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A STUDY OF DUAL USE
OF MODERN AND TRADITIONAL MENTAL HEALTH SYSTEMS
BY THE BEDOUIN OF THE NEGEV

by

Alean Al-Krenawi

A Thesis Submitted in Conformity with the Requirements
for the Degree of Doctor of Philosophy,
Faculty of Social Work, in the
University of Toronto

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0-612-35428-8
Title: A Study of Dual Use of Modern and Traditional Mental Health Systems By The Bedouin of The Negev

Degree: Doctor of Philosophy, 1995, Faculty of Social Work, University of Toronto

By: Alean Al-Krenawi

This study analyses the utilization of modern and traditional mental health care systems by the Bedouin, with particular emphasis upon such patterns of dual use from the patients' perspectives. In addition, the study describes the patients' experiences through the course of the treatment in both systems, and the reasons for utilizing both systems concurrently. It also examines particular aspects of the modern and traditional systems that treated the same patients, among them, etiology/explanation, diagnosis, symptomatology, prognosis, and course of treatment.

The first subject set consisted of an initial population of 60 Bedouin patients newly referred to the psychiatric outpatient system. Of these, a subset, consisting of 20 patients (10 female and 10 male) used both the modern and traditional healing systems concurrently.

There were gendered differences in terms of help-seeking processes, perceptions, patterns of utilization; decisions regarding which system to utilize, and degrees of familiarity with the modern and traditional mental health systems. The modern system was helpful with respect to medications, follow-up, certain types of instrumental support, and for female patients especially, in providing a greater network of support outside the home.
The traditional system was quite useful in mobilizing the patients' families as networks of support. It was also therapeutically significant in addressing and improving family dysfunction. The Bedouin patients find the modern system helpful in addressing somatic issues, and the traditional system, in addressing emotional and behavioural aspects of illness. The patients' families played an important role in terms of managing the treatment in both systems.

The second subjects were seven Jewish psychiatrists, who treated the Bedouin patients. They graduated from medical schools in Russia, Romania and Italy. The third subjects were twenty traditional healers who treated the same Bedouin patients. The psychiatrists' relationships with their patients tended to be formal, and diagnoses Western, whereas the traditional healers built quasi-familial relationships, shared the same world view as their patients, and used familiar terminology.

The implications of these findings for the integration between both systems, social work practice, and the significance of social work in the modern health systems are discussed.
Acknowledgements

I am extraordinarily grateful to so many people who were important over that three year period when I worked on the PhD. It is impossible to cite every name, but several cannot go without mention.

Sincere thanks are extended to my supervisor, Professor Ben Zion Shapiro for his patience, support, and assistance, particularly with respect to conceptualization. Professor Howard Irving has been very helpful and supportive throughout my doctoral journey; without his encouragement, I never would have come to the University of Toronto. Professor Adrienne Chambon was particularly helpful in opening up avenues of qualitative methodologies and conceptualization; I am enormously grateful to her. Likewise, Professor Morton Beiser of the Clarke Institute of Psychiatry provided enormously helpful analytical and methodological critiques which have considerably improved the final version. To all, my sincere thanks.

Many thanks to the internal appraiser, Professor Margot Breton and the external examiner, Professor Alfriede G. Schlesinger, of Rutgers University, for their helpful comments. Heartfelt thanks are extended to my friend, doctoral colleague John Graham, for his helpful comments and for all the time we spent together. I am confident that we will continue to collaborate together, and to learn from each other, in the coming years.

Sincere thanks also are extended to the patients, psychiatrists, and healers, for their participation in this study.

To my family I owe a debt of gratitude greater than what words could ever convey. Special thanks are extended to my brother, Talal Al-Krenawi, Mayor of Rahat City, for his encouragement and support. Love and thanks are extended to my father and mother for their unending support. My wife Rajaa has been unceasingly and without exception, a paragon of support, encouragement and support. Without her, I never would have completed the programme. To paraphrase one Arabic expression, one’s successes are intimately dependent upon a spouse’s help and support. And to paraphrase a second, I could never find suitable-enough words to thank her.
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Chapter One

INTRODUCTION

"Walking with the Wind"

My interest in this study arises out of my experience as a psychiatric social worker and as a Bedouin. I was born into, and raised within what is by western standards a relatively traditional culture. There are no written documents indicating how long my family has lived in the Negev region; but according to an oral tradition, we have been there on an on-going basis for several hundred years. My grandparents, like their forbearers, were a nomadic people; my parents had been raised in similar contexts, and only became semi-nomadic during my early childhood, in response -- at least in part -- to the significant social changes around them.

Ours remained a tribal existence; we lived in a tent, and in close proximity to the some 2,000 other members of the Al-Krenawi tribe; the influence of cousins, grandparents, aunts and uncles, and other tribal members upon everyday life was considerable. I am the third of fifteen children, and was blessed with the opportunity to be educated. I rode a donkey ten kilometres to school, returned home every day to tend sheep, carried water from a well to our home. At school, my values and frames of reference naturally diverged from those of virtually most of my tribe and many of my family members. Not only could I read and write, but I had gained entry into -- and perhaps a growing sympathy for -- the western, modern modes of thinking and valuing. I did relatively well at
school, was encouraged in my work, and was the first in my family to attend university. Here, a process of western acculturation was accelerated. I completed an undergraduate degree in social work in Israel. But this was in an era when "cultural sensitivity" had not yet become a strong pedagogical undercurrent. In hindsight the models of social work intervention, the values, skills, and epistemologies underlying them, were strongly western. In learning them, I did not feel particularly empowered regarding my own culture. Nor, to be blunt about it, was I that interested in using this education as a point of departure for cultural empowerment. True, I was a Bedouin, proud of it, and deeply committed to working with, to helping my own people. As I saw it, as my tribe perceived it, this was my calling in life.

But at the same time, this process of professional training had distanced me from my people. In any professional relationship there is an implicit chasm between two individuals; it is impossible to completely transcend the differential experiences and different social locations that invariably distinguish patient from helper, however much a therapeutic alliance might be a partial vehicle to this objective. But for me, there was a second aspect which exacerbated this particular dynamic of professional-patient "separation": in my professional training I had been acculturated into a "western", "modern" tradition. I did not realize it at graduation, but my task, in practice, was to be able to integrate what I had learned in the context of my culture. I had been given no precedents, knew of no mentors; and the skills that I had
learned could only partially equip me for what lay ahead.

Over an eleven year period, I worked with the Bedouin population of the Negev (southern Israel), in two settings: (1) in the department of psychiatry in the general hospital of Soroka Medical Centre, of the city of Beer-Sheva, the main and capital city of the Negev (1981-1992); and (2) the main, primary health care centre in the Bedouin city of Rahat (1981-1992). During my work with this community, I encountered numerous questions about psychotherapy and mental health issues. Being trained in Israel with Western approaches to social work and therapy, my thinking was like any Western therapist. I tended to analyze the patient's difficulties from my point of view; I did not pay attention to belief systems, cultural patterns, nor to the patient's perceptions of the disease or problems. I tried to see everything from a scientific viewpoint, and like the other medical professionals I focused on the patient's symptoms, ignoring other aspects of the patient's life.

