.

Reid (1989) suggests that the dominant culture, male and middle-class, is characterized by an orientation toward the future rather than the past or the present as well as an emphasis on the importance of doing over feeling and competition over collaboration. Beutler and Bergan (1991) point out that people with this profile seek to conquer frontiers, control the weather, constrain natural forces, and domesticate animals, in contrast to the inner-city poor who focus on the present, on group identity instead of autonomy, and on mistrust of people outside their group (Reid 1989).

In cross-cultural therapy, worldview and cultural identity are mediating variables used to understand the cultural and gender identity of the client (Ibrahim 1991). Worldview is a significant contribution of the cross-cultural counseling and therapy literature to the generic fields of counseling, psychotherapy, education, training, and development (Ibrahim 1984; Sue 1978; Sue and Sue 1990). This mediating variable makes knowledge of a specific cultural group and knowledge of culture-consistent and culture-specific techniques meaningful (Ibrahim 1991). Without worldview as a mediating variable both knowledge of specific cultures and culture-specific techniques can be misapplied, leading to charges of ethical violation and cultural oppression. After clarifying a client's worldview, culturally sensitive theory and research can be applied. An understanding of individual worldview also helps in focusing on intra-group variation and on the role gender identity plays in the client's self-definition (Hansen and Gama 1996; Sue 1988; Sundberg 1981; Trindis and Brislim 1984).

The acknowledgment and acceptance that individual worldview may vary within a group makes the intervention "client-specific"—that is, useful and meaningful for the particular person, not only as a representative of a certain racial, cultural, religious, age, or regional group but also as an individual. Without basic knowledge or skills to assess and fully understand worldview and the cultural identity of a client, a therapist or educator has no alternative but to apply preconceived notions regarding the specific culture of a client, at best, or simply impose his or her worldview on the client, at the worst (Al-Krenawi 1998b).

Applying cultural information too generally or assuming that the client is similar to the therapist can lead to cultural oppression and malpractice because it forces an idiosyncratic client into a perceived model (Dana 1993). Treating persons as stereotypes of their cultural group violates the person's individuality and may lead the client to terminate therapy prematurely, with minimal therapeutic effectiveness, and possibly engendering negative perceptions of the therapist and the field of psychotherapy (Al-Krenawi 2000b; Al-Krenawi and Graham 2000; Al-Krenawi, Graham, and Kanda 2000; Dwairy 1998).

Proposals and models that enable therapists to increase their competence in cross-cultural encounters by expanding their awareness, knowledge, and skills exist (Devore and Schlesinger 1999; Weaver 1998). Therapists need to understand their own cultural identity, worldview, and philosophy of life through a process of self-reflection, whereby they make a cultural self-assessment within the context of their individual culture, socioeconomic level, race, age, life stage, ethnicity, gender, sexual orientation, and sociopolitical history (Weaver 1998). The therapist's worldview is especially critical because the client's welfare is dependent on the therapist's ability to provide appropriate assistance. If therapists cannot confront their cultural identity and worldview and do not reflect on the multiplicity of factors that have shaped their lives, they will be unable to provide effective cross-cultural therapy, as cultural assumptions will operate in the therapeutic encounter.

Therapist-Client Cultural Match

Beutler and Bergan (1991) indicate that the average middle-class therapist might have significantly different values from the clients with whom he or she

may work. Furthermore, cognitive and information-processing theories propose that it is the therapists' attitudes, not their demographic background in isolation, which determine how a person perceives and responds to interpersonal events (Tataryn, Nadel, and Jacobs 1988). Tayler, Sussewell, and Williams-McCoy (1985) recommend cultural matching to overcome the problems and issues inherent in cross-cultural encounters. Sue (1988) argues that cultural matching is more relevant than ethnic matching, based on the premise that ethnic similarity does not necessarily imply cultural similarity because of the multiplicity of factors that can influence therapy. Sue also notes that although ethnicity is important, what is more valued is the meaning of ethnicity to the client. Furthermore, he states that while research on the treatment of ethnic clients has focused on ethnic factors, cultural factors have garnered the most attention among cross-cultural therapists. Sue proposes that a cultural match can be studied in terms of three variables: (a) diagnosis of the client's problems, (b) modes of problem-solving and decision-making, and (c) goals for treatment. Cultural matching requires the client's worldview to be understood because of the wide variability within ethnic and cultural groups (Ibrahim and Kahn 1987; Sue 1988; Sundberg 1981). This information allows both the therapist and the client to assess their cultural compatibility and encourages conditions that will enable an effective formulation of both process and goals.

