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Socio-Political Aspects of Mental Health Practice with Arabs in the Israeli Context

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Abstract: Since the 1948 establishment of the Israeli state, an event described by Arab peoples as *"Al-Nakbah"* (catastrophe), the Arab minority in Israel has experienced oppression, trauma and social exclusion; they feel defeated, disempowered and poorer. There are huge gaps in quality of life between Arab and Jewish Israelis. Such social inequities, as well as other issues such as polygamy, have been identified as risk factors for psychological distress. This situation puts the Israeli Arab, like other post-colonial peoples, in an attitude of ambivalence towards modern mental health services. On the one hand, certain forms of intervention, particularly medicinal, may improve peoples' lives. On the other, mental health services, as part of the colonial process, continue to present limited cultural sensitivity towards Arab peoples. A cultural gap leading to mistrust is a given when a non-Arab mental health provider comes into contact with an Arab client. Religious beliefs, the importance of the family and the stigma attached to mental health problems have substantial influence on the Arab's perception and reaction toward mental health problems and their treatment. The expression of conflict and negative feelings are not well accepted within Arab culture. For this reason, mental illness is often denied and kept away from professional help or expressed as a physical illness. There is also a difficulty for a male being treated by a female and for the individual to ask for help outside his family or community. Arab Muslims also generally have a tendency to resign themselves to God's care and thus may neglect or deny symptoms. Another tendency is the preference for using traditional healers and folk medicine. Other problems in mental health work are the passive attitude of the patient and the degree of authority vested in the therapist. To facilitate bridging this cultural gap, the therapist's first task is that of educating him/her self about the religious, cultural and national background of the client. Cultural competence and self-reflection are key components to effective cultural practice.

Over the past half-century, the Palestinian and Israeli peoples have lived in an exceptionally contentious situation (1, 2). Ongoing violence from both sides has wrought traumatic consequences (3). Within this context, economic deprivation, the suppression of political rights, and continuous psychological stress and social dislocation has become normative in both sides.

The Arabs in Israel

Since the 1948 establishment of the Israeli state, people of Arab descent have experienced oppression, trauma, social exclusion and related socioeconomic and political problems. Indeed, Arab peoples describe 1948 as *"Al-Nakbah"* (catastrophe), and it represents the loss of the homeland, the disintegration of society, the frustration of national aspirations and the beginning of a hasty process of destruction of their culture (4).

The psychosocial and economic consequences have been severe: people lost their homes, livelihood, and political power; families were displaced, separated, and communities were destroyed. *Al-Nakbah* is the moment when a part of the Palestinian people became homeless, a state that is associated with a deep sense of insecurity. In light of this, the house key has become a symbol of the former home and of the return to it and to normality (4).

Between the establishment of Israel in 1948 and 1967, the Arabs in Israel were under a military regime. The traumatic impact of this social exclusion continues to the present time, as reported by Israeli and other scholars (5).

Arabs in Israel find themselves in a difficult and complicated reality. They perceive themselves primarily as Palestinians. Many have first and second degree relatives in the occupied territories. Most identify nationally and emotionally with the Palestinian people in the occupied territories (6).

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Palestinians are now a minority within Israel, constituting 1.3 million of the country's total population of 6.6 million. Over 700,000 Palestinians are Muslim, roughly 150,000 Christian and almost 100,000 Druze, Circassian or other groups. The vast majority resides in all-Arab towns and villages located in three main areas: the Galilee in the north, the "Little Triangle" in the center, and the border that separates Israel from the occupied West Bank (7)

There continue to be huge gaps in quality of life between Arab and Jewish Israelis (8). Over 100 Palestinian Arab villages in Israel lack official government recognition. More than 70,000 Palestinian Arab citizens live in villages that are threatened with destruction, prevented from development and are not shown on any map (7). Over 36% of Arab children are under the poverty line, compared to 18% of Jewish children (9). A study by ADVA (Center for Information on Equality and Social Justice in Israel) notes that the income of the Arab citizens of Israel is the lowest; in fact, relative to the average income, this income has been declining since 1995 (10). Arab women suffer from a higher proportion of this poverty. In 1997, 80% of Arab women of working age did not work, compared to 45.8% nationwide women (11). In May 2001 a discussion held in the House of the President of the State of Israel revealed that 42% of the Arab families in Israel are poor compare to 14% in the Jewish sector (12).

