

Reconciling Western Treatment and Traditional Healing: A Social Worker Walks with the Wind

This article relates the experience of the first Bedouin-Arab clinical social worker in Israel in dealing with a largely Bedouin-Arab clientele in the Negev. In the psychiatric and primary health care settings where he worked, efforts to apply Western techniques with which the patients were unfamiliar created barriers to understanding and treating their mental health problems. After much frustration, the author decided to learn about the Bedouin-Arabs' own ways of dealing with mental health problems. The paper recommends that modern practitioners who work with traditional ethnic groups be more culturally sensitive and accept their clients' utilization of traditional healing. Showing the overlap between traditional and modern healing, it urges that modern professionals incorporate knowledge of traditional diagnoses and healing approaches into their practice.

by
Alean Al-Krenawi, Ph.D.

Alean Al-Krenawi, Ph.D.,
Lecturer, Department of Social
Work, Ben-Gurion University
of the Negev, Israel.

In the last two decades, helping professionals have come to appreciate the importance of "cultural sensitivity," that is of respecting and taking into consideration the specific culture of their clients in the design, planning and implementation of their interventions (Al-Krenawi & Graham, 1996; Burgest, 1982; Devore & Schlesinger, 1991; Green, 1982; Lum, 1982; Ragab, 1990). Yet practice remains harder than preaching, especially when deeply rooted Western practices come into contact with equally or more deeply rooted non-Western ways.

This paper recounts the gradual re-awakening of the author, a Western-trained Bedouin-Arab clinical social worker, to the culture of his people and his struggle to find a satisfactory way of helping his largely Bedouin-Arab clientele in the Negev region of Israel. Having learned from my clients their own traditional ways of dealing with mental health problems, I am writing the paper

to urge the integration of modern and traditional modes of healing and to suggest ways of bridging the gap between "modern" clinicians and their "traditional" clients.

Similar points have been made by other writers on cross-cultural therapy, and I myself have made them elsewhere in more academic form. In this paper, I have chosen to make them by telling about my own experiences in the hope that the account of the personal and professional dilemmas I faced as a Western-trained social worker, and of the ways in which I gradually resolved them, will give the reader a more tangible and sympathetic understanding both of the professional journey that is required to bridge the gap and of the traditional people whom we can help.

Before embarking on my personal account, I think it would be useful to provide a brief overview of the Bedouin-Arab of the Negev.



The Bedouin-Arab of the Negev

The Bedouin-Arab are a traditionally nomadic and tribal people who have inhabited many areas that are now in countries of northern Africa, the Arabian peninsula, and the Middle East (Hebrew Encyclopedia, 195). Bedouin-Arab have lived in the Middle East since before either Islam or Christianity became established religions. Among other places, they inhabited the Negev desert. There are currently about 20 Bedouin-Arab tribes in the Negev, with a total of about 100,000 people. Forty percent live in villages, and sixty percent in clusters outside the villages (Al-Krenawi & Graham, 1997). Traditionally, Bedouin-Arab have been nomads, earning their living by raising cattle, goats, and sheep. In the last 25 years, a rapid and dramatic process of urbanization has occurred, with increasing numbers of Bedouin-Arab settling in villages and working in industry or services (Al-Krenawi & Graham, 1996).

Yet although this process has been accompanied by major cultural and social upheavals, Bedouin-Arab society is still anchored in its traditional ways. Like other traditional peoples, Bedouin-Arabs have a high context social structure, marked by a relatively slow pace of societal change, a high sense of social stability, and an emphasis on the collective over the individual (Al-Krenawi & Graham, 1997; Hall, 1976). In many essential ways, the society and culture of the Bedouin-Arabs of the Negev

is still much like that of other traditional Arabs.

The core of the Arab — and Bedouin-Arab — social structure is the family. There are four main concentric family units. The largest is the tribe. Each tribe is headed by its own sheik and made up of several hamula. The hamula is the kinship group extending to a wide network of blood relations. Tribal decisions are made by forums of male elders representing the hamula (Abu-Kusa, 1994; Marks, 1974). Each hamula consists of the extended family, made up of parents, siblings, and their spouses and children. The smallest unit is the nuclear family — the married couple and their children (Al-Haj, 1989). The family is crucial to the homologous relationship between the individual and the group. To a considerable extent, social status, safety from economic hardship, and opportunity for personal development continue to rest on tribal and family identity.

Bedouin-Arab society is patriarchal, with men exercising the authority in the household, economy, and polity (Al-Krenawi & Graham, 1996). Polygamy is common practice, even among the well-educated and young (Al-Issa, 1990; Chaleby 1986; Chamie, 1987). Women's social status is strongly contingent on being married and rearing children, especially boys (Al-Sadawi, 1977). Bedouin-Arab women rarely leave the home unescorted, spend most of their time caring for the family, and generally still do not work outside the home (Al-Krenawi, et al, 1994; Mass & Al-Krenawi, 1994).