In its application, Ibrahim's (1991, 1993) theory includes the following perspectives:

- Both the therapist's and the client's worldviews must be clarified. This must include an analysis of both cultural and gender identity (Ibrahim 1992) of the parties involved and implies ethnicity, culture, age, life stage, socioeconomic level, education, religion, life philosophy, beliefs, values, and assumptions.
- Once clarified, these worldviews must be placed within the following contexts: sociopolitical acculturation level, languages spoken, and comfort with mainstream assumptions and values (Ibrahim 1991; Ibrahim and Schroeder 1990).

The defining characteristics of the client's cultural and gender identity must be viewed within a context that incorporates the following variables (Ibrahim 1990, 1992, 1993):

- how gender is conceptualized in the client's primary group;
- how gender affects the client in the familial and primary cultural context;
- sociopolitical history;
- social conditions experienced by the client's group and status of the group;
- religion (degree of religiosity);

- age and its meaning in the client's primary cultural group and the mainstream culture;
- life stage and its meaning for the client in the primary cultural context and in the mainstream culture;
- birth order in family or only-child status;
- languages spoken (impact of the philosophies underlying the bilingual or trilingual languages spoken, status or lack of status associated with the language); and
- ability or disability status and how this is viewed in the client's own culture.

These variables will provide basic information on how clients view the world in terms of their values, beliefs, and assumptions (Ibrahim and Owen 1994).

After clarifying the client's cultural identity, the therapist can work toward developing a relationship with the client in which both parties feel they understand each other enough to develop trust. One way by which to do so is through an open sharing of similarities and differences in worldview between the therapist and client. This needs to take place on the premise that in cross-cultural encounters the issues of trust and relationship development become very complicated (Beutler and Bergan 1991). This sharing experience will not only enhance the client's trust, but also help the client understand the therapist as a person and increase the client's self-knowledge, a critically important goal in therapeutic encounters. Eventually, this knowledge can lead to the development of a shared worldview (a composite of the therapist's and the client's overlapping belief systems). This shared worldview, according to Torrey (1986), is the basis of highly effective therapeutic relationships in cross-cultural and intracultural encounters. Kelly (1990) holds that convergence of client-therapist values results in improved feelings or functioning for the client. The next step is to develop the process and goal for therapy that would be consistent with the client's beliefs, values, and cultural identity. Finally, the information gained can help the therapist in using culture-specific techniques to create the necessary conditions for therapy. This may lead to positive outcomes in psychotherapy (Rogers 1957).

Bedouin Arab Society

Bedouin Arab is the general name for all Arabic-speaking tribes in the Middle East. The Bedouin Arabs are distinct from other Arab populations in the world because the Bedouin inhabit deserts. However, this should not infer a unified racial, ethnic, or national group with a homogeneous style of life. Bedouin Arab populations reside in Egypt, Israel, Jordan, Saudi Arabia, and Syria among other countries (Barakat 1993). The society is of high context, which means a society that emphasizes the collective over the individual and is characterized by a slower pace of societal change and a greater sense of social

stability (Al-Krenawi 1998a; Al-Krenawi and Graham 1996, 1997; Barakat 1993; Hall 1976). In contrast to the Western liberal concept of individual autonomy, Bedouin Arab identity is inextricably linked with the collective identity of the family, extended family, and tribe (Al-Krenawi 2000b).

Bedouin Arab society is authoritarian and group-oriented rather than egalitarian and individualistic (Sharabi 1975). A hierarchical order is maintained within the family in which the dominance of male over female and older over younger is observed. Gender differences in Bedouin Arab society are distinctly defined, gender segregation is widespread, and the social structure is patriarchal—asserting men's leadership authority in the household, the economy, and the polity (Al-Krenawi 2000b; Al-Krenawi, Graham, and Al-Krenawi 1997).