Despite the achievements of Israel's education system, there are great disparities between Arabs and Jews in facilities, funding allocations, number of pupils per class and academic achievement. Funding structures for education, as well as for other municipal and social services, disproportionately hurt Arab peoples. For instance, of the 50 localities which receive the lowest government allocation for education, 41 are Arab (13).

Though it has declined absolutely over the last few decades, the infant mortality rate for Arabs is still twice as high as for Jews: 9.3 per 1,000 live births, as compared to 4.9 per 1,000. The difference is especially striking in the post-neonatal mortality rates (deaths occurring 28-365 days after birth): 5.8 per 1,000 for Arabs in Israel, and 1.8 per 1,000 for Jews (14). According to the Israeli Center for Disease Control: "Mortality at this age is primarily related to environmental causes, such as infectious diseases and accidents, most of which are preventable" (15, pp. 39-41).

The dynamics of social exclusion, religious differences, the constant threat and experience of destruction, increased poverty and its impact on women and children, lower educational standards and opportunities, and high infant mortality rates are significant determinants of health — physical, spiritual and mental. These factors contribute significantly to the social and mental well-being of Palestinians living in Israel. In particular, four psychosocial factors are highlighted: mental health services as an instrument of social control, mental health problems associated with Arab cultural practices such as polygamy, and how economic problems and experiences of social exclusion resulting from political conflict impact mental health status.

Psychosocial Factors Affecting Mental Health and Treatment

Arabs in Israel, like other post-colonial peoples, have reason to be ambivalent towards modern mental health services. On the one hand, certain forms of intervention, particularly medicinal, may improve peoples' lives (16). On the other, mental health services, as part of the colonial process, continue to have limited cultural sensitivity towards Arab peoples. Indeed, there is a significant body of literature from this and other non-Western communities on services for people of African, Asian, Australian and North American Aboriginal, South American descent (17-20). Moreover, mental health services are widely understood to have consequences and motivations that are political. Delivery systems in some instances — such as China (21) or the Soviet Union (22) — have explicitly served political regimes that oppress people whose ideologies are contrary to, or a perceived threat to, the regime. In other instances the psychiatry-polity (i.e., that aspect of society that is oriented to politics and government) relationship may be less overt but still significant in carrying out social control and in defining deviance and social exclusion (23). As we argue, it is impossible to appreciate services for Arab in Israel without reference to the geopolitics of the Middle East — particularly the relationship between Arabs and Jews in Israel.

The economic problems that the Arab in Israel

faces create many problems within the Arab society as a whole and among the families as well. Among the economic sources of marital disputes and tension are the inability of the husband to provide financial support or secure appropriate accommodation for his wife and children. Closely related to this issue is the failure of many husbands to secure separate dwellings for their nuclear families. Co-residence with parents-in-law, often the husband's parents, has caused a lot of tension in the relations between the spouses, with the wife being particularly disadvantaged. In addition, wide differences between the spouses in educational levels, income, social position or status and personality type can also cause additional tension between them.

The Arabs in Israel experience stress stemming from being a minority group. Many perceive themselves as suffering from systematic economic, educational and cultural discrimination (14). Such social inequity has been identified as a risk factor for psychological distress (24), feeling of worthlessness, helplessness, powerlessness, and of being regarded with disdain, as well as sadness and fear (25).

The practice of polygamy can lead to co-wife jealousy, competition and unequal distribution of household resources (26). A greater prevalence of mental disorders has been found to occur among women in polygamous marriages (27) and, relative to their number in the general population, a higher proportion of women in polygamous marriages are psychiatric outpatients (28) and inpatients (29). Among psychiatric patients, polygamous marriage is associated with depressive disorders, a state of anxiety (30), depression, somatization disorders (31) and low self-esteem (32).

