Training Arab Practitioners in Culturally Sensitive Mental Health Community Interventions

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ABSTRACT
The present paper describes an innovative initiative aimed to facilitate Arab MA students to develop integrated cultural competencies and act to promote mental health within the Israeli Arab community. In order to achieve this goal the initiative took the form of an Arabic language seminar that strove to bind the students’ familiarity with Arab culture with reading materials and research literature on mental health issues and practices from the Arab world. We describe the need, development, processes and the outcome projects of the seminar. The academic setting is described as a nourishing and facilitating environment for training and preparing future community leaders who will bring about social change in mental health issues.

INTRODUCTION
Community mental health is a body of knowledge and practice in which individuals’ wellbeing and resilience is believed to be mutually influenced by the community’s resources and its strength. Researchers and practitioners in this area study how social norms and values affect mental health issues and how, by collaborating with key figures and organizations in the community, these norms can be modified and adapted to the needs of those who cope with psychiatric disorders. Practitioners in community mental health seek debilitated populations in which psychiatric disorders are more likely to appear, and look for ways to empower individuals with these disorders and enhance their social integration. One of these populations is the minority group of Israeli Arabs who experience a transition from a traditional and collectivistic society into a modern and an individualistic one. In this paper we describe a special innovative initiative with MA Arab students to train them as culturally sensitive social agents by learning how to bind their familiarity with local Arab culture with their growing knowledge of community mental health concepts and practices.

We will begin by describing the mission of training practitioners in culturally sensitive mental health community interventions by integrating the social norms and cultural attitude and community mental health concepts and strategies. We will further depict the training process of Arab students participating in the seminar taught in Arabic at Haifa University, their challenges and achievements and the developmental process they experience in this seminar.

Culture refers to characteristics that people share such as language, race, religion, ethnicity disability, sexual orientation, and social class (1). Within a culture people often share beliefs, values, and typical ways of feeling, thinking, acting, and viewing the world (2). There is wide agreement regarding the importance of cultural competence in mental health to which the disparities in services are an important reminder. Lower rates of service access, gaps in assessment and diagnosis and discrepancies in treatment recommendations for consumers from different cultures are well documented.

Israel is a multicultural and pluralistic society comprised of two major ethno-national groups, Israeli Jews and Israeli Arabs who differ in many aspects (3, 4), including their religion, cultural values and social constructs (5). Religion differentiates Israeli Jews and Israeli Arabs whose religions are Islam, Christianity and Druze. Concerning cultural values, Israeli Arabs are often referred to as a traditional collectivist culture while Israeli Jews have been described as a modern, individualistic and western culture (6-10). In terms of social constructs, Arab societies are often characterized by patriarchy, primary group relations with an emphasis on collective over the individual (6, 11) in contrast to Israeli Jews (10). With regard to mental health
service utilization, data have consistently revealed large gaps, with much higher use among the Jewish population (12, 13). According to the Central Bureau of Statistics (CBS) (14), despite the Arabs comprising 20% of the population only 7% of those consuming psychiatric rehabilitation services in Israel are Arab.

The low use of mental health services among the Arab population is attributed to various reasons including lack of information and knowledge about services and access to them, language barriers, stigma and a preference for conventional religious treatment over traditional treatment (15).

Efforts to address some of these well documented and disturbing issues include helping non-Arab rehabilitation practitioners to acquire the important cultural competence (16). However, Arab practitioners who wish to be trained in providing community mental health services to Arab consumers must also acquire cultural competencies: They need to learn how to integrate their first hand knowledge of Arab culture and values with their growing understanding of community mental health concepts to provide effective services for the Israeli Arab population. They specifically need this training because they come to represent for these consumers the dominant majority’s western ideology which is perceived as trying to influence and change traditional perspectives and values. To be successful in achieving integrated cultural competence, implementation needs to occur at multiple levels, including training and supervising practitioners and adopting policies and procedures at an organizational level to enhance an organizational culture that supports cultural diversity.