As one Arab scholar has observed, Muslim patriarchy considers female sexuality as extremely powerful but subversive to the social order (Mernissi 1975). Women are taught from childhood that their sexuality rather than their own personal self is the inalienable and permanent property of the *hamula* (extended family). "Sexual purity and lineage honor are seen as inseparable" (Haj 1992, 764) and a woman's sexual identity is of concern to all. Accordingly, women's sexual integrity is maintained by family and community surveillance and control.

The ethnic Bedouin Arab client actualizes a fundamental collective sense of psychosocial being which Al-Krenawi (2000b) refers to as a "collective ego identity" in explaining the Bedouin Arab client. Thus, the concepts of independence and individualism, so strongly emphasized and highly valued in Israeli culture, are alien to young Bedouin Arabs who, socializing in the traditional manner, stress interdependence and affiliation. For example, Hsu et al. (1983) describe the core American national character as "rugged individualism" which they define as the intrinsic and unquestionable values of self-containment, autonomy, self-reliance, and self-determinism and which results in the individual taking personal responsibility as the ultimate value rather than taking responsibility for others. In contrast, indigenous peoples such as the Bedouin Arabs manifest their values and worldviews in terms of social collectivism: a social order that is essentially family based and interpersonally or collectively oriented.

The formal idea of family in Bedouin Arab society extends family identity and membership backward through all the ancestors in the male family line to the present and to those future descendants who have yet to appear. One's sense of family is not time-bound or limited only to those important living kin. While the father is the head of the nuclear family household and is responsible for the family's economic and physical well-being, he still shows deference and loyalty to his living or dead father. Elders in the father's extended family are also respected. The mother is included in the extended family of her husband. As a mother she is the emotional hub of her new

nuclear family, responsible for nurturing her husband and children (Al-Haj 1987). While wielding tremendous emotional power and often acting as the relational and communication link between father and children, she nevertheless has little public power and authority and defers to her husband, his mother, and the elders in the husband's extended family (Al-Krenawi 2000b).

Dynamic social harmony—requiring varying degrees of social cooperation, adaptation, accommodation, and collaboration by all individuals in the social hierarchy—is the major social rule governing all meaningful interpersonal relationships. In Bedouin Arab society hierarchical social roles are based more on family membership, gender, and age than on qualification and ability, and age and life experiences are associated with wisdom and competency. Deference and respect from an individual in a subordinate position requires the person in the superior social position to look after the subordinate individual (Al-Krenawi and Graham 2000).

The ingredients necessary to maintain social harmony are self-restraint and stoicism, conscientious work to fulfill one's responsibilities, heightened social sensitivity, and other such directed actions. A person's breech of social obligation or duty can potentially damage the social harmony of the family, group, or larger community. Furthermore, unlike Western notions of individuals as masters of their own fate, Bedouin Arabs believe that one is not in ultimate control—individuals are always an integral part of the larger encompassing universe that has authority over them (Al-Krenawi 2000a).

From a Bedouin Arab perspective, the prescribed forms of interpersonal interactions are intended to preserve dynamic social harmony by minimizing direct conflict and social discordance. Communication, as an aspect of social interaction, is highly contextual and tends to flow downward from superior to subordinate, often in the form of directives (Al-Krenawi 2000b). Both verbal and written communications are indirect in the passive tense and at times may appear convoluted. Furthermore, much of the communication is nonverbal especially where the conduct and not the content is most meaningful. These principles of Bedouin Arab communication styles serve to maintain vital social harmony in any interpersonal interaction (Al-Krenawi 2000b).

The Bedouin Arab socialization process develops highly differentiated adult individuals with mature levels of deep emotional interdependency and strong feelings of responsibility and obligation. The sense of collective self is both co-determined and co-owned (Al-Krenawi 2000a; Dwairy 1998). But within the context of Bedouin Arab social reality physical distress may appropriately exemplify psychosocial distress. For instance, among Asian Americans, gastrointestinal disorders are often viewed as a normal expression of psychological stress over an intense interpersonal conflict and are not necessarily seen as "symptoms" or indicators of the client's inability to cope with psychosocial conflict (Devore and Schlesinger 1999). Alleviating

the physical symptom may be an appropriate treatment for a relational conflict one has no control over.

