THE EXPERIENCES OF A FEMALE SOCIAL WORKER IN MENTAL HEALTH SETTINGS IN JORDAN

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The following narrative describes the author's unique experience as a female social worker struggling to modify Western methods to suit Muslim clients.

I have been fascinated with the social work profession since my early years. I have appreciated the opportunity the profession provides to contribute to people's lives, and its promise for social change. These things were important for me as a female growing up in socially- and politically challenging environments in North Africa and the Middle East. I grew up in an era when people talked all the time about colonization, wars, poverty, women's rights, social problems, dictatorships, freedom and the urgent need for change. Social work seemed to be the right tool to contribute to change. I developed an early interest in working in mental health, an area that provoked curiosity in me. I met various individuals during my school years who still struggle with mental health issues, and I have always admired their strength and the way they cope with their problems. I became passionate about helping people with mental health problems because, for me, the helping role of the social worker is not only a professional, but a spiritual experience as well. Work is important in Islamic tradition and teaching: it is worshiping practice. The Qur'an says: *"Work (righteousness): Soon will Allah observe your work, and His Messenger, and the Believers"* (Qur'an 9:105). This is especially important if the job involves helping disadvantaged, needy individuals (Sahih Muslim, p. 1417)

In the following narrative, I reflect back on my experience as a female clinical social worker in mental health settings in Jordan.

Sharing the story

In telling my story, I hope to share my journey as a female social worker in a mental health setting in a non-Western society. By sharing this experience, I also hope to highlight the need to develop curricula that meet the needs of people from traditional, Islamic, Arabic cultures. This might provide insight for professionals who encounter patients from traditional Muslim backgrounds. As Al-Krenawi (1999, p. 56) says, *"Cultural differences affect the ability of the mental health practitioner to diagnose and treat patient's problems."* Al-Krenawi and Graham (1997, p. 211) also observe that:

When patients from non-Western societies are referred to Western psychiatry for treatment, they do not abandon their own perceptions, culture, or belief systems regarding diseases or medicine. Likewise, patients have their own ways of expressing difficulties and of decoding their practitioner's messages, often deviating from the latter's styles of communication and comprehension.

They further explain, *". . . there are often miscommunications between a patient and a mental health practitioner who is not familiar with their patient's culture that lead to problems in therapy"* (1997 p. 211). Such issues are especially important in an increasingly globalized world (Lyons, Manion et al., 2006).

Beginning the Journey

The idea of writing about my experience first arose when I returned to Jordan to collect data for my Ph.D. research and to work at the National Centre of Mental Health in Jordan, after having lived in Australia for many years. Prior to moving to Australia, I started working formally as a social worker at the National Centre in 1987. That year, there were more than twenty young male and female psychologists, sociologists, and social workers employed at the Centre. Around this time, mental health services in Jordan were expanding. Most of us shared the view that there was a gap between the theory and the practice in our work. It was obvious that there was difficulty in applying knowledge and skills when interacting with patients and their families from Arabic-and Muslim backgrounds. I continued working in the Centre as a social worker for more than seven years, before migrating to Australia in 1994. When I returned, I was fortunate to be able to resume my previous position at the National Centre of Mental Health.
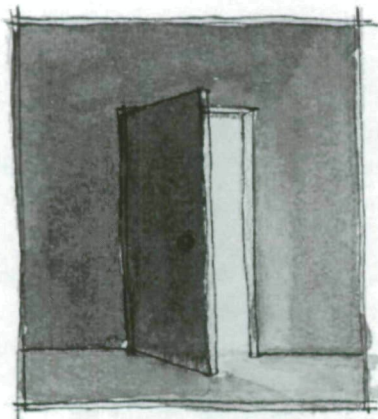
A New Environment

My time in Australia helped me to reflect on my earlier experiences with patients. I undertook academic studies in social work, and gained employment in various mainstream and multicultural agencies. I also engaged in many conversations with social workers from different cultural backgrounds, which helped me to gain perspective on my experience as a female social worker in mental health settings. While in Australia, I had exposure to many scholars who emphasized the importance of cultural sensitivity (Kleinman, 1980; Marsella, 1993; Lefley, 1994; Al-Issa, 1995; Al-Krenawi & Graham, 2000). Experience in multicultural societies, exposure to literature that emphasized cultural sensitivity, and interactions with diverse patient groups and professionals, helped me to reflect on my professional experiences in Jordan, and to develop insight about my role and interventions there.

While I was in Australia, I became more informed about new emerging literature that highlighted the importance of incorporating and considering religion when working with individuals with mental health problems (Koenig 1990; Larson, Wood et al. 1993; Loewenthal 1997). Religion, as Pargament (1997) indicates, is increasingly considered an important source of understanding about human beings and their ways of coping with psychological problems.