Training new practitioners in the area of culturally sensitive mental health requires that practitioners recognize contextual and systemic dynamics such as gender, age, socioeconomic status, culture/race/ethnicity, religion and provide appropriate individual and systemic interventions (17, 18). However, implementing these contextual and cultural concepts can be difficult, even among experienced therapists from the same culture (19). Simply knowing about cultural issues does not sufficiently qualify practitioners as culturally competent clinicians (20). What is needed is an experiential learning approach to acquiring a cultural and contextual awareness and integrating it with conceptual thinking (21, 22). Most training interventions address the issue of improving cultural competence of providers of one culture to work with consumers from other cultures and backgrounds (23–30). Few programs have focused on improving the skills of same culture mental health workers to improve services in their communities of origin (31, 32).

One report describes the training of indigenous mental health workers during the development of the Papago Psychology Service for Native Americans. Khan et al. (31) report several benefits to provide mental health workers with better skills to interact with their own communities and to improve their confidence to implement successful mental health interventions. As with other experiences, like the educational training program for Aboriginal and Torres Strait Islander Instructors (32), the training was felt to be empowering and provided information that was seen as highly relevant and important in assisting people with a mental illness in their communities. To address the important issue of providing training in integrated cultural competencies, the Department of Community Mental Health at Haifa University developed a seminar offered to Master Level Arabic speaking students focusing on training them to identify and respond to the Arab population’s issues of people with Serious Mental Illness (SMI). In the next section we will describe the process of planning and carrying out this seminar followed by a brief presentation of a number of the students’ fieldwork projects.

**DESCRIPTION OF THE SEMINAR**

The first stages of preparing for the seminar that has been presented now for three consecutive years were characterized by anxiety and hesitation, not least due to previous abortive attempts to promote mental health in the Arab sector. In the past it left all involved disappointed and disheartened, and left the field with the same needs that had generated the attempts in the first place: absence of experience in teaching the subject in Arabic, lack of agreed upon mental health terminology in the Arabic language and a mistaken notion that Arabic professional material does not exist or is inaccessible. On the other hand, there were motivating forces. Most important was the hope that an academic seminar of this kind would initiate a body of agents for social change in the sphere of mental health in Arab society. The Arab students themselves were perhaps the main impetus, after so often articulating their aspirations in so many diverse opportunities to do precisely this.

**TARGET POPULATION**

Each year the seminar had consisted of approximately eight Arabic speaking students pursuing an MA degree at the Department of Community Mental Health at Haifa University. The students represented the Arab Israeli sector in their heterogeneity: Muslims, Christians and Druze,
some from all-Arab villages and towns and others from mixed Jewish-Arab cities, some religious and some secular, with a few of the female students dressed in traditional religious attire including head-dress and others in western garments. Most of the students have had no prior experience in the application of the more recent rehabilitation and recovery theories and methods. Some were social workers or nurses while others were fresh graduates of the behavioral sciences, with little experience.

**THE TRAINING PROCESS**

The seminar, consisting of weekly classes throughout the entire year, covered the following three areas of knowledge:

**The first** was an overview of the attitudes and conceptions of Arab Israeli society pertaining to mental health consumers and families and common means of care within their specific social cultural context. So, for example, the students learned about the four sub-groups that comprise the Arab Israeli population with regard to the kind of mental health services most suitable for each. The religious Muslim population, both rural and urban, relate more comfortably to practitioners familiar with Islam and who themselves lead an observant traditional way of life, including modes of dress and speech. Secular, mainly urban Muslim culture is more accommodating towards care givers of both genders and services outside the immediate geographical vicinity. In the villages this sector is more conservative, with regard to the gender if not the religious observance of the service giver. The Christian group is by and large considered to be the most similar to the general Israeli secular public requiring no special modifications in the services available to the general population. Lastly, the Druze contain two distinct populations – the northern rural population and the two villages on Mount Carmel. The former are more traditional and conservative and resemble the rural Muslims discussed above, in terms of both the gender specifics of the preferred care giver and the geographical location of the services required.

**The second area** touched upon identifying needs and collecting data about the potential projects the students could undertake as part of the seminar requirements. For example, one female student chose to propose and pilot an outreach program to unemployed people with schizophrenia without prior affiliation to any rehabilitation or therapeutic agency. This student prepared an outline about the illness, available treatment and ways of making contact and establishing trust with the consumers and their families, available means for improving their standard of living, and ways to deal with consumers and/or family members who show no desire to change the state of affairs. She was guided to create a plan to engage potentially helpful local resources such as family members or religious authorities. In addition, she was directed to address the praxis of the recovery oriented rehabilitation approach as it applies to the specific social cultural context.