My professional inclination to be a western-thinking practitioner was strongly reinforced by my professional colleagues. I worked with several Arabs, Jewish and Bedouin general practitioners (GPs). They, like myself, tended to ignore the phenomena of traditional Bedouin modes of healing. Several practitioners derided their patients' experiences with traditional healers. All treated and communicated with their patients through the symptoms, invoking little in the way of social awareness or gender sensitivity, and so paid little attention to what was behind

Other aspects of this professional culture, sadly, entered into the darker side of rank insensitivity. In one instance, a Bedouin GP recounted to his colleagues how a Bedouin woman had been unable to explain the location of pain in her body, and demonstrated no medical reasons for her symptomatology. In his later account were interspersed mimicking references to the patient. Other physicians jokingly described how their patients complained about heartache, yet pointed at their stomach. It seemed as though none of the staff appreciated the cultural reasons why a Bedouin woman would not point to her breasts. Apart from such examples of cultural insensitivity, another reason for the physicians' lack of clinical success with the Bedouin may well be because of the narrow approaches of Romanian, Russian, and Italian medical schools from which the physicians graduated, and whose curricula may have overlooked the psychosocial aspects of diseases. But to some extent, the etiology of the problem did not matter as much as the symptoms themselves: in several respects, there were unwelcoming aspects to the places where I worked. Early in my career I suspected that things needed to be changed. And gradually I learned what these were, and how to go about realizing them.

Unknown to me at first, the means by which I would eventually come to bridge "western" and "Bedouin" ways of looking at the world was through the prism of the Bedouin traditional healers. As a child I had first encountered various modes of traditional healers -- fortune tellers, Dervish, amulet writers. My grandfather had
been an amulet writer; I knew something about the practices, and
understood, at some level at least, that these modes of practice
were anathema to the western education that I had received.
Consistently, however, the traditional healers, whether I liked it or not, were an implicit part of my patients' lives. What had always been clear to me -- but became increasingly so, the longer I worked -- was that there was a false distinction between "We" and "They"; the patients and the traditional healers were on one side (They) and the professionals on the other (We). Like my professional colleagues, I worked with the patients, I was dedicated to helping them -- this was my livelihood, my vocation. But the knowledge and skills that I brought, the context in which I worked, could only have partial meaning to many of my patients.

In point of fact, a patient's reality was totally different from what the medical practitioners thought, both in the psychiatric and the primary health care systems. The GPs knew that the patients consulted traditional healers before, during and after the modern treatment, but "we" ignored this system because traditional healing was deemed "unscientific." I too was one of those who ignored the traditional system and the help-seeking process among the Bedouin patients.

During social work interventions many of my patients referred to me as a doctor (physician); and by the end of the sessions they expected medication and a medical examination. I was frustrated, as a social worker, by how difficult it was to practise social work with this community. Many patients terminated the treatment
process after one or two sessions and many ignored that they were mentally unwell or had problems in their personal or interpersonal lives. Others were very upset when I talked to them and emphasized that they had no physical problems and that the diseases or the problems emerged because of psychosocial and/or psychiatric reasons.

During my work with Bedouin patients, there was one common element which characterized all patients, regardless of their gender, education or social class. After the assessment stage they invariably asked "Now what are you going to do?" The emphasis was on the second person pronoun. In the patient's view, he or she had told the practitioner about his or her situation, and now the therapist was to treat the diseases or the problems. Typically, some Arab mental health patients are said to present "resistance," since many of the patients do not assume responsibility for their diseases or problems (Al-Krenawi, Maoz, & Riecher, 1994; Allgood, Bishoff, Smith, & Salts, 1992; West, 1987). Only later did I realize that Bedouin patients were influenced by the traditional healers' procedures of dealing with the disease. Often the patients are passive and the healer is the active one, taking care of the patient's disease or problem. After a period of time, I experienced frustration and dissatisfaction with the way I was helping patients; I consulted my father about my professional career. A typical Bedouin, he also had no idea what a social worker does. He told me a wise saying which aptly reflected the situation with which I was troubled. He said, "Do not walk against
the wind, and if you do you are going to lose; you have to walk with the wind cautiously to find a way out." Also he said, "You are riding an airplane; the people you talking about are walking on their feet." My father's sayings reminded me of some of the basic tenets of the social work profession: 1) join with the patients and understand them in their own environment; 2) avoid imposing intervention techniques on them with which they are not familiar; 3) look for and strengthen the natural sources of help; 4) think systematically; and 5) accept the patients as they are, and respect their belief systems. These principles needed to be put into practice: I was impelled to be more culturally sensitive. I was too break the distance between "we" and "they," and to create a close alliance in order to promote the treatment goals and to validate the patients within their cultural context.

Thus my own professional experience expanded my interest and motivation to understand the Bedouin's way of dealing with mental illness issues and how they coped with emotional difficulties. For this purpose I decided "to walk with the wind" and to leave the "airplane" to join the patients in their environments. In order to understand the patients' world, I believed, one needed to share and understand their world perceptions, including their perceptions of illness. And so arises the following question: How do the Bedouin deal with mental illness in a traditional context?

I began to learn more about the Bedouin traditional healing system from my patients as well as from my family. Also, I started to go back to my own experience as a Bedouin and to think about the
traditional healing system, how this system functions, and why the Bedouin utilized it in response to emotional and physical illnesses. I was determined to get close to the patients, and to cultivate a mutual trust, in order to reach the goal of learning about traditional healing in Bedouin society from the patients' perspectives. One had said to me, "You do not respect this type of treatment and you laugh at the traditional system."

The question -- although never explicitly articulated -- was how could I, a western-trained, and in many respects a western practitioner, use my knowledge and skills in an effort to understand, and eventually to incorporate, the traditional healers' practice with what I was doing with my patients. Fortunately, there were several researchers who provided studies which provided me with an initial entry into the emerging topic of cross-cultural medical/psychiatric practice. Bilu's study (1978) among the Israeli-Moroccan, "traditional psychiatry in Israel" is most revealing. He described and analyzed Jewish-Moroccan ethnopsychiatry in Israel, as reflected in the reports of Moroccan-born traditional patients from two Moshavim and their healers. The outcome research of this population with psychosocial problems has demonstrated that traditional psychiatry has success rates of seventy percent, which are comparable to those of modern psychiatric interventions (Bilu, 1978). In addition, Bilu and Witztum conducted several studies among the Jewish ultra-orthodox patients in northern Jerusalem. They decided to join the patients and to treat them based on their perceptions, dream

Dr. Witztum is a psychiatrist working with religious Jewish patients in a community mental health centre, Ezrat Nashim, in Jerusalem. He established an ethnomethodological way of understanding the patients, their rituals, their interpretation of the diseases and integrating modern and traditional methods of treatment. Moreover, Witztum and his co-authors called for the psychiatrists and therapists in general to be profoundly aware of the patients’ cultural background (Greenberg & Witztum, 1991; Greenberg, Witztum, & Buchbinder, 1992; Heilman & Witztum, 1994; Witztum, Buchbinder, & Van der Hart, 1990; Witztum, Margolin, Bar-On, & Levy, 1992).

Similarly, Dr. Maoz, a Jewish psychiatrist, talked about his experience first as a GP and later as a psychiatrist. He stated, "I learned from my experience as a GP that in order to treat emotional and interpersonal problems, one needs more than medical knowledge, ‘natural’ empathy, patience, and devotion" (Maoz, Rabinowitz, Herz, & Katz, 1992, p. 6). Maoz described how he decided to join his patients and spent more time with them to understand the nature of their diseases. By acting this way he created good relationships with his patients and their families, so much so that even his patients asked him for personal advice in nonmedical matters (Maoz et al., 1992).