The relation between the individual and family in Bedouin-Arab society is different from that in Western society. In Western families, children are expected to separate psycho-socially from their parents and form their own autonomous identity (Erikson, 1963; Mahler, 1968). In Arab society, as in the traditional societies of Africa, Asia, South America, and the Middle East, the individual is expected to remain embedded in the collective family identity (Hofstede, 1989; Sue & Sue, 1990). Individuals live in a symbiotic relationship with their families, seeing themselves as extensions of a collective core identity. A family member who attempts to assert his/her own individuality will be condemned as deviant.

The development of modern therapy in Europe and North America was an extension of the development of Western individualism, nurtured by the climate of democracy. In Western therapy, as in Western society, the individual is viewed as an independent entity whose needs, rights, opinions, and values are to be respected and whose "self-actualization" is considered a worthy and important goal (Fromm, 1976; Pederesen, et al, 1989). The clinician working with Bedouin-Arabs, on the other hand, must treat the client in the framework of his or her family.

Traditional Mental Health Healers Among the Bedouin-Arab of the Negev

Among the traditions that the Bedouin-Arab of the Negev still keep is that of the healer. The traditional Bedouin-Arab view of mental illness is that it comes from outside through sorcery, the evil eye, or evil spirits. Any of four types of traditional mental health healers may be consulted to counter the magic or expel the evil spirit: 1) The *Khatib* or *Hajjab* are male healers who produce amulets that are worn on the body to ward off evil spirits. This tradition is usually passed down from father to son, provided the latter is perceived as having sufficient literacy and community acceptance; 2) The *Dervish* treat mental illness using a variety of religious and cultural rituals. Both males and females can become a *Dervish* by receiving a *baraka* (or a blessing) from God, which is endorsed by a recognized *Dervish*; 3) The *Moalj Bel Koran*, or Koranic healer, works on the basis of religious principles derived from the Koran and treats patients who have been attacked by evil spirits. All *Moalj Bel Koran* are men and most have some form of post-secondary education (Al-Krenawi & Graham, 1996). Koranic healing has gained popularity recently with the revival of Islam throughout the Muslim world; and 4) The *Al-Fataha* is a fortune teller, who is usually consulted about psycho-social problems and who uses coffee grains to reveal any secret the patient may have. The role is

usually passed down from mother to daughter (Al-Krenawi, 1995a; Al-Krenawi, et al, 1995).

Because of the structure of Bedouin-Arab society, an individual's illness, whether physical or mental, is consid-



ered the problem of the whole family, and the process of help seeking is a collaborative one in which the person's nuclear family, and sometimes the extended family as well, all take part. In response to the rapid social changes that Bedouin-Arab society of the Negev is undergoing, many families concurrently consult both modern practitioners and traditional healers (Al-Krenawi, 1995a, 1995b). While the GP at the local health fund clinic will refer the person to a social worker or psychiatrist, his or her family will also bring him or her to a traditional healer. Usually it is the woman of the house who encourages the visit to the traditional healer (Al-Issa, 1990; Al-Krenawi, 1995a; Koss-Chiokino, 1992).

A 1974 study found that 70% of an examined population of Bedouin-Arab patients in Is-

rael utilized traditional healers in tandem with modern treatment (Ben-Asa, 1974). The author's own study in the early 90's found that a good portion of his study population were still doing so (Al-Krenawi, 1992). Moreover, recent findings in various settings have shown that a combination of modern medicine and traditional healing can be quite effective in remedying mental health problems (Bokan & Campbell, 1984; Edwards, 1986; Jilek, 1994; Lambo, 1978; Lefley, 1986; New, 1977; Ruiz & Langrod, 1976a; Yoder, 1982).

Nonetheless, most Western-oriented professionals still give traditional healing short shrift, even when working with people who believe in it and who find the Western approach to mental health alien and not entirely helpful (Ruiz & Langrod, 1976b). This paper is aimed at rectifying the bias.

Walking With the Wind

I was born and raised in what is by Western standards a "traditional" culture. There are no documents indicating how long my family has lived in the Negev, but oral tradition places it at several hundred years. My grandparents, like their forebears, were nomads. My parents became semi-nomadic only in my early childhood. Living in a tent close to the other 2,000 or so members of the tribe, we led tribal lives. My cousins, grandparents, aunts and uncles, and other members of the tribe all exerted considerable influence on our daily doings. As a

child, I was familiar with the various kinds of traditional healers. My grandfather, with whom I lived for several years, was an amulet writer, one of the four types of traditional healers I wrote about above. I used to serve his clients coffee and tea as they waited to see him. When the treatment was carried out in front of everyone, as it often was, I watched. I often chatted with the clients and my grandfather was happy to answer my many questions.

The third of fifteen children, I was blessed with the chance to get an education. I rode a donkey ten kilometers to school, returned home every day to tend sheep, and carried water from a well to our home. For high school, I attended a boarding school in an Arab village in the center of Israel, far from home. This was the first time in my life that I was among well educated Arabs. Since I did well in my studies and received a good deal of encouragement from my teachers, I gradually came to see myself as part of this world, the educated world. On my monthly visits home, I felt increasingly distant from my family and their way of life. My parents and siblings were living in a tent with no electricity, running water, or any of the other conveniences to which I had become accustomed at school. We saw things differently, and I felt that they didn't understand my needs. I asked questions that they couldn't answer. When I challenged or disagreed with them, they became angry and said that I had changed for the worse.