Psychosocial Development of the Individual in Bedouin Arab Society

The previous generation of psychological theory asserts that during the course of human development individuals undergo an important psychosocial separation from their parents leading to the formation of a unique, autonomous identity (Erikson 1963; Mahler 1968). But as recent diversity research emphasizes, individual development in Africa, Asia, South America, or the Middle East may occur differently (Sue and Sue 1990). For in these societies the collective identity of the family remains central (Hofstede 1986) and the individual is embedded within this collective identity (Al-Krenawi and Graham 2000; Sharabi 1975).

Indeed, if one were to contrast the Bedouin Arab community with those in the West, eight differences would be especially salient:

(1) Group affiliations and interdependence rather than competition prevail (Rotheram and Phinny 1987). That is, a "collective ego identity" prevails in which behavior and social strictures are referenced to the group.

(2) Orientations are passive and accepting rather than active and achievement-based (Rotheram and Phinny 1987).

(3) Authoritarian hierarchy, rather than egalitarianism, characterizes social organization.

(4) There is an external rather than internal locus of control. Living in a collective-authoritarian context, individuals learn that occurrences in life are determined by external powers such as family, social leaders, life experiences, or God. Religious people fatalistically believe that their destiny is *maktoob* (it is written). Individual responsibility for behavior therefore may be emphasized less than in other societies (Al-Krenawi 1999b, 2000a; Bazzoui 1970; West 1987)

(5) The self is unindividuated. The psychological autonomy and individuation that many Western psychosocial theories describe bear only limited relevance to the common pattern of psychosocial development in collectivist Arabic cultures (Dwairy and Van Sickle 1996; Gorkin, Masalha, and Yatziv 1985; Timimi 1995). The Bedouin Arab's identity is more strongly derived from the family, as self-concept is enmeshed in the family concept and an individual's needs, attitudes, and values stem from those of the family. If a family member contradicts social norms the entire family may be seen to have been shamed or if a family member is successful in professional or remunerative terms it is to the credit of the entire family (Al-Krenawi 2000b).

(6) Sources of distress are interpersonal rather than intra-psychic. Bedouin Arab individuals are conditioned through external threats of sanctions making external controls more significant than internal (superego) ones.

Therefore, shame (group-oriented) rather than guilt (individual-oriented) may ore often regulate behavior (Gorkin et al. 1985; Sharabi 1975), and inter- ersonal coping strategies become more effective than intra-psychic defense echanisms (Dwairy and Van Sickle 1996).

- Communication styles are restrained, impersonal, and formal rather than overt, personal, and expressive (Rotheram and Phinny 1987).
- Emotions are expressed indirectly. In Bedouin Arab society as in other Arabic societies, people tend to avoid expressing negative emotions such as anger and jealousy towards family members (West 1987). Individuals are expected to exhibit emotions congruent to societal norms and to hide authentic expressions. Other emotions are expressed through acting-out behavior away from the attention of others or through body language; these are often problems presented to the therapist (Al-Krenawi 1999a, 2000a).

One of the dilemmas individuals invariably experience is the choice etween conformity and self-referenced objectives (Al-Krenawi and Graham 2002). This dynamic is especially present in, but not restricted to, people dur- ng adolescence and early adulthood or among those involved in the Israeli mainstream culture and who experience acculturation. When the conformist choice is adopted the individual accepts support provided by the family and social environment in exchange for realizing a more pronounced expression of individuality. If the self-referenced choice is made, the individual asserts that he or she has the right of self-expression and personal decision-making but social support of the family and traditional community may be reduced. Traditional social norms of Arab society may condition the individual from early childhood towards choices that conform to community norms (Al-Krenawi and Graham 2000) and the forces that encourage conformity remain in place during adulthood. Young couples, for example, may continue to require the economic and social support of extended family members. This support may be seen as a covert agreement that encourages the couple to conform to community and broader familial norms. As one psychologist emphasizes, such behavior should not be perceived as transference of a child-parent role but as an adaptive response to authority (Dwairy 1998).