These researchers strongly influenced my emerging sense, as a
practitioner, of how we should respond to a Bedouin population. In this regard, I had to "unlearn" several wrong assumptions that had been imparted over the course of professional training. Social work practice in most Islamic and developing countries, it must be stressed, has followed the Western model in the belief that professional practice is universal. Al-Dabbagh (1993) states that after fifty years of social work practice in Arab (Islamic) countries, however, this model has largely failed due to its exclusion of religious values and spiritual aspects.

In many ways, my professional experience supports this claim. Social work practice, like many Western social sciences has not adequately dealt with cultural diversity.

I returned to university to pursue a master's degree in social work in 1988. One of the first areas in which I began formal research was the phenomenon of the Dervish (traditional healer) among the Negev Bedouin. My master's thesis was titled the "Role of the Dervish as a Mental Health Therapist in the Negev Bedouin Society: Patients' Expectations From These Treatments and the Extent of Materialization." This was the first study to examine the role of the traditional healers in treating mental illness, among the Bedouin of the Negev. A previous study had indicated that 70% of an examined population of Bedouin patients utilized the traditional healers in parallel with the modern treatment (Ben Asa, 1974); however, it did not examine why they utilized the traditional system, and who the traditional healers are.

My master's degree findings surprised me at first. I found
many patients utilizing the traditional healing system in parallel with the modern. The majority of the Dervishes' patients, as well, were satisfied with traditional treatments. What, I wondered, was wrong with the "modern" modes of helping? What was right about the "traditional" practices? Could the two co-exist in mutual understanding -- ultimately, could they nurture one another?

While working on the thesis I practised new strategies of dealing with the Bedouin patients who were referred to me for treatment. These included respecting their perceptions of the diseases or problems, their way of manifestation of their symptoms, and the cultural influence upon the patients' behaviours and symptoms. More attention was paid to the traditional healing system; to the therapeutic components in the traditional healing system; the combination of modern and traditional healing treatment with Bedouin patients; the family strategies when one of the family members falls sick; and lastly, how to bridge the gap between the modern professional and the traditional cultural canons (Al-Krenawi & Burman, 1995; Al-Krenawi et al., 1994; Al-Krenawi, 1993; Al-Krenawi & Graham, in press; Al-Krenawi, Maoz, & Shiber, 1995; Graham & Al-Krenawi, in press; Mass & Al-Krenawi, 1994).
The Present Study

The former study and my experience guided me to the present study examining the phenomenon of dual use of modern and traditional mental health systems by the Bedouin of the Negev -- since, in particular, this pattern of co-utilization is so prevalent. The present study addresses the following research question: What are the patterns of dual use of modern and traditional mental health systems by the Bedouin of the Negev? This central question leads to subsidiary questions related to the two systems involved in the treatment of these patients. Areas considered are etiology/explanation, diagnosis, symptomatology, prognosis, and course of treatment. There are no studies done on this topic among the Bedouin of the Negev; and little research has been undertaken in this area in general. Since Bedouin society is highly stratified by gender, the question of the impact of gender on the above areas had to be considered in detail.

The study examines three types of subjects: patients, psychiatrists, and healers. Of the patients, the initial sample was 60 Bedouin patients, all new referrals to the psychiatric outpatient system; 37 were female and 23 were male. The present study focused on a final sample of 10 male and 10 female patients who used the modern and traditional systems concurrently; and who were diagnosed in the modern system as neurotic, and in the traditional system as victims of sorcery, the evil eye and/or spirits' activities.
The second group of subjects were seven Jewish psychiatrists, who treated the Bedouin patients. Five were recent Russian immigrants to Israel; of these, three were male and two female. The remaining two were an elderly male Romanian and an Ashkenazi female psychiatrist-in-training. The seven psychiatrists graduated from medical schools in Russia, Romania and Italy. None spoke Arabic, and none were familiar with the Bedouin culture nor the Islamic religion.

The third group of subjects were 20 traditional healers who treated the same Bedouin patients. There were four types of healers. The first type included five Dervishes, three of whom were male and two female. The second type of healer consisted of five male amulet writers (Khatib or Hajjab). The third type of healer comprised six female fortune tellers (Al-Fataha). The fourth type were four male healers who treated according to the Koran (Sheikh-Din or Moalaj BelKoran) (two were Bedouin and two Arab from Gaza).

Can Traditional Healing and Modern Psychiatry be Integrated?

The study of traditional healing by anthropologists has gone through two broad phases. In the first, the main topic of debate was whether healers or shamans were mentally ill -- typically schizophrenic or epileptic. By the 1950s and 1960s, it was more or less firmly concluded that shamans were not like mental patients; and anthropologists accordingly began to ask about similarities
with psychotherapists. In the process, the explicitly religious dimensions of healing practices progressively receded as analytic attention became focused on therapeutic aspects of ritual healing (Fernando, 1991). The efficacy of traditional healing was assumed on the tenuous basis of what we may call the "psychotherapy analogy." That is, traditional healing works because it is like psychotherapy, which was presumed to work.

According to Jilek (1971), the shamans' image in Western thinking is changing; they are increasingly perceived as traditional healers-psychotherapists, in Western terms. Healers' techniques, such as suggestion, persuasion, and manipulation are similar to those used by psychiatrists (Frank, 1973; Katz, 1982; Kiev, 1964a; Nelson & Torrey, 1973; Ruiz & Langrod, 1976a; Seguin, 1973; Torrey, 1972b). Bravo and Grob (1989) pointed out that psychiatrists should be more open to learning from shamans, particularly regarding their perceptions of illness and its treatment.

Many studies recently conducted indicate that there are psychotherapeutic elements in traditional healing systems (Al-Krenawi & Graham, in press; Atkinson, 1987; Bankart, Koshikawa, Nedate, & Haruki, 1992; Daie, Witztum, Mark, & Rabinowitz, 1992), including such concepts as catharsis, venting and relaxation (Levi-Strauss, 1963a; Scheff, 1979). Moreover, studies show that there are several therapeutic approaches in the traditional system, at the individual, family, group and community levels (El-Islam, 1967; Grotberg, 1990; Hajal, 1987; Kennedy, 1967; Napoliello &
Sweet, 1992; Vontress, 1991). Thus, as modern services have become available, the patients have established an integration between the modern and traditional systems; but often they do so without telling their Western clinicians about this dual utilization (Nyamwaya, 1987; Rankin & Kappy, 1993; Waldram, 1990).

Hence we have a model of integration between both systems, initiated by the patients themselves. But it is mainly a unidirectional interaction between the two systems. Psychiatrists tended not to be interested in traditional healers. But the healers, in contrast, were interested in learning about what goes on in the modern system.

Most researchers' methods have been to describe a traditional healing practice and argue that it is effective for one or more of the following reasons: a) it establishes a homology between the symbolic and the experiential; the former metaphorically transforms the latter; b) it triggers a non-specific mechanism such as suggestion, catharsis, or placebo effect; c) it offers social support or the resolution of social conflict; and, d) it transforms the meaning of affliction for the sufferer through a rhetorically powerful, symbolic performance (Scheff, 1979). Rarely is the interactive process considered in detail; even more rarely is the experiential process examined, and almost never has a systematic comparison between traditional healing and psychotherapy been attempted by anthropologists, psychologists, or psychiatrists.