When I graduated from high school, my family expected me to become a teacher in the elementary school in our area, a job which was considered very high status at the time. It took some doing for me to persuade my father to let me attend university. He had no idea what university was, and it wasn't until an uncle of mine who worked on a kibbutz and knew what university was interceded on my behalf that he gave his consent.

It was at university that my Westernization began in earnest. Whole worlds were opened up to me in my classes, as well as by the Jewish friends I made. I took part in their conversations, was invited to their parties, and was made welcome in their homes. My professors were also remarkably forthcoming. My university experience affected me in more ways than I can enumerate, but I think that the major one was that it turned me into a questioning individual with ideas and opinions of my own. I could no longer accept things without examining them, and I could no longer keep my peace just because my elders believed differently. I also lost any belief I might have had in amulets, sorcery, and the evil eye.

I completed my B.A. in social work before the days of "cultural sensitivity." The models of social work intervention that were taught, and the values, skills, and epistemologies underlying them, were entirely Western. It did not occur to me or, probably, to anyone else at the university that they might

not be entirely suited to work with non-Western peoples. I assumed that I would go back to the Negev and simply apply my new and shining knowledge.

Yet, though I was proud of my Bedouin-Arab roots and deeply committed to helping my people, my professional training had created a gulf between us. In any professional relationship, there is bound to be a gap between patient and helper since it is impossible to completely transcend the inevitable differences in experience and social location that distinguish the two. But for me, the gap was exacerbated by the Western acculturation which removed me from my roots and from my people and their perception of illness.

Over an eleven-year period, from 1981 to 1992, I worked with the Bedouin-Arab population of the Negev in two settings: (1) in the Department of Psychiatry in the general hospital of Soroka Medical Centre in Beer-Sheva, the capital of the Negev; and (2) in the main primary health care center in the Bedouin-Arab city of Rahat. At the hospital, I was the first and only Arab mental health professional; at the clinic I was the only mental health professional.

With my Israeli training and Western approach, my thinking was like that of any Western therapist. I tended to analyze the patients' difficulties "scientifically" and to ignore their belief systems, cultural patterns, and perceptions of their illness or problems.

These behaviors were strongly reinforced by the Jew-

ish, Arab, and Bedouin-Arab GPs with whom I worked. They, like myself, tended to ignore traditional Bedouin-Arab modes of healing. Most derided their patients' experiences with traditional healers. All treated and communicated with their patients through their symptoms. They showed little social awareness or gender sensitivity and paid little attention to what was behind the symptoms-behaviors which have been reported by others as well (Abdul-Menaim, 1991; Walker, 1995).

Some of their conduct was quite callous. For example, one Bedouin-Arab GP, in telling his colleagues about a Bedouin-Arab woman who was unable to indicate the location of her pain for which he found no medical reasons, actually mimicked her. Other physicians would mockingly tell of how their female patients complained about heartache while pointing to their stomachs. None of the staff appreciated the cultural reasons why a Bedouin-Arab woman would not point to her breasts. I didn't enlighten them. With my admiration for their learning and status, I wanted to be one of them, so I shared their disdain.

It is not surprising that the physicians I worked with were not particularly successful in dealing with their Bedouin-Arab patients' mental health problems. Many patients left feeling hurt, angry, and bewildered. One, I recall, was outraged that his GP demanded that he throw away the amulet he was wearing. More than a few were upset with the con-

tempt the physicians showed for the power of the healers and, they believed, for God.

I wasn't very successful either. For the first few years of my work, my encounters with my patients were a bitter comedy of cross-expectations. In contrast to what I had been taught to expect, my patients did not come to me for help with their "emotional" problems. Without exception, they were all referred to me by a physician, usually a GP though sometimes a psychiatrist, with physical symptoms for which there was no medical explanation. They called me "Doctor" and expected a physical examination and medication.

True to my training, I tried to uncover the roots of their somatization by asking them about their personal and family lives. Most of them were disinclined to tell me. Some of them became extremely upset when I told them that they had no physical problems and that their symptoms arose from psychosocial or psychiatric causes. "What, do you think I'm crazy?" was not an uncommon response. Other clients simply ignored the information. Many terminated treatment after one or two sessions. The few who persisted wanted to know what the connection was between their symptoms and the personal questions I asked them. My efforts at explanation—telling them that their problems stemmed from traumas or developments in their youth—only made them more upset.



Moreover, whatever their gender, education, or social class, at the end of my initial evaluation, they invariably asked, "Now what are you going to do?" Their emphasis was on the second person, the practitioner. As they saw it, they had told me their problem and it was my job to treat it. One woman, on learning that my treatment would be to talk with her, informed me bluntly that she had other people to talk with and didn't need me for this.