Implications for Psychotherapy with Bedouin Arabs

1. Clients of Bedouin Arab origin have a negative view of mental health and psychological services due to their strong religious beliefs; therefore, they tend to mistrust and underutilize these services. It is well known and documented that historically the relationship between psychiatry and religion has been dubious at best, and outright inimical at worst. This is as true for Arab populations of various religious origins as it has been of other religious groups. Although there are some exceptions based on the level of education

and degree of acculturation, it can be safely assumed that most Arabs view mental health in a negative light and, consequently, the utilization of mental health services is scarce. Few distinctions are made among psychiatrists, psychologists, or other professionals in the mental health field. All are viewed suspiciously as researchers or doctors who discard religious values and fail to see them as a "true" source of solace and healing. Within such a context it is difficult to establish trust (Al-Krenawi, Graham, and Kandah 2000). There is no notion that the therapist-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.

Clinical Response

A cultural gap leading to mistrust is a given when a non-Arab mental health provider comes into contact with a Bedouin Arab client. Therefore, the therapist's first task is that of self-education about the religious, cultural, and national background of the client. Before formulating a treatment plan a detailed history should be taken including information such as level of social and family support available and degree of religious affiliation. Thus, an assessment of the client's personal background and level of acculturation will alert the sensitive clinician to potential cultural conflicts regarding treatment.

In addition to learning the background of the client, the therapist must understand the following issues: the Bedouin Arab view of health and medicine (including mental health), the Bedouin Arab family system, and the Bedouin Arab's opinion of Western society. The Israeli view of Bedouin Arabs might also assist the clinician in better understanding the Bedouin Arab client.

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2. Bedouin Arab clients and their families place a great deal of responsibility on the mental health practitioner to provide a solution to their problems while providing little or no input. The Bedouin Arab client will generally assign a great deal of authority to the therapist and conform to what is advised or prescribed, at least on the surface, because to disagree is equated with confrontation, an action which is considered rude. The mental health provider can expect the Bedouin Arab client to remain passive during the assessment interview and the helping process in general.

Clinical Response

The clinician must develop a comprehensive understanding of Bedouin Arab views of mental health practice as well as an acceptance that the client will likely be passive. Additionally, the clinician should develop techniques that will encourage trust and openness between the client and clinician.

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3. Bedouin Arab clients often experience somatization of affective disorders. (Somatization in the context of the present paper is the expression of emotional or psychological difficulty through the body with the unconscious motive or hope of being cured of the physical ailment as well as what it symbolizes—its underlying dynamics—even if the client does not know what the underlying dynamics or illness are.) Therefore, they expect mental health treatment to be similar to physical medical treatment in its timeliness and in its lack of demand for client interaction. As a result, traditional Western improvement approaches may be inappropriate.

As explained by Kulwicki, "Arab-American clients often expect doctors to make medical decisions without the need of the collection of 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" (1996, 201).

Clients might wait to be questioned by the therapist and may not complain much about emotional distress but would probably do so for physical ailments. Because their psychological symptoms are often experienced and interpreted physically rather than emotionally, Bedouin Arab clients frequently expect to be "cured" of symptoms without having to divulge many aspects of their personal lives, much like one does when seeking a physician's help for somatic complaints (Al-Krenawi 1999a). 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 clinician stays very close to the here and now and be prepared for the possibility of short-term work.

Depression and somatization are so intertwined in Bedouin Arab culture that it is almost impossible to separate them into two distinct categories as is done in the Diagnostic Statistical Manual (DSMIV). Indeed, as cross-cultural studies of depression have so far 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 et al. 1985, 306)

The expression of conflict, whether internal or external, and the expression of negative feelings are not well accepted in the Bedouin Arab culture.

The anxious self-absorption that often accompanies a depressed mood is negatively viewed as "thinking too much," which is a narcissistic self-preoccupation (Al-Krenawi 2000a). Physical symptoms, however, are accepted as legitimate, 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, "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" (1970, 196).