The significance of culture in the lives of people with mental illnesses prompted me to think about the possibility of research in the area. I began thinking about undertaking Ph.D. research. During that time I had many conversations with Maria, my supervisor, about issues related to culture and social work. We talked about the difficulties of applying theories to practice, especially when working with people from traditional cultures. I remember her asking me about my time in Jordan working with people with mental health problems. I remember stating for the first time that I wondered if I was betraying my profession because I was not following most of what I had learned at university, and that I had doubts about the effectiveness of my practices with people from Arabic Muslim cultures. I told her about my struggles, difficulties, and

uncertainties. She validated my experiences and encouraged me to reflect on my understanding, assuring me that there was an urgent and ongoing need to think about more effective ways to work with people from traditional cultures.

In short, my professional experience in Australia provided me with the opportunity to learn and understand many things about my practice experience in Jordan. It shaped my impressions, observations, and opinions about the applicability of the Western-based curriculum in traditional communities. It also allowed me to continue to adjust certain interventions to suit individuals from Arabic communities. It helped me to acknowledge my early thoughts, opinions, and views about encounters with patients, and about my limitations as a professional. I became more accepting of my efforts and the struggle to initiate a culturally sensitive assessment and intervention process.

Returning to My Roots

Coming back to the Centre after my experience in Australia made me feel more comfortable and more accepting of myself professionally. I re-assessed my early impressions about the suitability of the Western-based curriculum when working with patients from traditional societies. At the start of my professional experience, I tried to implement Western approaches when working with individuals experiencing mental health problems and their families. I sought to implement the theories, assessments and interventions that I had been taught in the social work curriculum. However, from the outset I had a feeling that these approaches were not always suitable for a cultural group such as Jordanians.

Jordan is a traditional society and is strongly family-oriented. Jordanian families, as with other Arabic families, are collectivists; that is, the family is more significant than the individual. Family members take care of each other during crises, despite there being a gradual change from the extended family structure to the nuclear family. The link between the nuclear family and the extended family has always been strong. Children are

raised to be obedient and to respect the hierarchy within the family. These factors, among others, make professional practice in a traditional society such as Jordan unique and challenging, as well as rewarding.

The Ongoing Struggle

I felt that my training in the social work curriculum wasn't enough to prepare me to deal with the patients whom I was seeking to help. I always felt a need to understand more. In my search for answers, I returned to university for further training. I studied a Masters in Counseling at the University in Jordan, as there were no postgraduate social work courses at that point. Even though it helped to improve my skills, this training didn't answer my concerns and questions. It seemed that, at either graduate-or post-graduate levels, course content was mainly based on Western approaches and theories. The curriculum didn't prepare me to apply more appropriate modes of assessment or to conduct interviews with Muslim patients, nor did it provide insight about ways to develop culturally sensitive approaches. On many occasions, I felt the need to adapt some of the interviewing techniques and interventions to suit the patients. There were times when I considered myself to have been successful in dealing with patients and their families.

Mixed Reference Points

There was no reference point for me to use in reflecting on my experience, or to predict the effectiveness of my practice. There were times when I struggled with doubts about my competency as a professional. These feelings wouldn't leave me even when I had good feedback from patients and their families, or colleagues who referred patients to me. What made the matter worse were the high expectations of the clients and professionals at the Centre with regard to my role as a social worker. Not much was known about the role of social work or other professions, such as psychology and sociology; therefore, little was known about the differences in the roles of these professionals. The dominant expectation was that the social worker was the one who would solve "the problem" and who could

analyze personalities. I think that such impressions were mainly obtained from films and television.

As a result, I was expected to solve all the problems of individuals with mental health challenges and provide a direct practical solution in every area; whether it was domestic violence, sleeping problems, parenting, bed-wetting, academic difficulties, or any number of other problems. I was under pressure to learn and read continuously in order to be able to deal with such problems. Of course, the only literature available dealt with Western theories and approaches.

Being Female

I hadn't learned much about my role as a female social worker, or what to expect as a female in the professional relationship. This role has particular importance in a gender-based society such as Jordan, where the male–female relationship is important and has unique characteristics. At university, I was taught to smile and maintain eye contact with patients, whether the patient was male or female. I quickly realized how harmful and wrong this could be. Some of my patients were religious and, for them, maintaining eye contact was considered unacceptable and even embarrassing. Even with patients who considered themselves only moderately religious, eye contact did not always make them feel comfortable. Within traditional Jordanian society, having confidential conversations with the opposite sex about sensitive issues is problematic. I soon adapted my interviewing techniques accordingly and avoided eye contact. I found that this made the patients more relaxed and comfortable in talking. I didn't consider their lack of eye contact as a demonstration of low self-esteem, nor as an indication of an unsuccessful professional relationship.