**The third area** had to do with strategies for planning, developing and carrying out the projects and specifically communal ones focusing on location of the project to be established, to whom it is planned to serve, its immediate environmental conditions, dialogue and potential partnerships, communal services involved, governing principles and values and implementation strategies.

**THE STAGES OF THE SEMINAR**

**The first stage** began by processing students’ worries and skepticism regarding their competencies to cope with the requirements of the seminar and open classroom discussions about the students’ personal attitudes toward and conceptions of mental health difficulties and means of treating them. The atmosphere was accommodating and accepting, allowing room for the emotions that surfaced and stories from their personal and professional experience. Each story generated class discussions exploring students’ personal attitudes and posing thought provoking questions. Sometimes terms such as recovery as compared to cure had to be redefined and normal functioning and ways to conceptualize and assess it were discussed.

The seminar in general and more specifically the development of the students’ professional self-identity involved a quest for source material, and for methods of organizing and presenting it to their peers. Some students noted that independent learning in preparation for the presentations “increased a sense of commitment and responsibility,” while others said that their newly acquired knowledge of mental health in general and knowledge relevant to Arab society in particular “enhanced self-confidence and a sense of mastery in preparation for bringing projects into effect,” or that the coaching in class using simulation techniques of intakes with consumers or families was “particularly instructive and furnished them with a multitude of tools and proficiencies.” Some noted that the open discussions and exploring of their personal attitudes “changed them and instilled in them optimism.” In a feedback session towards the end of the semester most participants testified that by the midway point the seminar imbued them with a sense of competence. The few who found it hardest to
relinquish old attitudes were those for whom the new knowledge clashed too harshly with and was grasped as a threat to religious or personal values. For example, a female student for whom mental impairment was always a sign of religious slackness and the result of witchcraft, found the notion hard to accept that just like any other illness, the mental form has a biological and genetic basis. By extension, she maintained her belief in traditional religious interventions in preference to the conventional, “I see that they do not work,” she said of the latter.

In the second stage, towards the end of the first semester students started to present their proposed projects. Often the student’s own experience was the incentive behind the choice in preparation for the class lectures. For example, the two students who presented the topic of coping with mental illness in the Arab family decided to establish a support and empowerment group for wives of consumers in the village of Iksal near Nazareth. In other cases the choice of project emanated from prior knowledge and experience. So, for example, a student with a degree in special education chose to organize a group for improving interpersonal communications and promoting emotional expression for children with autism. Another chose as her project to translate a Ministry of Health Rehabilitation Basket (the benefits granted individuals recognized by national security as legitimate consumers of mental health services, in employment, housing, education and recreation) brochure from Hebrew to Arabic. Based on previous experience, she identified it as a vital tool for Arabic speaking consumers to access rehabilitation services and ease the task of Arabic speaking practitioners. The next step was to establish contact with communal services and functionaries that the projects required in order to consolidate viability.

Each proposal was discussed in class, and views and personal opinions pertaining to the rationale behind the choice were voiced. This contributed to the final shaping of the proposed projects and transforming them into viable plans of action. The ideas were studied in depth with reference to relevant bibliographical items, examination of the aim and projected contribution, mapping of the resources that would be required for implementation – including body of knowledge, tools and proficiencies, identifying the local people who could promote and support the attempt as well as those who may hinder and oppose it, the tools for successful handling of the obstacles, and finally - standards for evaluating the project’s outcomes. Besides studying the theoretical aspects of their projects, and in order to furnish the students with experience of the challenges they were about to face, seminar participants performed simulations of anticipated encounters on the path to full implementation of their projects. After each simulation tutorial a conclusion drawing session was held and the experience was processed in class to glean from it new tools for intervention. During the discussion it was clarified that the learning process the seminar participants were undergoing throughout the planning and implementation of the project was quite as important as its anticipated results.

The academic process involved in the theoretical preparatory study of the project had a distinct emotional angle which was constantly present in the questions that the students brought to class. This angle was handled through sessions of reflective learning aimed to help the students cope with the emotional evocation of the challenge before them. For example, how does one begin an intake with a consumer with schizophrenia who barely speaks and has hardly left his house for years; how does one respond to the family’s frustration with the services’ laxity toward a family member and how does one encourage a consumer to consider going to therapy for the first time in his or her life. In the course of one of these sessions, two of the students shared a disturbing experience they had with a social worker whom they had approached for help in making contact with two families of consumers. She voiced her opinion – without ever meeting them – that they were not up to the task. Early encounters with consumers, families and local service providers were rife with such emotionally disturbing events. They were brought up by the students or the facilitator and processed through simulation. By repeating the experience in class the students could review events calmly, accumulate relevant knowledge and competence but mainly restore their self-confidence and sense of competence.