In America, when treating depression as described in the DSMIV, the clinician should be attentive to symptoms such as a depressed mood or loss of interest in most activities; physical symptoms such as fatigue, insomnia, or 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 indicate a curious lack of mood symptom for both depressed and manic or hypo-manic clients (Al-Issa 1995). That is, when clients are asked if they feel sad or elated they generally answer "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 clients may feel incapacitated by psychomotor retardation, they will not interpret extreme fatigue and other physical symptoms as mood related, which would be a typical North American interpretation.

Because suicide is considered a criminal act, Bedouin Arab clients are less inclined to commit suicide, but when they do feel suicidal, they may not divulge it easily. While working in Saudi Arabia as a psychiatrist, Dubovsky discovered that when patients are "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" (1983, 1457).

Clinical Response

Working with the somatic client: These clients, especially women, may be passively dependent upon 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 (Al-Krenawi and Graham 1999). As Racy 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 a specific picture of the 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" (1980, 214). He suggests that the clinician may effectively utilize a client's passivity as well as the authority placed in the therapist to engage the client in her own treatment, as in having her keep a diary or perform certain tasks, or plan an exercise regimen.

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4. The family's involvement in individual mental health care is considerable and often makes the therapist's work more difficult. In some cases, the family will intervene on behalf of the "identified patient," expecting much to be accomplished by the clinician while lacking trust in the therapist. For example, family members might try to control the interview by answering questions directed to the client in order to withhold information that may be perceived as embarrassing. The family members' involvement can easily be considered as arrogant, verging on insult, when they act as authorities on matters that pertain to the therapist's area of expertise. The family unit is sacred among Bedouin Arab people who are raised to depend on it as a continual source of support. Extended family members are highly valued as well. Family members are expected to be involved in matters and 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, 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" (1984, 76).

Differences in temporal perception can be challenging while working with families. In a clinic or hospital setting in particular, the Bedouin Arab family may have difficulty with limited visiting hours, which may have to be extended especially for them. Bedouin Arabs' notion of time is more fluid and not as structured or determined as in the West. As a result, Bedouin Arabs may not be very time-bound. The Arabic language holds no clear distinctions between various forms of past and future. As Patai explains, "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" (1971, cited in Al-Krenawi and Graham 2000, 70). Psychologically speaking, this can be viewed as advantageous in that it affords flexibility in one's adaptation to life's circumstances which fosters an ability to react quickly when facing the unforeseen. However, it is a disadvantage when living in cultures requiring a

time-sensitive attitude. Thus making and keeping appointments at fixed times or starting and ending sessions promptly might be a source of difficulty.

The Bedouin Arab's idealization of the family as a central source of social organization may induce psychological conflict when living in a Western country where psychological health and maturity rests on the young adult's ability to separate and establish his own individuality apart from the family. Additionally, family problems that a mental health provider may encounter are often of a marital nature or involve parent-child issues. A study carried out by Aswad and Gray (1996) at a community mental health center for Arab Americans revealed that marital problems were mostly construed by Arabs as being a woman's problem: for instance, an unemployed husband could not pay his bills yet he would not let his wife work (50 percent); immigration problems (30 percent) such as husbands bringing a second wife from abroad or marrying another woman for a green card; spouse abuse (7 percent); and problems relating to children, especially discipline issues (38 percent). Because the cultural norm requires a woman to be a virgin at the time of her marriage, adolescent girls are prone to have a great deal of conflict, guilt, and trouble over dating and sex. Indeed, as reported by Aswad and Gray, the threat of suicide in their sample primarily came from adolescent girls. They also noted that "the majority of cases reported were shown to be difficulties between mother and daughter (43 percent), mother and son (36 percent), father and son (17 percent), and father and daughter (4 percent) while mothers are held responsible for their children's behavior and their daughter's reputation are a major concern to the family name" (1996, 232). It should be noted however that 80 percent of the Aswad and Gray sample seeking help were women, which aptly reflects the gender tendency of women, rather than men, to seek clinical help. Had the sample contained a greater representation of men the identified issues might have been different.