The literature refers, with some frustration, to the "resistance" of Arab mental health patients who apparently refuse to assume responsibility for their illnesses or problems (Mass & Al-Krenawi, 1994; Devore & Schlesinger, 1991; West, 1987). I felt similarly stymied by their attitude.

To make matters worse, I was so cut off from our shared culture that I ignored the obvious. I had forgotten how much Bedouin-Arabs speak in metaphors and ignored it when clients told me of their distress using popular proverbs. For example, when a young unmarried male client told me that he was "a baby camel left alone in the desert," I didn't pick up his feelings of abandonment. Nor did I ask what he meant. Similarly, I paid no attention to the strong interdiction against Bedouin-Arab women making eye contact with men, so when my female patients kept their eyes averted, I interpreted it as resistance. I also put out of my mind the fact that women in mourn-

ing wear blue embroidery on their dresses, so I didn't connect the depression of one of my patients with her bereavement. These are only a few examples of the meanings I missed. Looking back on them, I attribute my obtuseness to a combination of training that did not include cross-cultural awareness, a matter which did not reach Israel until many years after it was commonplace in Social Work schools in the US and England, and my own very hefty dose of denial of my connection to my Bedouin-Arab roots. On both counts, it was easier for me to search for the "facts" and "information" that I had been taught to look for.

I also ignored everything having to do with traditional views of illness. When my clients told me that they were possessed by demons or the evil eye—agents of mental illness in Bedouin-Arab culture—I ignored the revelations. Nor did I pay attention to my patients' terminology of mental illness, even though I actually knew what it meant. Thus, when a client told me that he was afflicted by "air from evil spirits" (in Arabic *Nafasmn Al-Jinn*), it took me some time to acknowledge that she was depressed. When I was told that another patient had been "attacked from evil spirits inhabiting the earth" (in Arabic *Darbaat Blaad*), I didn't immediately translate the statement into the Western terminology that she was psychotic. I now know what traditional healers mean when they say that evil spirits from the earth have entered a person's body.

For several years, I was unhappy with my work and angry with the people I served. I also felt frustrated professionally. I wanted to make a career as a clinical social worker, and these people weren't letting me. I began to wonder whether Bedouin-Arabs had any use for social workers. I even began to entertain thoughts of working with Jewish clients, who, I believed, would better understand what I was doing and would be better for my career as well.

Feeling increasingly dissatisfied with the way I was helping, or not helping, my clients, I began to sense that things would have to change. But I didn't know what or how. I had been given no precedents, had no mentors, and the skills I had learned only partially equipped me for what lay ahead. For a long time, I felt caught between my hurt at the doctors' attitudes towards my people and my anger and frustration at my Bedouin-Arab patients for not behaving in the ways I expected.

apy" and terminated after one or two sessions, it dawned on me that the responsibility might not be all theirs. In a burst of desperation and hard won humility, I decided to ask my father what he thought. Our relationship was much better now than it had been when I was an alienated adolescent and he trying to cope with a rebellious son. Both my parents were very proud of me when I graduated from university and began to work at the clinic, and I now enjoyed listening to my father tell his stories about the Bedouin-Arab and their way of life. At this point, his lack of schooling, and the fact that he had no more idea than my clients of what a social worker does, struck me as a positive advantage.

After listening to my predicament, he gave me two pieces of advice. One came embedded in a Bedouin-Arab proverb: "Don't walk against the wind. If you do, you're going to lose. You have to walk cautiously with the wind to find a



It took me a long time to shift my focus to myself, though, and to wonder whether and how I could do things differently. Finally, after about five years of banging my head against the wall as most of my patients refused to engage in "talking ther-

way out." This proverb, which draws for its emotional force on the foolhardiness of walking headlong into a desert sandstorm, conveyed the message that change can be made by going with nature, or reality, not against it. That is, change must

be made slowly, carefully, and with awareness of and respect for the circumstances.

The other piece of advice was: "You're riding an airplane; the people you're talking about are walking on foot." Telling me not to regard my patients from the lordly position of my superior education but from their own position, this point supplemented the first.

Though I understood the words, it took me a while to fully grasp what my father meant, and even longer to apply it. For about half a year, I struggled internally, looking for a way of translating his rich metaphors into the language of the profession I had learned. By the end of this period, my father's sayings brought me back in touch with some of the basic tenets of social work, which seem to have gone by the wayside in the years of frustrating practice: 1) Work with, not against, the clients and understand them in their own environment; 2) Avoid applying intervention techniques that are unfamiliar to the client; 3) Look for the clients' strengths and natural sources of help; 4) Think in terms of all the systems in which the clients are involved; and 5) Accept the clients as they are and respect their belief systems.

In terms of my own work, it became clear to me that the distinction that my colleagues and I had made between "us" and "them," our Bedouin-Arab clients, was a false one. I realized that for all my efforts, most of my clients would never fully understand the knowledge and skills that I brought to my

work, and that it was my job to bridge the gap. I finally realized that my professional task would have to be to integrate what I had learned into the cultural context of my people.