But what is meant by "rituals"? For purposes of the following study, "rituals" are defined as "prescribed formal behaviour for
occasions not given over to technological routine, having reference to mystical being or powers" (Turner, 1967, p. 19). In traditional societies, the ritual serves both as an occasion for healing and as an arena for shamans -- or other traditional healers -- to establish themselves as influential "men of powers" (Wolters, 1982) or wielders of "spiritual potency" for local communities (Atkinson, 1987).

The beauty and power of rituals also has been used in counselling and psychotherapy. Therapists have used rituals but have not always explicitly identified them as such as part of a psychotherapeutic framework (Cf. Palazzoli, Cecchin, & Prata, 1978; Van der Hart, Witztum, & de Voogt, 1988). Instead, they have usually been attributed the status of "off the record" therapist-initiated activity, stated as a task given to the patient yet with no explanation of its purpose (Yalom, 1980). Even when rituals have been given a legitimacy in therapy (Renner, 1979), there are few detailed accounts of how, when, and why rituals are used. A notable exception is an article by Rando (1985) outlining clinical observations.

This dissertation presents support for the position 1) that mental health practitioners would do well to learn about, appreciate and show respect for other cultures, particularly traditional and religious approaches to psychological healing; and 2) that they should, in their interventions, draw upon and support the conjoint use of traditional healing methods (e.g., rituals) embedded in the patient’s religion and culture (Azhar, Varma,
Dharap, 1994; Koltko, 1990). My central argument is that, in view of commonalities in healing approaches, mental health workers and, more importantly their patients, would likely benefit (i.e., in outcomes) from implementing the above position.

Based on the similarities between the modern and traditional mental health systems, many researchers have called for integration between both systems (Ezeji & Sarvela, 1992; Heilman & Witztum, 1994; LaFromboise, Trimble, & Mohatt, 1990; Jilek, 1994; Lambo, 1978; Lin, Demonteverde, & Nuccio, 1990; Ogunremi, 1987; Schwartz, 1985; Wessels, 1985). The following study supports this view that there is a place for integration between both modalities of treatment for the benefit of the patients. Since the mental health practitioner's task is to promote the patient's welfare, how can such traditional models of helping be overlooked? Moreover, the dissertation is one of few studies (See also Press, 1969; Nyamway, 1987; Woods, 1977) to examine dual use and integration of mental health systems from the standpoint of the patients. In so doing, the study emphasizes what can be learned from patients about the possibility of integration; and what may be the prospects both for mental health workers, including social workers, and for traditional healers.

Finally, it should be noted that the Bedouin have inhabited the Negev for centuries. Traditional culture and ways of life have proven persistent. This society, despite the impact of modernization, has tried to keep to its roots in several matters. Women's socially-proscribed roles have remained, by the standards
of the west, relatively traditional. So too has there been a persistence of traditional ways of dealing with disease in general and especially mental illness. But the Bedouin also have adapted techniques from the modern mental health systems and have combined them into the Bedouin culture. In this "acculturation process," they resist leaving old approaches, but do not reject the modern. This adaptation, in fact, is a microcosm of a broader reality: because of the living conditions of the Negev, Bedouin in virtually all aspects of life have developed strategies of coexistence between both worlds. Throughout history, forms of traditional healing have existed, and the modern period is no exception.

The Structure of the Dissertation

The chapters are set out as follows:

The introductory chapter provides an overview of the study and the central issues with which it deals and the interest of the researcher in studying this topic. Chapter two deals with the Bedouin background of the research population including gender differences, social class and the traditional healing system. Psychological aspects and medicine in Islam also are discussed.

Chapter three examines the theoretical underpinning of the two mental health systems. It describes their religious origins and parallels among different psychotherapeutic approaches. It also examines the analogy between modern and traditional mental health systems based on religion; and reasons for taking religious and
ritual healing seriously. The rituals and the role of symbols, focusing on the traditional healing rituals and their therapeutic significance. It also examines the role of rituals in various Western systems of psychotherapy, including a social work approach. In addition this chapter highlights the issue of integration between the modern and the traditional mental health systems; similarities and differences between both mental health systems are set out.

Chapter four describes the research questions. Chapter five outlines the study's methodology and design. Chapter six analyses the encounter of the Bedouin patients with the modern psychiatric system. Chapter Seven describes the encounter between the patients and their traditional healers. Chapter eight analyses the experience of dual use of the traditional and modern mental health systems, and discusses major findings regarding the entire patient population under study. The concluding ninth chapter summarizes the main findings of the study, and outlines principles for modern practice with the Bedouin population, as well as the role of social work in the primary health care. It also highlights the links of Islam and social work, particularly with reference to a more culturally sensitive practice theory. And it considers directions for further research.
Chapter Two

BEDOUIN SOCIETY--AL-BADU

Introduction

This chapter deals with the background of the research population, and why, in particular, they are predisposed to use a traditional mental health/healing system. It begins with a discussion of the background of Bedouin society, including its tribal, kinship, familial, social class, and gender structures. Attention is given the political and spatial patterns of village settlement; the concepts of mental illness and healing in Bedouin society; contemporary methods of traditional Bedouin healing; and various aspects of healing, as determined by Islamic religion.

Bedouin Society; General Background

The Bedouin Tribes

"It is impossible to know a race or tribe of people unless you understand them. It is equally impossible to understand those people unless you know them. To know them you must live with them. You need not think as they do; nor need you act as they do in all things. At least you must rub shoulders, eat with them, if you would have complete understanding." So wrote Aref Al-Aref in a book about the Bedouin in the Negev (southern Israel) (1944, p. 1). Westerners typically have difficulty understanding the complicated
lifestyle of the Bedouin.

"Bedouin" is a general name for all the wandering tribes in the Middle East and North Africa that originate from the Arabian peninsula (Jazirat-Al-Arab). The name is rooted in the word Badia, which means "desert." Kay (1978) described the Bedouin as follows:

...nomadic Arabs who live by rearing sheep and camels in the deserts of the Middle East... The word "Bedouin" is the Western version of the Arabic word badawiyn which means "inhabitants of the desert," the Badia. Strictly speaking the term "Bedouin" should only be applied to the noble camel herding tribes, but again it has been used as a general term in English to cover all nomadic Arabs. (p. 7)

To both Arabs and anthropologists, the name Bedouin implies not only a certain life style, but also a certain social status, social origin, social organization and set of values (Marx, 1974). Coon, in the Encyclopedia of Islam (1960), defined Bedouin as "pastoral nomads of Arabian blood, speech, and culture... found in the Arabian peninsula proper and in parts of Iran, Soviet Turkestan, North Africa, and Sudan" (p. 872).

Now Muslims, the Bedouin in the Negev, Southern Israel, have lived there since before Islam or Christianity became established religions (Hebrew Encyclopedia, 1954). The Bedouin community of the Negev consists of numerous tribes which used to be nomadic or semi-nomadic, deriving their subsistence from a combination of dry agriculture and herding goats, sheep and camels. Reichel, Newmann, and Abu Saad (1987) have stated,

The Bedouin in Israel constitute a ...traditional, conservative Middle Eastern society, operating within a modern, Western-oriented country. The Bedouin... have developed a well-defined value system that instructs, directs, monitors and sanctions behaviour and interpersonal relations. Consequently, patterns of behaviour are predictable, with a
The Negev Bedouin are of Arab descent and came to the Negev from the Arabian peninsula and from Egypt via the Sinai (Ginat, 1966). They have until the last twenty-five years obtained their livelihood by exclusively practising pastoral nomadism. These pastoral nomads move cyclically within an arid zone. During the period of Turkish and British rule (A.D. 516-A.D. 1918 and 1918-1948 respectively), the Bedouin were the sole inhabitants of the Negev and lived according to the stringencies of physical environment (Ginat, 1966). The small town of Beer-Sheva in the northern Negev served as an administrative centre for the Bedouin (Al-Aref, 1934; Flah, 1989; Maddrell, 1988; Sharon, 1964).