Clinical Response

The cultural characteristics of family and gender in Bedouin Arab society can best be utilized by therapists willing to educate themselves regarding Bedouin Arab family values so that they can, in turn, sensitively educate the family about necessary requirements for a workable beneficial relationship. The clinician working with a Bedouin Arab individual will by necessity come into contact with the family and needs to understand that what might seem to be detrimental involvement, overprotection, or blatant codependency on the part of the Bedouin Arab family may well be highly appropriate actions in a culture where any less involvement would be considered neglect, if not abandonment. The therapist should reconsider what would constitute intrusion concerning the privacy of the client and the help necessary for the client based on the latter's expectations and not on Western standards. The therapist would do well to establish clearly, from the beginning, rules regarding appointment time, tardiness, and missed sessions. This will be part of the therapist's role as an educator about the process of psychotherapy, the therapist's role, expertise, and goals.

The cases reported in the literature suggest that conventional modes of operation had to be modified in order to facilitate a more personal and supportive relationship between client and staff (Al-Krenawi and Graham 1999). The family has to be actively engaged in the treatment process and must be reassured that "they were part of the care and treatment scheme. This approach emphasized social rather than psychological integration" (Budman et al. 1992, 365). For example, if the cultural gap is too wide (a language barrier involving a cultural consultant), mediation between the client and the clinician through a member of the client's cultural milieu might be imperative, especially if working in a hospital or clinic setting. Often, an Arab social scientist or health worker is used to consult with client, family, and staff. "A consultant who 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" (Meiles and La Fever 1984, 85). As an example, most Middle Easterners are hypersensitive regarding matters of "ingestion and elimination" and consequently may refuse medication or medical treatment that would lead to constipation or other abdominal discomfort. In the case reported by Meiles and La Fever, "proper nutrition and elimination and conditions for restful sleep were promptly established" as an important aspect of the psychiatric treatment plan (1984, 85).

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5. Cultural expectations regarding gender can complicate the beneficial relationship. Bedouin Arab men may have difficulty accepting a female therapist's directions. When this problem occurs it does not necessarily arise 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. In reference to Iranian families, Jalali wrote: "the patriarchal organization of the family is to be acknowledged by addressing fathers first 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" (1982, 308).

Clinical Response

A male-female client-therapist dyad is complicated and impractical at best. As previously mentioned, it would be more difficult for a male client to trust a female therapist. 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. Such attachment will most likely lead to conflict and confusion. Every attempt should be made to educate the client about the appropriateness of the attachment, the transference, and reassurance which should be offered so that the relationship is safely protected by professional standards. Likewise, a female-male practitioner-client dyad is best responded to with such culturally appropriate techniques as referring to the client as "my sister," and maintaining minimal eye contact and appropriate physical distances between client and worker while integrating the family in many, if not all, stages of treatment (Mass and Al-Krenawi 1994).

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6. The therapist should acknowledge that religion carries some meaning and has had an impact on the individual's development. The Bedouin Arab Muslims would not appear to be devout based on their behavior or lifestyle. Mental health providers may never guess the patient's religious sentiments if they don't actively ask and pursue the question. Such a person might say, "Yes, Islam is important to me. I feel God is with me at all times but I get to pray only when I can and when I do it feels really good."

Islam imparts a sense of personal responsibility regarding one's health, which is a gift of God that needs to be preserved with utmost respect. However, the Bedouin Arab Muslims also generally have a tendency to resign themselves to God's care and thus may neglect or deny symptoms for a long time. As pointed out by Dubosky:

> Very difficult to manage is an almost universal attitude known as *in'shallah* (as God wills), a pervasive belief that good or bad outcomes, including whether one becomes ill, improves, or dies, are entirely in God's hands. As a result, patients may not obtain immunization, follow through with a medical regimen, or remain in the hospital, while they convey a passivity that mimics helplessness and makes achieving a therapeutic alliance in which the patient is actively involved in his or her own care extremely difficult. (1983, 1456)

Mental health problems such as depression and psychotic illnesses cause even greater passivity in that it is often believed to be a result of loss of faith in God. As Kulwicki explains, "Madness is perhaps the illness most feared by Muslims. Since humans are considered the highest form of life because of their possession of a rational faculty, loss of reason is the most serious illness that can befall them. The only cure . . . is for victims to reaffirm their belief in God. This can be done directly or through the assistance of a religious intermediary or folk healer" (1996, 195).