The next step was to figure out how to act on my new understandings. I began with the most basic of social work practices: asking and listening to my clients. In particular, I tried to elicit their perceptions of their illness and ways of dealing with it. Instead of looking for the etiology of their symptoms in their personal and family background as the first order of business, I would ask the patients themselves what they believed caused their problem. If their answer was demons or evil spirits, I now took their explanation seriously and inquired further. Why did the demons attack? How? What did they do and say? This would usually lead fairly quickly to the interpersonal and intrapsychic issues behind the symptoms.

I also began to pay more attention to traditional healing. Like the GPs I worked with, I knew that my clients consulted traditional healers before, during and after their modern treatment; but also like them I ignored the "unscientific" practice. With my decision to leave the "airplane" and "walk with the wind," I began to accept the fact that the traditional healers were part of my patients' lives, and I set out to learn more about them.

At first, my patients refused to tell me anything. They were afraid of revealing secret knowledge involving their communication with supernatural powers and jeopardizing their treatment or being punished for it. Also, they didn't trust me very much. As one healer said rather bluntly: "You belong to the university and clinic. No one on your side believes in what we do. You laugh at our treatment. All the people I see had been at the hospital first, and none of them felt that their symptoms improved till they

came to see us." Luckily, my uncle happens to be sheik of our tribe, and he was willing to vouch for me. This opened the door to the male healers who, after some negotiations, agreed to share their knowledge and experience with me, excluding some sensitive areas of their practice, such as the language of the evil spirits and the healers' communication with supernatural powers.

The doors of the female healers were still closed to me, though. To open them, I asked their husbands for permission to meet with their healer wives but was turned down. Then I brought my mother along. She promised their husbands that she would accompany me to all the meetings and act as a kind of chaperone. This got me entrance.

I encountered similar difficulties in getting my clients to talk about the healers they



saw. One client I asked responded bluntly: "You don't respect this type of healing and laugh at it." Still, I persisted. When patients told me they had been attacked by evil spirits, I asked whether they had consulted a traditional healer. If they said that they had, I asked how the traditional healer diagnosed and treated their complaints. The approach worked wonders. Clients who would have clammed up had I asked them about their personal feelings and relationships suddenly opened up and shared things with me. To give only one of many possible examples, I had a female client who started to suffer from various unexplained aches and pains after her husband took a second wife. In the past, I would have asked her to tell me what was bothering her or about her family life, and she would either have focused on her symptoms or left the treatment. But now I asked her how she explained her symptoms and whether she had done anything about them before her GP referred her to me. These questions unlocked her story. She told me that she had seen a traditional healer who had told her that her husband's new wife had done sorcery against her in order to create problems between her husband and herself. I didn't cast doubt on his evaluation, as I would have done in the past, and encouraged her to continue talking about the sorcery. My reward was that in talking about the sorcery, she revealed her anger at her husband and his second wife. She returned session after session, eager to vent

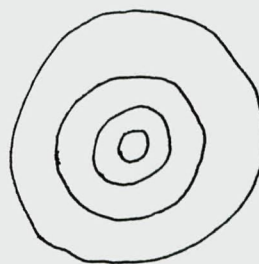
her difficulties in her polygamous marriage.

Simultaneously, I approached traditional healers to learn how they viewed and treated mental illness and how they related to their patients. I even observed and participated in healing rituals that traditional healers performed on members of my extended family. For example, I joined my family in the common ritual of visiting a saint's tomb. I listened to the Koran reading and watched as candles and incense were lit beside the grave and a white cloth was hung on the tomb. I heard the vows made to appease the saints and to special requests to keep tragedy or illness from striking the suppliant and his family. I became aware of the potential in this and other healing rituals for self-expression, catharsis, ventilation, self-satisfaction, and psychological release.

Throughout it all, the driving question in my mind, though I never articulated it, was how could I, a Western-trained and, in many respects, a Western thinking practitioner, use my knowledge and skills to understand the traditional healer's approach and integrate it into my own work?

Fortunately, I had two very good mentors in the professional community. One was Y. Bilu, whom I "met" through his 1978 study of ethnopsychiatry

with Moroccan-born patients in Israel who used traditional healers. His findings, showing that traditional healing had a 70% success rate in this population, were both revealing and encouraging. This success rate is comparable to that of conventional Western psychiatry, and Bilu's discovery that traditional healers were as effective as Western ones bolstered my growing conviction that the traditional healers in my own community had a good deal to teach me. I was heartened, too, by Bilu's call for the integration of traditional healing into Western psychiatry. Bilu's pioneering work provided recognized, academic support for my own quest. It reinforced my sense that I was going in the right direction and



wasn't working in a vacuum in my small, out-of-the-way station in the Negev.

My other mentor was my supervisor at the Soroka hospital psychiatric clinic, the Jewish psychiatrist Dr. Maoz. Maoz was a humane and broad-minded physician who emphasized the need for "natural" empathy, patience, and devotion in treating emotional and interpersonal problems. He provided a personal example of a professional who spent time with his patients and their families, who was interested in more than their symptoms, and who made it a cardinal rule to form good relationships with the people he treated (Maoz, et. al., 1992).

While the GPs I worked with regarded my forays into traditional healing with amused skepticism, Maoz was all for them.