Implications for Mental Health Practice with Arab Peoples in an Israeli Context

Mental health and mental health treatment are strongly influenced by the ongoing geopolitical conflict between Israel and the Palestinians. I will focus on six reference points that influence clinical processes, including mental health service utilization: the negative view of psychological services, relationship with the clinician, problem identification, family involvement, gender and religion. It is important to note that I do not intend to "totalize" when I speak about psychosocial problems and their resolution with Arab peoples living in the Israel context. There are exceptional differences within communities and between peoples. These experiences vary according to individual experience, gender, and so many other factors. Yet it is possible to state that Palestinians may have a strong identity based on ethnic, familial or socio-economic identities based in several major faith traditions (Christian, Druze or Muslim), and from communities immersed in a broad spectrum of traditional to modern norms and values. Historical experiences are implicit to the worldviews of Palestinians living in Israel — most important among these historical experiences has been the resurgence of Islamic loyalties since the 1980s, which coincided with the resurgence of Arab autonomy and likewise have provoked internal energies within the Arab world (33).

Negative View of Psychological Services: Current mental health literature has revealed that Arab clients tend to underutilize health services in general and mental health services in particular (34, 35). This phenomenon has been attributed to the fact that cultural sensitivity and religious belief have substantial influences on the Arabs' attitudes toward formal mental health services. However, few studies have been conducted to examine the factors that mediate the individuals' decisions to seek treatment for mental health reasons. A number of barriers, which may influence the individual to not seek formal services, were observed within these studies. It is well known and documented that historically the relationship between psychiatry and religion has been dubious at best, and outright inimical at worse. 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. There is not much distinction made between 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 (35).

Another significant factor found to influence the Arab individuals help-seeking behavior was the

stigma attached to mental health problems. Arab people tend to feel more stigmatized when seeking mental health services due to cultural sensitivity and the stigma of shame (17, 34, 35). For this reason, mental illness is often denied and kept for long term in the Arab individuals' lives, keeping them out of professional treatment and intervention. Al-Subaie and Alhamad (36) claimed that Arab persons tend to deny the existence of mental health problems because they think that the problem may shame their family and affect individual well-being within his or her community.

Perhaps most importantly, there is a political dynamic to any intervention process. Arab peoples have had limited historical exposure to the helping professions; the recent introduction of helping professional practices coincides with the establishment of the Israeli state — which is seen by many as yet another stage of colonial settler regimes extending back centuries to include the Crusades, the Ottoman Empire, the British Empire, Egyptian occupation (37). These colonial processes have upset social structures, community relations — indeed all areas of Arab life. The most recent example of what many perceive along this continuum — the Israeli state — may be viewed negatively. So too may the mental health systems — funded and often carried out by the institutions of the state — may be perceived as coercive. Moreover, mental health services are frequently unavailable within Arab communities, often necessitating travel outside the community (38), further reinforcing the mental health system's sense of estrangement with Arab society.

The negative beliefs that Arab people hold toward mental illness, its treatment and mental health practitioners may also discourage their utilization of the formal services and encourage their silence about their illness and feeling. In one study, Al-Krenawi and Graham (34) showed that Arab individuals do not distinguish between mental health practitioners (e.g., psychiatric vs. psychologist), nor are they aware of the type of services offered by those professionals. This was attributed to unfamiliarity with formal social services since most use traditional healing more than biomedical services.

In addition, some studies concluded that the use of non-native practitioners in mental health settings might decrease the Arab individuals' willingness to seek help. Al-Subaie and Alhamad (36) attributed underutilization to the fact that mental health service practitioners were non-Saudis and do not speak Arabic. This induced the Arab individuals with mental problems to seek treatment from traditional practitioners who share their identity and speak their language (39).

The lack of adequate and affordable mental health services provided within their community may also influence the decision not to seek help. Okasha and Karam (40) emphasized that the underutilization of mental health service among Arabs can be best attributed to the implementation of new government mental health policies that lead to increase of private mental health services sectors and decrease of the public, free services. Furthermore, Okasha (41) showed that mental health services were not successfully introduced to clients in their settings and there was little effort provided by Arab governments to publicize services due to the mismanagement of financial resources. Okasha (41) further discussed the impact of the bureaucracy, that individuals are required to pass through many different health care filters before they reach mental health specialists.