In speaking of psychiatry in Saudi Arabia, Dubovsky explains the challenges one faces when attempting to reconcile Islamic principles and folk medicine with modern knowledge of psychiatric disorders "mainly due to earlier widespread belief that mental illness was caused by 'curses', possessions of demons, failure to follow rituals for avoiding harm, and fate" (1983, 1456). Among the rituals for avoiding harm is the utterance of certain Koranic sayings such as *in'shallah* (if God wills), *ma'shallah* (what God has willed), and *Alhamdulillah* (praise be to God, or thank God). For example, when receiving compliments, especially regarding one's children, the latter two sayings need to be used to avert the evil eye.

Kulwicki reports that Muslim Americans also believe in the evil eye. "The evil eye is typically cast by women jealous of the good fortune of another who has beautiful and healthy children. In admiration, they praise the beauty of a child or youth but fail to mention the name of God or the Prophet" (1996, 203). Folk medicine is often used to heal illnesses believed to be caused by the evil eye, which is cast by a jealous or envious person (Al-Issa 2000, 1990). The burning of frankincense and the use of amulets are the most frequently used forms of warding off the evil eye. This can be a preventive measure as well as a healing one. The phenomenon of the evil eye is reminiscent of such psychological concepts as projective identification, which is considered a defense, through which the undesirable aspects of the self are projected outside of the self into another (Al-Krenawi and Graham 2000). The evil eye is an example of how one's own envy or the secret wish to be the object of others' envy is projected into somebody else's eye, who then embodies the badness attributed to it. However, the mental health practitioner can learn much from traditional healers. The client is passive while the healers are active, directing, advising, guiding, giving instructions, and suggesting practical courses of treatment such as rituals and so on (Al-Krenawi 2000b). Thus, we may say that the traditional healers meet the clients' expectations, which may have an impact on the therapeutic outcomes.

Conclusion

Bedouin Arab clients often exist in at least two if not more interacting social worlds. One is the collective—based on the social world of their Arab-identified families, religions, and communities while the other is individual—based on the social order of the dominant Western society (which enters non-Western cultures through the globalization process). Western approaches to mental health treatment is geared to restoring the vitality, effectiveness, and autonomy of the client's individualistic self, with scholars rarely mentioning cultural components such as family, tradition, or the collective attributes that encompass the life experiences of Bedouin Arab clients (or other non-Western societies) as important aspects of a treatment plan.

To deny the collective part of "self" in treatment may negate the effectiveness of therapeutic work since the Bedouin Arab "self" is strongly influenced by the way individual conduct will affect family. And here family takes on a very broad level of importance since family in many Arab countries provides the client with a sense of identity which may affect every aspect of life from birth to death. Family is a broad concept, including an extended nuclear group, *hamula*, or tribes. What an individual does in Bedouin Arab society has broad consequences, for it may affect the way the family is viewed by the broader community. Consequently, working with the individual "self" may have little resonance with many non-Western clients. All therapeutic work must therefore consider the impact of change on the extended family. Furthermore, in a family-based society, changes in the client, however small, may impact family life and affect not just the client but all members of the family in ways that are often unpredictable (Al-Krenawi 2000a).

A constraint in therapy is that the client may stay emotionally ill because to get better could have a negative impact on the family. Or, conversely, the client's improved mental health may positively affect all family members. Unlike most Western therapeutic work, however, the impact of any treatment strategy with the Bedouin Arab client must consider how the family might be affected and whether the resulting change may adversely affect the client's affiliation with family members.

In sum, to be effective in their work with the Bedouin Arab people, human service providers must become culturally competent. Cultural competence can be summarized by three major principles: First, human service providers must be knowledgeable about Bedouin Arab culture, including a sense of Bedouin Arab history, values, and norms. Second, human service providers must be self-reflective enough to recognize biases within themselves and within the profession. This means that therapists must look critically at their own belief systems, values, and worldview and the ways in which they affect practice. Finally, human service providers must be able to integrate this knowledge and reflection with practice skills when serving different ethnic groups.

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