Both Bilu and Maoz strongly influenced my emerging sense of how one had to work with a Bedouin-Arab population. Each in his own way served as an example for me to follow. They also helped me throw off the erroneous assumption imparted in my professional training that the methods of social work practice are universally applicable. This method is a Western model that was adopted in most developing countries, but, as Al-Dabbagh (1993) points out, it has failed in Arab (Islamic) countries, due largely to its exclusion of religious values and spiritual considerations (Ragab, 1990). My own professional experience supports this claim.

When in 1988 I enrolled in an M.A. program in Social Work, I soon began to do formal research on the Bedouin-Arab approach to mental health. My Master's thesis, "The role of the Dervish as a mental health therapist in the Negev-Bedouin-Arab society: Client's expectations from these treatments and the extent of materialization" (1992), was the first study that dealt with the subject in any depth. My choice of subject derived from my growing conviction that, as a social worker, I needed to understand the culture of my clients and especially its way of dealing with mental illness.

My research led me to spend yet more time visiting traditional healers. I sat with the patients while they waited for treatment, sometimes joined in their talk, and observed the incipient group dynamic that developed, through which they found relief by sharing their stories and problems. I participated in rituals in the healers'



homes and watched the healers apply their therapy. I could do this because ritual healing, at least as the Bedouin-Arab know it, is carried out in public—unless the patient asks for privacy—in front of both the patient's own family and the patients and their families who are waiting their turn.

I saw something very different from anything that I was familiar with in a western clinic. For example, the Dervishes rarely asked questions of the patients. Instead, after ascertaining the cause of their illness by looking at their symptoms, touching their heads, or examining some item belonging to the patient, they would proceed to energetically expel the evil spirits. They would com-

municate, sometimes loudly and angrily, with the spirits and give the patient instructions. Sometimes they would even beat the spirits out of the patients. Throughout it all, the patients remained passive as the Dervish worked on them.

I also saw that the healers took care to assure the patients that their illness wasn't of their own making but something that came upon them from outside, whether directly from God or evil spirits or through the agency of sorcery or the evil eye. Being able to project their problem left the patients feeling good about themselves and strengthened their determination to fight the illness. I also realized that the healers and their patients share the same "poetic" terminology of illness that I had scorned.

As I learned, I gradually changed my entire approach. One major difference was that I became more active. Instead of asking my clients to talk about their lives, I gave instructions and advice. For example, when a mother came complaining of her son's enuresis, instead of trying to ascertain its cause, I simply instructed her on what to do to try to stop it. My approach became more cognitive, more behavioral, and more directive. I provided information about the illness or symptoms the patient presented and dealt directly to alleviate the symptoms. These methods of interventions met the patients' expectations

and increased their trust of the practitioners' abilities to address their problems.

I incorporated some traditional practices into my work, which had the double advantage of being meaningful to my patients and of enabling me to play an active role. For example, in a group I led, I helped Bedouin-Arab widows to deal with their survivor guilt manifested in fears that they would be killed by the spirits of their dead husbands, by having them carry out the traditional mourning ritual (in Arabic *Rahama*) and then discussing their experiences and the feelings that the ritual had raised or resolved (Al-Krenawi and Graham, 1996). Most of the widows I did this with felt relieved afterwards and no longer had nightmares of their dead husbands coming to attack them. With other patients, I visited saints' tombs, after having done this with my own family as I described above. Saints' tombs are holy places, and visiting them is traditionally used to relieve personal anxiety, heal physical and mental ailments, and mediate requests to God (Al-Krenawi & Graham, 1996; El-Islam, 1967). Although I myself do not believe in spirits or sorcery, I could feel in myself and recognize in my patients the sense of belonging, safety, and relief that these rituals afforded.

Another traditional practice I turned to was to elicit the assistance of family members in my work with patients (Al-Krenawi, 1995a, 1995b; Al-Krenawi & Graham, 1996; Al-Krenawi, Et. Al., 1995; Graham

& Al-Krenawi, 1996; Mass & Al-Krenawi, 1994). The mourning ritual involved, among other things, a ceremonial family meal. A more specific instance was in the case of a patient suffering from hallucinations brought on by an argument with his mother in which he nearly hit her, an act which so violates Bedouin-Arab behavioral norms that it is considered sinful. In this case, I arranged for a reconciliation between the patient and his mother in the presence of his brothers. The reconciliation followed my use of accepted Western techniques: paradoxical techniques to alleviate the patient's terrors of the malevolent spirits of his hallucinations, and role playing to clarify his feelings of guilt and expectations of punishment for his act (Al-Krenawi & Graham, 1997).

I also let my clients know that I accepted their concurrent utilization of traditional healers. I asked how their traditional healers viewed their problems and tried to make use of their perceptions. Sometimes I accompanied patients to their healers or consulted the healer directly about the patient. In the case of the patient discussed above, following the reconciliation with his mother, I urged the family to arrange a visit to a Dervish to expel the evil spirits because the patient viewed the spirits to which he attributed his illness as having been sent by Allah to punish him for his disrespect. This meant that, to the patient, only someone with supernatural powers could free

him of the spirits. I should note that it was not necessary for me to believe in spirits, in the healer's supernatural powers, or in the "exorcism" he performed, but only to accept that the patient did and to treat his belief with respect.