Historically the Bedouin lived under domination of several countries including Turkey, England, and Egypt. Since 1948 they have lived under Israeli rule. The post-1948 period has been characterized by an initial expulsion/exterrmination/fleeing of 80% of the Arab population from the region. The 65,000-95,000 Bedouin of the Negev were reduced to fewer than 13,000 by 1951, and the structure of tribes and tribal confederations was severely disrupted (Flah, 1989; Maddrell, 1988). For an eighteen year period, between 1948 and 1966, the whole Arab population of Israel lived under military rule. After 1966, they were accorded Israeli citizenship. Their population gradually increased, so much so that their number today about 80,000. Of the Bedouin, 40% live in villages, and 60% live semi-nomadically outside of the villages (Association for Support and Defence of Bedouin Rights in Israel,
1991). An increasing proportion of the population in today's villages works in industrial or service fields.

There are three types of Bedouin who live in the Middle East region, divided according to the kinds of animals that they rear:

1. Rahalah. Fully nomadic, these Badu who have no specific person in charge, are called Rahalah or Aljammale (people who rear Camels). They call themselves the original Bedouin; they are found on the desert of Syria and the Arabian desert. Their movements are far from settlements and from authorities (Gabriel, 1960; Ginat, 1966; Sharon, 1964).

2. Maazh. These people raise goats; they live in the desert in places where they can find grass for their flocks and water for their animals and for themselves. They did not move to far places because of the needs of the goats.

3. Shawwaye. These people rear sheep; their life conditions resemble those of the Maazh.

The Bedouin in the Negev are Maazh and Shawwaye. They also rear camels, and some of them work on the land (Ginat, 1966; Salman, 1980). Although they come closer to the "ideal type" of Bedouin, they are a far cry from the North Arabian nomads so well described by Burckhardt (1830), Doughty (1936) and others. In the Negev, there are also a large number of peasants (Flahin) newcomers among the Bedouin, but the old, established herdsmen are politically the dominant element. The latter are organized on a tribal basis, and pastoralism is one of their major sources of
income, second only to farming.

Bedouin life in the Negev has been, and is being, shaped by complex environmental factors. These can be grouped under four headings: there are, first, the geographic factors, such as the land, the water, and the climate of the area. Second, there is the politics of the Israeli administration, with its bureaucratic machinery, and the special Military Administration for the Bedouin of the Negev. Third, there is the strong, growing Israeli economy involving wage labour, taxes, and so forth. And lastly, there is the cultural background of the Bedouin: their Islamic religion, Arab language, and the other cultural strands connecting them to Middle Eastern society, not to mention their own particular history.

Each of these factors impinges on Bedouin society in many ways, and one cannot always identify the specific effects of a single factor. This is particularly true of the cultural factors. So inextricably are these cultural factors bound up with the organizational aspects of Bedouin society, that it would be futile to treat them separately. It is feasible, however, to present the ecological data and to analyze the administrative framework as it affects the Bedouin. The ecology and the administrative framework combine to form the environment within the Bedouin live; they act in many ways as delimiting, boundary-setting factors to the Bedouin individual’s range of action (Marx, 1974).
The Structure of the Bedouin Society

Bedouin tribes are divided into units of different sizes based on kinship and descent. The partitioning of the Bedouin social scale is, from largest to smallest: a confederation ("Qabilah"), a tribe ("Ashira") and enlarged family ("Hamula") and Ahl or Ailah (family) (Al-Aref, 1934; Al-Fual, 1967; Ginat, 1966; Marx, 1974).

The confederation (Qabilah). The confederation (nation) is the largest unit, and it includes a group of tribes collected together as a union; but in fact it is only an association to gain comfort and a sense of belonging to one polity because each tribe has its own settlement. As mentioned before, the nation does not belong to one place; its unity goes far back in generations. The reason for the association, the origin of the nation, is given in an ancient patriarchal legend: The leader of this association is called "Sheikh Al-Mashaikh," (the leader of leaders) and all the leaders of the tribes were subject to him. Therefore, the mutual bond for all tribes was based on the same traditional origin (Al-Aref, 1934; Al-Gamdi, 1990; Marx, 1974).

The tribe (Ashirah). The tribe is a union of families (A-ial) which stay, wander, shepherd and work the land together (or, at least, on a mutual basis) under the rule of the leader of the tribe (Sheikh). The tribe is a united community, well organized, but it includes smaller social groups, for instance, a number of extended
families (Hamula). The tribe lives in a specific territory, speaks a special dialect and recognizes its own unity. With the assistance of a committee, the Sheikh serves as judge (Al-Aref, 1934; Al-Fual, 1967; Ginat, 1966; Marx, 1974).

The extended family (Hamula). This unit includes a number of generations. Members had an ancient, common father from the past; hence there is a closeness among several families. Usually members of the Hamula try to keep in touch with their fellow members no matter where they are. The principle of a mutual guarantee of security among all is very strong in this group; Marx (1974) calls these groups "security guarantee groups". Weddings are made between couples from the Hamula. Each Hamula has a representative in the forum that makes the decisions in the tribe; usually he is the oldest male in the Hamula (Al-Aref, 1934; Cohen, 1965).

The family (Ahl or Ailah). If we look into the ways of life of the tribe, particularly the extended family, the man is the dominant authority for all family decisions and is responsible for all the family's relationships with others. Thus the family system is a kind of communal arrangement headed by a patriarch who is always the final authority; everyone, including his sons, their wives, and their children, is under his aegis (Al-Krenawi, 1993; Al-Krenawi et al., 1994; Ginat, 1966; Kacen, Anson, Nir & Livneh, 1992).
The Social Stratification; Social Class

The Arabs divide themselves into two main groups: Al-Hadhar and Ahl wabbar-Badu. Al-Hadhar are those who dwell in permanent stone or mud houses, i.e., townsfolk or villagers; Badu are those who live nomadic lives, own camels and live in black, hair tents (Dickson, 1949).

There are three social strata in Bedouin society: True Bedouin, peasants (Flahin), and the slaves (Abid) (Lewando-Hundt, 1978; Meir & Ben-David, 1993). The mainstream of the Bedouin society is divided into the following Qabials or Sfuf "nations" or "confederations" in the Negev: Tayaha, Azazmah, Gderat, Zullam, Tarabeen (Al-Aref, 1934; Marx, 1974). According to Bedouin standards, True Bedouin belong to one of the above nations. Those who do not belong to one of these nations are considered by the Bedouin as Flahin.

Before the Israeli state was established, there were Arabs from Gaza who emigrated to Palestine and lived among the Negev Bedouin. The Bedouin call them Flahin (singular, Flah). The Flahin worked the tribes' lands; some of them became shepherds for the Sheiks. When the Israeli state was established, the Flahin were considered as a part of the tribes. The Bedouin attitude toward the Flahin is that they are inferior to the Bedouin; they did not own land; they merely worked as shepherds on lands belonging to the tribes. The True Bedouin men marry women from the Flahin; but conversely, they forbid any Flah man to marry a Bedouin.
woman, even if the woman wishes to (Bar, 1985; Lewando-Hundt, 1978; Marx, 1974).