In dealing with male patients, I needed to be careful about shaking hands, as this habit has become less common between males and females due to the increase in strength of religious orientation among Muslim communities. Many now consider shaking hands to be forbidden. I had also been taught to conduct interviews behind closed doors to promote confidentiality; however, this was difficult and sometimes led to uncomfortable feelings for patients. Some might have gotten the wrong impression, so I decided to keep the door of the interviewing room partially closed. By doing this, I protected the confidentiality of patients while not contradicting the traditions of their culture.

I soon learned that I also needed to be conservative in welcoming patients; for example, smiling could be interpreted the wrong way, and some might have even become embarrassed or confused. To make the professional boundaries clear, I decided to conduct the interview with a desk or a coffee table separating the patients and me.

Slowly and surely I gained respect and acceptance from patients. Many opened up to me, and talked about confidential issues. Increasingly, the male patients discussed their issues openly and honestly. Sometimes they told me things that they hadn't shared with the psychiatrists. For example, on one occasion a patient told me that he had visited a traditional healer who helped him to remove an effect of sorcery, and that he was not willing to share this with the psychiatrist because he didn't think that he would understand. Other times, male patients told me that they preferred to discuss certain details with the male psychiatrist because they were embarrassed and didn't want to share these things with me out of respect, because I was female. One example of this was when a patient told me that he wanted to talk to the psychiatrist about his problem because he was embarrassed to disclose something about his sexuality to a woman.

Cultural Matters

Mental health problems are highly stigmatized in Arabic cultures. Some patients gave false names, especially if they were from a well-known family, only revealing their real names to me if they felt safe enough. Many would ask about my family name and my background to find out if I could be related to someone they knew. Some patients introduced their problems as physical instead of psychological. For instance, they might complain of suffering from a headache, chest

pain, or having sore arms or legs. I learned that this was a way of taking the stigma away from their mental health problems. It was a way to allow them to discuss their feelings without talking directly about the psychological problem. I soon learned that I needed to stress confidentiality more than once during the interview, which I felt was important to build rapport.

Bringing it All Together

The curriculum in which I had been instructed trained me to apply techniques that were not suitable for individuals from traditional collectivist societies. An example that comes to mind is when I was working with a 22-year-old male patient, whom I will call Ahmed, who was diagnosed with depression. He sometimes complained of being taken advantage of by members of his extended family. I tried to help him become more assertive with his brother, who kept borrowing his car. This created feelings of annoyance for Ahmed, so I applied an assertive technique to help him stand up to his brother and say "no" to him. Ahmed objected gently and told me that this was difficult because, while he was not comfortable with his brother's behavior, he still felt obliged to lend him the car because he was family. This was the expectation within the family: brothers were to help each other and saying no would have created more problems instead of helping him. It was apparent that assertiveness training was not useful here.

I was also taught to avoid the subject of religion when working with patients. I challenged this at one of our lectures, only to be assured that this was the professional way to work with clients. I was reminded of theories and frameworks such as Albert Ellis's cognitive theories, and was told that religion should be avoided in order to achieve an effective professional relationship with clients. Religion was seen by most of my educators as a source of problems. Surprisingly enough, these views sometimes came from academics and professionals who were devoted Muslims in their everyday lives. This was one of the most challenging issues I faced. It was extremely difficult to interact with patients and their families and to exclude religion, especially in a society based on religion. For Muslims, Islam is a way of life. My patients and their families mentioned religion all the time when they talked about the causes of their psychological problems and their coping strategies. It was difficult, if not impossible, to avoid the subject. When I incorporated coping strategies into the counselling session, I was not quite sure where to draw the line, and whether what I was implementing was counselling or some form of religious teaching.

When I adapted what I had been taught in the curriculum to suit my patients and their families, I was able to establish better relationships with them. I learned that we need to be creative and to pay careful attention to what patients tell us. Interestingly, as a social worker, most of the time I felt overwhelmed at the amount of trust and confidence patients placed in me as a professional.

These experiences taught me how much need there is to develop social work curricula for application in Arabic countries. Such curricula could also be used to assist Western social workers (and other professionals) to work with communities from Arabic backgrounds. There is no doubt in my mind that scholarly research needs to be based on the views of Arabic "consumers"—people accessing mental health services—as well as on the learning of practitioners who have worked in cross-cultural settings. My experience as a female social worker became the springboard for this research and for my ongoing interest in researching the intersection of social work practice, mental health services, and Islam.

One important principle that has underpinned my interest is the need to be open to other experiences around the world. Exposure to the perceptions of practitioners working overseas and in cross-cultural settings will enhance the creativity and confidence of social workers in exploring innovative approaches to social work. Such exposure has brought me to acknowledge the need to have curricula that are appropriate to Arabic and Islamic societies.

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