A related change was that I became more careful about intimating that a patient's disorder had an internal cause, an etiology which implies that the disorder is somehow of his or her own doing and evokes a great deal of anger, shame, and denial. Thus, as evident in the above example, I ceased to

challenge the common Bedouin-Arab view that mental disturbance is caused by supernatural powers (rather than internal conflicts). I did not engage in "insight" therapy or try to confront patients directly with their rage, guilt, and other culturally unacceptable emotions, but rather allowed them to resolve these feelings actively. For example, the reconciliation I facilitated between the patient discussed above and his mother enabled expiation, while the use of the Dervish provided a culturally acceptable way of closing the chapter on his anger.

I also began to relate differently to my patients. With male patients, I removed some of the patient-therapist barriers. I chatted with them in the waiting room. I moved the table in my office which had separated us and let them sit closer to me. With my female patients, I stopped trying to make eye contact. I also adopted the traditional healers' quasi-familial



terms of address. I called my unmarried female patients "sister," my middle aged matron patients "auntie," and my elderly women patients "grandma"—terms which encouraged the patients to see me as a concerned, protective family figure who would take care of them. This too made them more ready to open up.

I learned to communicate with my patients. I came to understand and build on their indirect ways of talking about themselves. When they talked in proverbs, I would try to interpret the proverb or ask them what it meant, and this would lead to a discussion of the feelings and experiences behind the proverb. I learned their terminology of illness, and although I didn't use it myself, I found that knowing the names and explanations that traditional healers give to patients' disorders helped me relay to the patients the modern diagnoses. Interestingly, traditional healers also distinguish between neurosis and psychosis, or minor and major mental health disorders. In the healers' classification, patients attacked by evil spirits which did not enter their body suffer from what they call an "easy" (in Arabic *khafif*) disorder. Those who behave bizarrely are believed to have been attacked by evil spirits which did enter their body, and are diagnosed as having a "difficult" (in Arabic *saab*) disorder (Al-Krenawi et al., 1995; Hes, 1975). In any case, in my discussions with patients of how they saw their illness—its causes and development—I could learn about

their feelings and aspects of their intimate lives. It was no longer necessary for me to ask them directly about their family lives and personal relationships.

My new understanding also helped me to cope with the "resistance" that had previously so thwarted my efforts at helping. I came to realize that what the literature labeled "resistance" was not resistance in the psychoanalytic understanding of the term, but rather a reflection of the bewilderment that my Bedouin-Arab patients felt at the non-directives of the Western practitioner and of their culture-bound expectation that the practitioner take an active role in the healing (Al-Krenawi, 1992). Once I became aware of this, I could deal with their attitude as a culturally based expectation. I could let my clients know that I understood where their lack of being forthcoming stemmed from and could work to create the trust that they needed to let me into their personal lives. The fact that many fewer clients now terminated their treatment after one or two sessions told me I was on the right track.

Can Traditional and Modern Mental Health Care be Integrated?

My thesis findings—that many patients utilized traditional healing alongside modern medical care and that the majority of the Dervishes' patients were satisfied with their traditional treatment (Al-Krenawi, 1992)—caused me to

wonder. What, I asked myself, was wrong with the "modern" mode of helping? What was right about the "traditional" practices? Could the two co-exist in harmony? Could they perhaps nurture and support one another?

In my own practice, I've found that they can. Recent research in the field bolsters this conclusion. The anthropological study of traditional healing has gone through two broad phases. The first focused on the question of whether healers or shamans were themselves mentally ill, namely schizophrenic or epileptic. By the 1950s and 1960s, it was concluded that they were not. The shift in assessment is actually similar to the one that I had undergone. In the second phase, anthropologists began to look into the similarities between shamans and psychotherapists. The explicitly religious dimensions of the traditional healing practices were pushed into the background (Fernando, 1991) and shamans have come to be increasingly perceived in Western countries as healer-psychotherapists (Jilek, 1971). Their techniques, such as suggestion and persuasion, are described as similar to those used by psychiatrists (Frank, 1973; Kiev, 1964; Nelson & Torrey, 1973; Ruiz & Langrod, 1976a). Some researchers (Bravo & Grob, 1989) even urge psychiatrists to be more open to learn from shamans.