*Culturally sensitive clinical response***:** A cultural gap leading to mistrust is a given when a non-Arab mental health provider comes into contact with an Arab client. To better facilitate bridging this cultural gap, the therapist's first task is that of educating him/herself 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/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.

Aside from learning about the individual background of the client there must be an understanding of issues such as: the Arab view of health and medicine (including mental health), the Arab family system as well as the Arab's opinion of Western society. The Israeli view of Arabs might also assist the clinician in better understanding the Arab client.

Responsibility of Mental Health Practitioners: Arab clients and their families place a great deal of responsibility on the mental health practitioner to provide a solution to their problems with little or no input from the client. The 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 considered rude. The mental health provider can expect the Arab client to remain passive during the assessment interview and the helping process in general.

Culturally sensitive clinical response: The clinician must develop a comprehensive understanding of 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.

Somatization of Affective Disorders: The Arab client often experiences somatization of affective disorders. Arab clients often do not distinguish emotional or psychological distress from somatic illness (34, 41). Savaya (38) showed that Arab women who experienced psychological problems were less likely to consult mental health specialists, and rather sought general medical services. 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.

The client might wait to be questioned by the therapist and may not complain much about emotional distress. Because their psychological symptoms are often 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 like one does when seeking a physician's help for somatic complaints (39). 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 positive long-term 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.

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 negatively viewed as "thinking too much," which is a narcissistic self-preoccupation (42). Physical symptoms, however, are accepted as legitimate, morally acceptable expressions of pain.

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 (43). 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 or other physical symptoms, he will not interpret these as mood related, which would be a typical North American interpretation.

Arab clients are less inclined to commit suicide, because it is considered a criminal act, but when they do feel suicidal, they may not divulge it easily. While working in Saudi Arabia as a psychiatrist, Dubovsky (44) 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" (p. 1457).

Culturally sensitive clinical response: Racy (45) 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 by having her keep a diary or perform certain tasks or plan an exercise regimen.

Family Involvement: 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 Arab people who are raised to depend on it as a continual source of support.

Differences in temporal perception can be challenging while working with families. Arabs' notion of time is more fluid and not as structured or determined as in the West. As a result, Arabs may not be very time-bound. In the Arabic language there are no clear distinctions between various forms of past and future. 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 quickly react 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 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 (46) at a community mental health center for Arab Americans, revealed that marital problems were mostly construed by Arabs as being a women's problem: i.e., an unemployed husband could not pay his bills yet he would not let his wife work (50%); immigration problems (30%) such as husbands bringing a second wife from abroad or marrying another woman for a green card; spouse abuse (7%); and problems relating to children, especially discipline issues (38%). Because the culture 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 (46), the threat of suicide in their sample primarily came from adolescent girls. It should be noted, however, that 80% 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.

Culturally sensitive clinical response: The cultural characteristics of family and gender in Arab society can best be utilized by therapists willing to educate themselves regarding 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 Arab individuals will, by necessity, come into contact with the family and needs to understand that what might seem to be detrimental involvement, over-protection or blatant codependency on the part of the 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.

Conventional modes of operation have to be modified in order to facilitate a more personal and supportive relationship (34). The family has to be actively engaged in the treatment process and must be reassured that "they are part of the care and treatment scheme." This approach emphasizes social rather than psychological integration (47). 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. As an example, most Middle Easterners are hypersensitive regarding matters of "ingestion and elimination" (ibid.) and, consequently, may refuse medication or medical treatment that would lead to constipation or other abdominal discomfort.

Gender: Cultural expectations regarding gender can complicate the beneficial relationship.

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 (48) 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" (p. 308).

Culturally sensitive 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," maintaining minimal eye contact and appropriate physical distances between client and therapist while integrating the family in many, if not all stages of treatment (49).