Lastly, there are a group of 'slaves,' Abid; they are considered to be inferior to the Flahin. According to the Bedouin, Abid were brought from Sudan and Egypt to the Negev as slaves. (Al-Gamdi, 1990; Bar, 1985). Similar marriage strictures, as noted above, affect the Abid.

Since the Negev became inhabited by Jewish settlements and Kibbutzim there are more opportunities for work. Bedouin lost their land, and as a matter of necessity, looked for jobs outside their tribes. This situation helped erase economic differences between the Flahin and the True Bedouin. With the passage of time, the gap between the True Bedouin and the Flahin Bedouin disappeared. The Flahin became rich and more educated than some of the True Bedouin (Ben-David, 1994). Even with the progress that the Flahin achieved, there are social differences between both groups such as marriage and social status as measured by belonging to the mentioned above nations. This situation creates tension and competition between the two groups (Ben-David, 1994; Meir & Ben-David, 1993).

The third group is still in the lowest status and they have not achieved advancement comparable to the two other groups. In Rahat, for example, this group have a higher rate of unemployment, a lower rate of education, and their economic situation is very low. The modern transition has put this group into a hard situation. They are influenced by the modern society, but many
have not adapted well, turning to drugs and alcohol. Such a situation has created social and family problems at different levels.

**Women in Bedouin Society**

*Sexual differentiation; Living space.* The norms governing the use of living space are very constant despite the fact that the Negev Bedouin live in a variety of dwellings. They live in tents, huts or houses. There are two kinds of tents. The winter tent (*bit asstia*) is made of strips of woven goats' hair which are sewn together. The summer tent (*bit assayf*) is made of jute sacks which are sewn together. The huts (*sirif*) are made from wood, or a mixture of straw and mud (*tibn*), or tin sheeting. The house (*bit hagar*) are made of stones or cement blocks (personal communication with Kamis Al-Krenawi, the Sheikh of Al-Krenawi tribe, 1994).

There is a certain principle governing the use of living space which is common to all families, whatever their economic basis and whatever the type of dwelling they live in. This is a division of dwellings into two sections. The divisions dividing the two sections take different forms, depending on the type of dwelling. In a tent, this division is made by a strip of woven sheep wool and goat hair (*manad* or *mahraam*), which in direct translation means ‘forbidden.’ In a hut or house, there are usually two different sections (or rooms) which have separate entrances.

These two sections have been called the ‘women’s section’ and
the 'men’s section.' These labels were derived from the fact that only male guests use the men’s section. What has been overlooked is that women of the household also sit in the men’s section when no unrelated, strange men are present, and that related men have access to the women’s section. Therefore it seems more accurate to consider this division of the home as one area exclusively for the family, and one area in which guests and strangers are received. The family section becomes specifically for women when male guests are present. These two areas within the home may also be viewed as a "front region" and "back region" in Goffman’s terminology:

We often find a division into a back region, where the performance of a routine is prepared, and a front region, where the performance is presented. Access to these regions is controlled in order to prevent the audience from seeing backstage and to prevent outsiders from coming into a performance that is not addressed to them. (1959, p. 239)

The women and family area is clearly a back region. It is usually messy by comparison with the guest section; untidy both physically and socially. There are in fact two different worlds which exist at the same time: the men’s world which is more public, and the women’s world which is more secret. Abu-Lughod (1985) pointed out that women spend much of their time apart from the men, living with the children in a separate world as some sort of community within the larger society. The Bedouin everyday social world is divided in two. In one half are adult men, in the other are women and children. There are different values and customs for the men and for the women; each gender has to follow its own codes. Therefore the Bedouin society has to teach children and young
people--male and female--their prescribed position, and roles in the divided society.

The two worlds coexist side by side, a function not of the wishes and power of particular men, but of the sexual division of labour and social system structured by the primacy of agnatic bonds (those between male and female parental kin) and the authority of senior kinsmen, and maintained by individuals whose attitudes and actions are guided by a shared value system. This society emphasizes notions of independence and autonomy in which a person’s status depends on his or her distance from social and natural sources of (perceived) weakness and lack of control. This code of honor and modesty discourages outward expressions of sexuality. The denial of sexuality is best expressed by avoiding members of the opposite sex with whom one might have a sexual relationship. Hence there develops the system of sexual segregation, upheld equally by men and women who wish to be respectable members of their communities and who derive their social positions and support through the family and tribe (Al-Abbadi, 1973; Abu-Lughod, 1986, 1985; Altorki, 1986; Dodd, 1973).

Honor (Ard). The concept of "ard" has deep roots in Bedouin society. It is normally translated into other languages as "a woman’s honor." However, when a Bedouin speaks of unsullied ard, it in fact has a wider, more familiar meaning. First, it signifies that no man has ever dared to dishonor him by dishonoring his wife or daughter, which means that he and his forebearers were powerful
enough to deter any outsider from looting their property or raping their women. Second, it indicates that he owes no moral debt and carries no stain upon his honor that would force him to sacrifice all he has to remove it. Bedouin believe that it is possible to erase any mark of shame—ar—that a man may sustain except a stain on his ard; The latter remains forever (Abu-Lughod, 1985; Arad, 1984; Dodd, 1973; Ginat, 1987; Mass & Al-Krenawi, 1994; Peristiany, 1974).

Because ard is so important for the Bedouin and Arab in general, the practices of sequestration and "protection" of women were developed. The Bedouin call the women Hariem, which comes from the root of Maharam (forbidden). The women's section in the house or the tent, Maharam, is forbidden to anybody except family members. This section of the house represents the man's honor. Likewise, there are several terms that the Bedouin use when they refer to females such as Aorah (in direct translation, disabled); Weliah (meaning that the woman is protected and supported by the man). All of these terms reflect the Bedouin concept that the women represent the man's honor; therefore she is under his protection and her behaviors are controlled by him (Al-Abbadi, 1973).

Traditional Bedouin communities were organized as warrior tribes, an organization that led to a division of roles between the sexes. While the man carries all the duties concerning outside affairs and politics, the wife deals with household duties and takes care of the children, especially the boys (Al-Krenawi, 1993;
Kacen et al., 1992). The Bedouin used to say "Al-Aolad Llfazah wa Al-banat Llrazah," meaning "the boys for war time and the girls for song" (Ben-David, 1982). In Bedouin society, sons have higher status than daughters. Sons are registered in the fathers' name, whereas daughters are registered in their mothers' name (Al-Abbadi, 1973; Habash, 1977; Kacen et al., 1992).

In Arab society, women are regarded as somewhat untrustworthy, since historically men have not trusted women's physical and intellectual capacities and since they can be sexually threatening (Al-Abbadi, 1973; Al-Aref, 1934; Sanua, 1979). In Libyan society, women are perceived as "physically and mentally weak in comparison to men" (Attir, 1985, p. 121). A similar situation is found in almost all Arab societies (Al-Khammash, 1973; Al-Sadawi, 1985, 1983; El-Islam, 1975; Fler-Lobban, 1993; Kaki, 1989). And so women face strict societal limitations (Al-Krenawi et al., 1994; Arad, 1984; Ben-David, 1982; Kressel, 1986; Mass & Al-Krenawi, 1994).