A fair number of recent studies point to psychotherapeutic elements in traditional

healing (Al-Krenawi & Graham, 1996; Atkinson, 1987; Bankart, et. al., 1992; Daie, et. al., 1992), among them catharsis, ventilation, and relaxation (Levi-Strauss, 1963; Scheff, 1979). Traditional healing rituals, it has been suggested, work by establishing a homology between the symbolic and the experiential in which the former metaphorically transforms the latter by triggering a non-specific mechanism such as suggestion, catharsis, or placebo effect; by offering social support or the resolution of social conflict; and/or by transforming the meaning of affliction for the sufferer through a ritually powerful, symbolic performance (Scheff, 1979). Moreover, studies show that, much like modern mental health care, traditional healing tackles problems at the various levels of the individual, family, group, and community (El-Islam, 1967; Grotberg, 1990; Hajal, 1987; Kennedy, 1967; Napoliello & Sweet, 1992). As modern services became available, these overlaps have enabled clients of various ethnic affiliations to integrate the traditional services with the new ones, though they often do so without telling their Western clinicians (Nyamwaya, 1987; Rankin & Kappy, 1993; Waldman, 1990).

For the most part, this patient-initiated model of integration between traditional and modern health care is one directional. While traditional healers are quite interested in learning about what goes on in modern health care, Western-trained mental health practitioners tend not to be interested in tradition-

al healing (Al-Krenawi, 1995b). Rarely has the interactive process in traditional healing been considered in detail; even more rarely has the experiential process been examined; and almost never has a systematic comparison between traditional healing and psychotherapy been attempted.

Moreover, although family and community rituals are sometimes used in counseling and psychotherapy, they have rarely been identified as part of the psychotherapeutic process (cf. Palazzoli, et. al., 1978; Van der Hart, et. al., 1988). Generally they are relegated to the status of a task that the therapist assigns the client, with no acknowledgment or explanation of their therapeutic purpose (Yalom, 1975). Even in the rare cases where rituals have been given legitimacy in therapy (Renner, 1979), there are few detailed accounts of how, when, and why they are used. A notable exception is Rando's (1985) article outlining his clinical observations.

My personal experience supports the positions that mental health practitioners would do well 1) to learn about, value, and show respect for their clients' cultures, and especially for their traditional and religious approaches to psychological healing; and 2) in their own practice to draw upon and support the conjoint use of the traditional healing methods (e.g., rituals) in the patient's religion and culture (Azhar, et. al., 1990). My main point is that, in view of the commonalities in the modern and traditional healing

approaches, both mental health workers and, more importantly, their patients would probably benefit from their integration. Indeed, many researchers have called for integrating modern and traditional healing (Ezeji & Sarvela, 1992; Heilman & Witztum, 1994; LaFromboise, et. al., 1990; Jilek, 1994; Lambo, 1978; Lin, et. al., 1990; Ogunremi, 1987; Schwartz, 1985; Wessels, 1985). My experience supports this call.



Guidelines for Bridging the Gap

Although modern and traditional models of helping conflict with one another at many points, the task of social workers who treat traditional clients is to approach both them and the traditional healing the clients utilize with an open mind. Only thus can we hope to win the trust that is essential to truly helping them. Instead of rejecting the traditional healers for their reliance on supernatural powers, we should give thought to what traditional modes of helping we can incorporate into our work and how we can do so.

The following guidelines are suggested as means to obtaining the information that is necessary if we are to treat our traditional clients in their own contexts and to make use of the healing resources of their culture:

1. We should seek to understand the client's culture, religion, values, and belief system.
2. In taking the client's history, we should try to learn more about his or her nuclear and extended family, asking questions such as: What are the relationships among the family members? Under what circumstances do they meet? Who are the authority figures? What are the family rituals?
3. We should investigate the relationship with the community, asking questions such as: Who is the respected spiritual leader (i.e. the rabbi, priest, sheik, or traditional healer)? Are there any community rituals, and what is their purpose?
4. We should investigate self-treatment: Does the client understand the symptoms? How does he or she deal with them? What sources has he or she consulted, i.e., family or community members, religious-spiritual leaders, traditional healers?
5. In addressing symptomatology, we should consider the client's own interpretation as well as how persons in the client's family and community assess the symptoms—that is, their tentative diagnosis and etiological explanation.
6. We should find out what treatment the traditional healers suggested and what their diagnosis

means from the client's perspective.

7. We should investigate the social construction (and legitimacy) of the sick role in the client's family and community (including the patient's rights and obligations).

The above information can help us to select the appropriate intervention techniques. For example, if we know who the authorities in the client's nuclear and extended family and community are, we can enlist them in our intervention (Al-Krenawi et al., 1994; Heilman & Witztum, 1994; Lum, 1982).

8. Lastly, in keeping with the client's expectations, we should adopt an active and directive role in the treatment sessions.

In sum, traditional healing may be highly useful for mental health practitioners who work with non-Western ethnic groups. Western and traditional healing are complementary and should be constructed to function alongside one another (Chi, 1994; Green & Makhulu, 1979; Rappaport & Rappaport, 1981). Because social work intervention is often based on intuitive as well as empirical knowledge, traditional healing can readily be integrated into practice with people of various cultures (Applewhite, 1995; Castellano, Et. Al., 1986; Gutheil, 1993; Kissman, 1990; Laird, 1984; Morrisette, et. al., 1993; Schindler, 1993). An understanding of the many and deep connec-

tions between modern and traditional healing approaches should enable Western practitioners to collaborate with their non-Western clients in the therapeutic process and, with them, search for viable resolutions of their difficulties in a culturally respectful manner. □

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