Therapists should be extraordinarily sensitive about the nature of Arab social construction of gender. The values of the therapist and those of the client's culture may be manifestly different. Haj (50) argues that Arab women are continuously negotiating patriarchal structures in their everyday lives. Therapists could helpfully encourage clients to seek avenues of negotiation that work best within the culture. But if a process of client empowerment precludes such cultural nuances, a therapist could be placing a client in a position of risk, both for her status within the cultural group, and in relation to the possibility of the community insisting that therapy be terminated. Client empowerment must incorporate cultural values. Clinicians are implicitly modeling values and behaviors to a client, and need to be aware of the limitations, as well as the prospects for change, within that client system (17, 34).

Religion: Religion is one of the most salient markers of cultural difference in Israel. Yet as Al-Badul-Jabbar and Al-Issa point out, "publications on psychotherapy in the Arab-Islamic world are rather limited" (51, p. 278). But there is much potential in research, theory and practice with Arab people. The values of Islam emphasize particular beliefs, ways of individual behavior, and norms of group involvement in identifying and responding to mental health problems (17). Islam provides a number of supports that enhance psychotherapeutic process, among them, patience (52), hope, responsibility for individual behavior (51), utilization of group and community support, and use of various religious practices and rituals that enhance group support, catharsis, sense of belonging and individual well-being (16).

It is important to acknowledge that Arab Muslims would not appear to be devout based on their behavior or lifestyle. The mental health provider may never guess the patient's religious sentiments if he doesn't actively ask and pursue the question.

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, Arab Muslims also have a tendency to resign themselves to God's care and may neglect or deny symptoms for a long time. As pointed out by Dubosky (44): "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" (p. 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 (53) explained, "Madness is per-

haps 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" (p. 195).

In speaking of psychiatry in Saudi Arabia, Dubovsky (44) 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" (p. 1456). Kulwicki (53) reported 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" (p. 203). Folk medicine is often used to heal illnesses that are believed to be caused by the evil eye, which is cast by a jealous or envious person (54). The phenomenon is reminiscent of such psychological concepts as projective identification which is considered a defence, through which the undesirable aspects of the self are projected outside of the self into another (17). The evil eye belief would be an example of how one's own envy or the secret wish to be the object of other's envy is projected into somebody else's eye, which then embodies the badness attributed to it (42). However, the mental health practitioner can learn much from traditional healers. The healers are active and the client passive. The healer directs, advises, guides, gives instructions and suggests practical courses of treatment such as rituals and so on (42). Thus, we may say that the traditional healers meet the clients' expectations, which may have an impact on therapeutic outcomes.

The most influential factor found to affect the use of mental health services was the overuse of alternative services such as traditional healers and religious leaders. Al-Krenawi and Graham (34) found that individuals with mental symptoms consulted and referred to traditional healers more than they did with formal mental health specialists, and attributed this pattern to the fact that traditional healers and religious leaders live in the individuals' community, share their worldview, make no labelling diagnoses, and use brief and spiritual treatments. Moreover, since the majority of Arabs are Muslim, it is natural that Arab people would tend to rely on the mosque and shéikh in dealing with emotional and mental difficulties (36).

There is political significance to Arab peoples in Israel consulting religious leaders or traditional healers during times of psychosocial distress. The biomedical system, it must be emphasized, may represent the forces of globalization and of a dominant Israeli Western culture. Healing practices and terminologies vary within Israel's Arab regions. By using the indigenous approach to help, as part of the cultural practices of the Arabs in Israel, Arab peoples are reinforcing part of their culture, collective memory and identity. Not surprisingly, Koranic healing is a growing practice in the Islamic Arab world, including Israel (34).

Because society is oriented to the collective, any problem involving an individual necessarily brings the family, and potentially extended family or community, into a clinical scenario. Interventions commonly involve family members in both problem identification and resolution (55). Moreover, the process of intervention could profitably be directive, rather than philosophical or abstract (55). Dominant members of a family or community are significant leverage points, and should be incorporated into any intervention as required: "Family practitioners who begin intervention only within nuclear families will soon find that they cannot ignore the extended family and 'hamula,' especially the elder members such as religious leaders and traditional mediators who are respected for their experience and wisdom" (56, p. 54).