In Bedouin culture, women are closely associated with temptation and seduction, as is evidenced in the Koran (Koran, Surah Ysusuf, v. 25-30). Muslims believe that, through women, the evil spirit (Iblis) tempts and misleads them, hence the saying: "Whenever a man encounters a woman, Satan is also present." Satan is the offspring of Iblis in Islamic theology (Mass & Al-Krenawi, 1994).

The good behaviour of the women in a Bedouin man's family, whom he is considered to own, supports his honor. To keep the
honor of the family inviolate, tradition has restricted a married woman’s social connections to the family cell. A woman must not be absent from her husband’s home except for everyday obligations. Females learn these rules by heart in childhood, and the rules gradually become more severe as she matures to womanhood. All her life she is controlled by a guardian, although her family and social status change when she becomes older (Ben-David, 1981; Lewando-Hundt, 1984).

Life stages. The Bedouin woman passes through three stages in her life, identifiable by her clothing; in each phase she has a different status, and the prohibitions on her social relationships change accordingly. From the age of ten until her marriage, she is separated from boys. The characteristic clothes for this stage are a traditional dress with blue embroidery (blue means she is single); a white mantle beneath a black shawl (abaya), which covers the whole body; and a blue belt (safia). She is forbidden to wear makeup or have contact with anyone who is not a close family member. Her social status at this stage is low.

The second stage is signalled by marriage. After the wedding, embroidery and belt become red. She can wear makeup—a symbol of fertility—and everyone who sees her knows she is a married woman. Her social network is extended beyond her father’s to include her husband’s home. The ideal woman brings many male babies to her husband’s family and is treated with honor and respect. Her status is strong because she relies on her sons’ power, and her social
contacts increase (Ben-David, 1982). The position of a woman who bears only daughters is very low, and her husband is encouraged to marry a second wife who can bring him sons (Al-Abbadi, 1973; Al-Krenawi, 1993, 1987; Al-Sadawi, 1980; Levi, 1987; Habash, 1977).

At the third stage of a woman's life, after menopause, there is a tendency to return to the blue embroidery and belt, now symbolizing nonfertility and nonsexuality. Her social relationships widen, and her social position rises. She sits with the males of the tribe and is in charge of hospitality when her husband and sons are absent. At this stage of their life cycles, women are not considered "dangerous" and "contaminated," but as respected matrons (Al-Krenawi, 1988; Lewando-Hundt, 1984; Maoz, Antonovski, Datan, & Wijesnbeek, 1970; Mass & Al-Krenawi, 1994).

Marriage is usually arranged by the fathers, when the parties are young and without consulting their wishes. The Koran gives more power to men than to women: "But men have a degree of advantage over the women" (Koran, Surah, II: 228). Further, men sometimes take more than the four wives allowed by the Koran (Al-Aref, 1944).

In case of divorce the husband is entitled to take all the children irrespective of age (Al-Aref, 1944). Thus many women endure an undesirable marital situation rather than lose their children. A divorce also knows that she can only remarry as a second, third, or fourth wife, or with an old man (Al-Abbadi, 1973; Al-Krenawi, 1993; Mass & Al-Krenawi, 1994). Bedouin women are thus at a structural disadvantage in family and society, where they are
left without recourse against the strictures of their social canon (Al-Krenawi et al., 1994; Mass & Al-Krenawi, 1994).

The place of women vis-a-vis men is being affected by changes in some of the Bedouin communities in Israel today. Women are frequently collaborating with their husbands in the handling of affairs outside the tribe; for example, women deal with the family's health problems, taking the children to health clinic. Provided with such a legitimate opportunity for social contact without family intervention, some of the women arrive at the clinic early and sit in groups, waiting and talking. Nevertheless, because every visit outside of the home has to be justified, they tend to bring a prescription for medication home with them (Al-Krenawi, 1993; Mass & Al-Krenawi, 1994).

The institution of polygamy leads to personal difficulties and social conflicts. The situation of a second wife can make her an object of pathos as well as a target for aggression (Strathern, 1972). Also this leads to fights and jealousy between the women, which may affect them psychologically (Al-Khammash, 1973; Al-Krenawi, 1993, 1987; Levi, 1987; Lewando-Hundt, 1976). Makanjuola (1987) reported that Nigerian co-wives and female rivals often feature prominently in the delusions of women patients. Among tribes, problems with co-wives and their families are also common associations of psychiatric disorders.

Polygamy has always been the accepted way of life in all Bedouin tribes in the Negev, and is widespread even among the more educated people (Al-Krenawi, 1987; Kaki, 1989). An explanation of
such a phenomenon is that in the Bedouin society, often the marriage is arranged by the parents while the couple is young. When the man grows up, starts to work and becomes independent economically, then he decides to marry a second wife. In fact the man was forced into his first marriage, but because of the family pressure and honor, he agreed. However, it is culturally acceptable to marry two or more wives; so these men find it is easier to marry a second wife rather than to get a divorce and fight with their families. The Bedouin prefer that a man marry a second wife rather than divorce his wife. Such situations indicate that the issue of polygamy is deeply rooted in the Bedouin and Arab cultures, even among the well educated and young males.

Another institution which causes suffering among Bedouin women is female circumcision (Thoor); the root of the word "Thoor" comes from "Taharah," purification. Some tribes still practise the ritual. The purpose of this act is to make the girl pure and to suppress her sexuality. This ritual is still practised in several Muslim countries such as Sudan, Egypt, Somalia and South Africa (Al-Sadawi, 1980, 1983; Al-Safi, 1970; Bishara, 1989; Toubia, 1985; Van der Kwaak, 1992). Circumcision is a sacred women's ritual performed by women; its persistence reflects, in part, the conservatism of Arab women (Al-Sadawi, 1980, 1985; Toubia, 1985). In a patriarchal system, women are tools for gaining social honor. Yet they receive and experience honor only indirectly, through the honor of their men, families and tribes. Grassivaro (1986) concluded, in an analysis of the psychological concomitant of
circumcision, that most women of Somalia, regardless of age, social status, or ethnic extraction, advocate continuation of the practice and are in favor of circumcising their daughters.

Psychological distress. Given the aforementioned social constructions of gender, and consequent social relations, it is not surprising that Bedouin women encounter numerous psychological, and psychosocial problems. But how are these experienced? In traditional societies, it should be remembered, those with familial and social problems often report somatic symptoms (El-Islam & Abu Dagga, 1992; Racy, 1980). Several studies have dealt with the topic of somatization among Arab women. Pamela-Ann (1987), in her investigation of psychopathology in Tunisian women, stated that the Bedouin women reported symptoms of somatization, anxiety, depression, and psychosis more than the urban women in Tunis. Similarly, women in the Gulf countries and Egypt expressed their emotional difficulties by symptoms of somatization (Al-Sadawi, 1977, 1983; El-Islam, 1975; El-Islam & Abu-Dagga, 1992; Kaki, 1989; Racy, 1980).

Al-Sadawi (1977) reported that the rate of neurosis among Egyptian female University students was 9.1%. Al-Sadawi concluded that the Egyptian society treats women badly, ignores their wishes, and imposes the men's wishes on them. She cited several cases to illustrate how Egyptian women struggle and suffer emotionally, while their families and the society ignore their struggle and suffering. She reported that male babies have higher status than
female babies, even among the higher class in Cairo. The families ignored the female babies and focused attention on their male babies' future. This study also dealt with the Egyptian women who live in the rural areas and are of the lower class. Generally these women are even more oppressed than urban women; Al-Sadawi found that they did not seek services from the modern psychiatric system. They found answers to their emotional problems in the traditional healing system.