The final two sessions of the first semester were devoted to reflective feedback by the participants concerning the personal process they had undergone, and – because it sometimes occurred during the break – to a final emotional, practical and mental preparation for the plunge into actual work. To complete the semester projects were submitted for the facilitator’s review and, where necessary, revision. They detailed the underlying idea, rationale, target population, stages of development and planning, requisite resources, implementation plans and standards for evaluation of the outcomes.

In the third stage, during the second semester students began to implement their projects which was a significant turning point, as one described “transition from the theo-
retical to the stage of real doing is extremely satisfying,” or as described by another, “you begin to feel like a mental health professional with a clearer, better defined conception, based on a stalwart body of knowledge and equipped with methods, tools and competencies that provide a sense of control, even if the end of the road is still away on the horizon.” Obviously, not all anxieties were entirely allayed. At this stage the facilitator himself was slightly perturbed, especially in anticipation of the fledglings’ “maiden flight.”

In view of the deep rooted attitudes – of community, extended family, local practitioners – pertaining to mental health that they were about to tackle, it was clear that what the seminar participants would need more than anything was that the facilitator would accompany the novice practitioner for immediate guidance and support. Some of the study sessions were duly transferred into the field, to the local agency implementing the project, or to accompany a student on an especially difficult mission, such as a house call for a first encounter with a consumer with difficulties in verbal communication, or with a local social services functionary trying to avoid the meeting: “because she dreads involvement in mental health issues with which she is unacquainted and therefore fears.” This was quite a common reaction even if all the local service person was asked to do was to help put the student in touch with families in her jurisdiction. Sometimes the facilitator accompanied the novice practitioner to house-bound consumers whose families objected to intervention, fearing that the consumer’s condition would deteriorate as a result. The sessions that were held in class at this stage were devoted to updates on progress made in the field with feedback from the facilitator, and to investigation, processing and responding to difficulties encountered vis-à-vis the consumers, their families and service providers or others in the community. The students’ professional credo took shape during this phase, their humanity and professional competence refined. Empowerment of the novice practitioner is a prerequisite for the empowerment of consumers and local services.

The entire process found conclusive expression through the final seminar papers describing the projects. Those were comprised of an introduction to what inspired the project (original, innovative, ground breaking, meeting a real previously unanswered need), background, target population and the rationale based on data and professional bibliography. It also included an outline of existing material relevant to the specific project, description of the stages of planning and establishing the project, standard evaluation tools, partnership and dialogue with the target population and community functionaries, trouble shooting methods, implementation and/or attempts thereof. The final papers ended with a factual update and a personal reflective one with individual insights and deductions concerning the entire undertaking.

A SAMPLE OF STUDENTS’ PROJECTS

Project one: Glossary for mental health terminology in Arabic

The rationale behind the original decision that the seminar be taught in Arabic was to encourage participants to begin creating the Arabic language of recovery. Having studied at the university in Hebrew, the practitioners did not have the opportunity to learn about recovery in their own language. It thus seemed essential to create understandable communication between service providers and the recipients especially as most of the literature in the field they are exposed to is not in Arabic. As a solution to the issue of terminology, an idea was raised by one of the students to create a collection of rehabilitation, therapy and mental health concepts in Arabic. As part of this effort, the first 10 minutes of each seminar meeting were devoted to creating a glossary of central terms in recovery. All students were expected to prepare in advance commonly used terms related to recovery and these were discussed and summarized with the goal to reach a consensus regarding the meaning of each concept. The dictionary grew in a steady, tangible manner.

It helped create a lingua franca that enhanced the confidence of students to plan and carry out their projects. Distribution of the glossary could facilitate the task of Arabic speaking service providers in their communities and ensure a respectful, top standard service to the Arab population of Israel.