The Political Impact on Therapy/Mental Health Practice

Trust and credibility are critical to establishing a working alliance between clinician and client. In any context, political issues are implicitly brought into alliance building. These include the contexts in which social problems are experienced, as well as the cultural-political representations of client and thera-

pist. In Israel, these factors are particularly evident; here we have a state whose identity has been contested, whose 56 year history has been fraught with internal and external geopolitical tensions. Any intervention involving a Jewish practitioner with an Arab client necessarily puts the clinical intervention into the crucible of this political dynamic. These, moreover, are exacerbated by the cultural, religious, and historical differences between Arab and Jew.

The Arabs are a minority people in Israel and by virtue of their political and economic disempowerment are justifiably seen as oppressed. The level of trust between majority Israelis and their Arab counterparts varies according to political circumstance and personal disposition. But cultural competence and self-reflection are not just key components to effective multiple cultural practice (34,57). They are also effective means of attempting, as much as one can, to overcome the very real barriers that persist precisely because of the geopolitical contexts in which both communities exist. Jews have biases towards Arab Israelis, and Arab Israelis towards Jews. The imperative in mental health practice is to allow neither to interfere with quality service. To this end, Jewish practitioners could take into account the traumatic political experiences the Arab peoples in Israel have experienced over several generations since 1948. These continue to the present day, in discrimination, stereotypes, social exclusion and lack of services compared to mainstream Israelis. And they must be addressed. To do so is ultimately a political decision that must be informed by more effective mental health training and practice. This is the essence of culturally competent intervention (57). Practitioners and educators have to adapt the models of intervention to make them more culturally appropriate. Policy makers should ensure services that are accessible, and delivered with greater cultural competence. Equally desirable are efforts at recruitment and retention of minority Arab students in various helping professional programs at Israeli universities. In the final analysis, all decision makers should reach out to Arab peoples to increase knowledge of mental health practice and to reduce the stigma and poor qualities of service that Arab peoples experience.

Several final issues bear emphasis. These include social justice for Arab peoples, peace for all, and the impact of political violence of Israelis to Palestinians, or Palestinians to Israelis. Some Israeli scholars tend to examine political dynamics influencing therapy from the perspective of dominant culture within Israel: be it the "spectre of terrorist threat" or stresses brought about by "loss from the holocaust or from war or from political terrorism" (58, pp. 356, 357). We strive for a more inclusive perspective involving the views of Jewish *and* Arab Israelis. For Arab Israelis or Arab Palestinians, Israeli violence towards Palestinians may create feelings of being part of a state that is killing one's people; for a Jewish practitioner, a Palestinian suicide bomb may create comparable feelings of vulnerability. Consider, for example, a therapist, or a patient, losing a loved one due to this cycle of political violence. These feelings may be implicitly brought into any therapeutic encounter; would the attendant feelings intervene in therapy, influencing process, transference or countertransference? Would they inhibit client or therapist communication? What might a Jewish practitioner think about Islam, or other aspects of a patient's culture, in the crucible of this broader political context? How might this broader political context interfere with a clinician's ability to render culturally competent services, or for both patient and therapist to join together in an authentic clinical encounter?

Jewish Israeli therapists could role model for the client in order to cultivate a therapeutic élan that does not bring unhelpful, overt politics into the clinical context (59). Arab clients tend to defer to therapists, projecting notions of hakim and of a respected elder or parent on to the therapist (4) — providing a cultural rationale that encourages therapists to provide leadership in removing unhelpful political contexts from a scenario. The behavior of the client needs to be understood from a cultural perspective, first; thereafter, political contexts can be understood, deconstructed, and where appropriate brought into an overt therapeutic situation in order to make the unhelpfully implicit, explicit. In Israel, perhaps more than in many other countries, helping professionals cannot ignore political realities, as they have a direct impact upon presenting problems as well as clinical processes.

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