Project two: Empowering wives of consumers in the village of Iksal, near Nazareth involved recruiting the village social services department to identify who might be good candidates and benefit from the project. Thirteen wives of mental health consumers began attending a weekly support group. The content was selected on the basis of personal interviews during which they shared the topics that were important to them, colored by their role as wives and mothers in the shadow of the disorder of the husband and father and its impact on themselves and their children.

Project three: Involving consumers in activities at the social-vocational club in Shefaram. Two students, jointly with the social services department and the club’s social workers, identified eight families with a member
suffering from a psychiatric disorder. The project was mainly conducted through home visits during which the students got acquainted with the consumer and his family and tried to motivate him to join the club activities.

**Project four: Raising awareness to mental health issues among 10th grade students in an Arab school in Haifa.**

Two students held eight meetings with 73 pupils, discussing stigma, mental health, treatment for mental disorders, psychological stress and how social rejection among pupils impacts their mental wellbeing. Worthy of note is that after the second meeting three pupils approached the students for help with mental distress they felt, and with their consent the students referred them for professional help. In addition, a questionnaire was passed around before and after the two meetings with questions about social stigma attached to mental health disorders and psychiatric treatment. A distinct change in the level of social stigma among the pupils on the issues at hand occurred between the first and second evaluation. The response of headmaster and teachers to the project was very positive.

**DISCUSSION**

In this paper we describe an innovative initiative to facilitate the process of Arabic speaking MA students developing integrated cultural competences, preparing them to become the future leaders of social change in values and attitudes towards mental health issues. The goals undertaken by the seminar, “Advancing Mental Health in the Arab Sector’s Projects,” consisted of a. combining the students’ knowledge of the Arab culture with their growing knowledge of community mental health practice; b. developing initiatives in improving consumer accessibility to mental health services, promoting change in social attitudes toward mental illnesses and their treatment and the prevention of psychiatric disorders in populations at risk. These initiatives served as training for students in providing culturally sensitive mental health services and promoting consumers’ inclusion within their communities. Using the Arabic language and familiarizing therapy and rehabilitation concepts and methods helped to achieve the goal of integrating the students’ knowledge of the culture with that of the field of community mental health.

However, the community activities within the Arab population that sought to promote change in attitudes toward mental illnesses were not merely culturally sensitive systemic interventions; there is an added complexity to them. These activities were carried out in with members of a minority group that struggles to develop and maintain its identity, resilience and unique characteristics as a community (33, 34), and influencing its traditional attitudes may pose a threat to their identity and perceived strength as a group. This seems to be a complex and highly sensitive mission as members in the Arab community may regard being critical of traditional values and adopting the majority’s values as representing an act of oppression (35, 36). Therefore, students in the seminar had to constantly process their feelings and attitudes during numerous discussions in order to consolidate their beliefs, feel empowered by the learning process and be able to empower the recipients of their interventions. It is reasonable to assume that had the students who participated in the seminar not believed strongly in the aforementioned cause they would not have been able to successfully carry out their mission.

The processing of the students’ emotional and cognitive responses as social change agents and their empowerment took place within the framework of their studies at the university. This provided the students with a safe and nourishing learning environment in which they could optimize their development and growth as new culturally sensitive professionals in community mental health. Such an environment stimulates their intellectual and emotional abilities while providing them with academic recognition (37). The seminar as a social change project has proved that an academic environment is highly recommended for strengthening the social change agent’s growth as professionals and human beings.

It appears that participating in the seminar that lasted the entire academic year has contributed to the strengthening of students’ two identities: as Arabs who live within a Jewish majority and as mental health professionals. Both identities are based on a strong sense of belonging to a community and sharing with others in this community values and beliefs, and engaging in the planning and carrying out of mental health promoting projects in the Arab society serves to consolidate both identities. The seminar discussions and the students’ assignments have helped to crystallize their sense of who they are as professionals and as Arabs.

In face of the great difficulties in the Arab society to accept western values and attitudes towards mental health issues and the poor accessibility of consumers to services, there seems to be a great need in promoting community organizations’ and social and religious leaders’ willingness to use these services and act to integrate consumers in their community. This policy should be implemented by Arab mental health professionals in Arabic, acting in culturally sensitive ways and integrating both their knowledge of the
culture with that of community mental health practices. These efforts should be carried out while the professionals repeatedly work out their issues and are accompanied by experienced Arab professionals who empower them as social agents and leaders in the community.

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