As well, Sidqi (1985) stated that the women in the Arab world suffer a great deal of mental illness because of the Arab social structure (cited by Kaki, 1989). Similar findings are given by Al-Saati (1984). She concluded that the Egyptian women in general suffer a great deal, while those who live in rural areas show even greater distress; they deal with their emotional difficulties by turning to the traditional healing system.

In a recent report, McGrath, Keith, and Stricland (1990) proposed that the higher rate of depression in women is not the direct result of biological differences between the sexes. Rather, they attribute this extra burden of depressive illness to a "biopsychosocial" combination of risk factors that operate to women's detriment in contemporary social settings: historically sanctioned passive-dependent behavioral patterns, physical and sexual abuse. Agoraphobia has been reported to be more prevalent in women. This phobia has been attributed, at least in part, to fear of object loss, separation, anxiety, and self-punitive efforts to control aggression (Regier, Myers, & Kramer, 1984).
Reproductive events, including menstruation, pregnancy, childbirth, and menopause, sometimes trigger mental illness in women (McGrath et al., 1990).

The problems of Bedouin women have been somewhat alleviated as the Bedouin communities become more modern. Bedouin men have more opportunities to participate in the (Israeli) society at large. They take jobs outside the tribes (Kressel, 1976; Meir & Ben-David, 1993). Thus the men in Bedouin society find themselves involved in a modern society, through education, and employment. This situation may affect their perceptions and attitudes regarding several issues, including those concerning women. This process of acculturation may also put Bedouin men in a situation of conflict as a result of the clash between modern and traditional social norms. In spite of the change that the Bedouin society is undergoing, men are still very rigid in terms of matters that concern women (Kressel, 1986).

Women symbolize the family honor, which is very important even for the educated among the Bedouin society. From an earlier study (Al-Krenawi, 1988), it was found that 97% of Bedouin high school students said they would not agree to marry a woman who had lost her virginity. There is a legend that the daughter of the Prophet Muhammad, Fatima, recommended "a separation between men and women" (Al-Bostani, 1988, p. 254). As one can see, Islam emphasizes the issue of sexuality in encounters between male and female (Al-Bostani, 1988; Al-Issawi, 1988). Regardless of the acculturation that the Bedouin society is undergoing, Islam and the social norms
couninually remind them of the issue of ard, and that separation of the sexes must continue. But having stated this, as the dissertation shall demonstrate, Bedouin women in a patriarchal context sometimes suffer (Al-Krenawi, 1993; Al-Krenawi et al., 1994), and, like their counterparts in other Arab cultures, may be vulnerable to mental illness (Al-Issa, 1990; Al-Sadawi, 1977; El-Islam, 1994; El Sayed, Maghraby, & Hafeuz, 1986; Grotberg, 1990; Racy, 1980; Sanua, 1979; Suleiman, Mossa, & El-Islam, 1989; Swagman, 1989).

Life in the Government Settlements (Villages)

It may be argued that recent developments in Bedouin settlement patterns have not been beneficial, with respect to a mental-health promoting social environment. Government settlements for Bedouin were begun in the late 1950s in Galilee, and a decade later in the Negev (Flah, 1983; Medzini, 1984). Today there are five planned settlements in the Negev and six in Galilee. The experience of moving into a planned village has been traumatic for Bedouin families and particularly for the older generation (Al-Krenawi et al., 1994). Living in close proximity to other households and next to other tribes is a difficult and stressful change for many families. Some, especially in the Negev, previously lived out of earshot of the next household and would feel their privacy invaded by a stranger passing within a hundred meters of their home. In the settlements women are much more
exposed to the men of other subtribes who may pass in the street or live in an adjacent neighbourhood. To avoid this, the women are required to remain in the house much more. In the old setting with wooden houses and particularly with tents, any problems with neighbouring households could be relieved by moving to another part of the family's land.

The Negev's first planned settlement, Tel Sheva (1965) was not built with separate neighbourhoods for the different tribes, and the government-built houses were close. The scheme was very unpopular, and twenty years later many of the original houses are still vacant or inhabited by non-Bedouin Arab school teachers (Medzini, 1984). When establishing Rahat, the next settlement, the authorities designated a separate area for each tribe and allowed each to build its own houses (Medzini, 1984). This has reduced some of the problems and today, as its population approaches 25,000, Rahat is regarded as a success by the government (personal communication with Talal Al-Krenawi, the mayor of Rahat municipality, 1994). It is easily the largest planned Bedouin settlement, and the first Bedouin city in Israel. The smaller villages have fewer than 1000 inhabitants.

In all the settlements the houses are large, two-storied concrete buildings with flat roofs, often spacious enough to house one or more married sons as well as the nuclear family. This feels cramped to the Bedouin, but to many Jewish-Israeli flat-dwellers, the Bedouin villages appear luxurious in this one respect. Families feel pressured to compete in building large houses and
often run into financial difficulties although they do most of the building work themselves. Houses frequently remain unfinished for years while the families live next to them in temporary structures and tents. Sons are persuaded to assist by leaving school and working.

Ben-David (1988) pointed out that the transition that the Negev Bedouin society is undergoing exposes its members to an unfamiliar way of life, without tools to cope with the change. Some Bedouin families have been placed in extremely hard positions and experience a sense of helplessness. They face mental and social problems as a result of the transition (Meir & Ben-David, 1993). In the changing Bedouin society, new problems have emerged, such as drug, alcohol abuse, among other conflicts between modern and traditional values. Nevertheless, the Bedouin are learning how to integrate the modern society and their own culture. One can see this in several ways, such as building tents beside the houses, and rearing sheep, cows and other animals in the villages. Ben-David (1994) reported that the Bedouin are asking for more schooling for their children and for better Bedouin schools; in the meantime, they appeal to the policy makers to include the Bedouin heritage in the school curriculum because they do not want to lose their roots.

Some of the Bedouin population in the Negev have adopted the integration strategy, because their primary school structure is that of the tribe, with its norm of collective responsibility. Collective responsibility manifests itself in two major ways: mutual assistance and blood revenge (Ginat, 1987). Every member of
the Bedouin society has rights and obligations to his or her own family, extended family and the tribe. In times of crisis or disease he or she gets support from them, which of course reduces the stress of the transition that this society is undergoing. On the other hand, the individual has commitments to the "co-liable group," and as a part of the group has to follow the cultural roles; if not, he or she will be placed in a marginalized situation (Ginat, 1987; Marx, 1974). In general, the Bedouin of the Negev have found the integration strategy to be the best way to survive under the influence of the modern society. They have tended to absorb new ways and have adapted them into their own culture, as will be demonstrated throughout this study. The following section deals with the traditional healing system among the Bedouin of the Negev.

Mental Illness and Healing in Bedouin Society

The Traditional Healing System

This section describes how the traditional healing system developed historically through three periods of time, and how each period affected later ones in terms of dealing with mental illness. Throughout history, traditional healing systems have existed, successively adapting to each new era. These may be divided into three major periods: pre-Islamic, Islamic, and contemporary.

The pre-Islamic period. In the pre-Islamic period, called in
Arabic Jahelia, which means "darkness," people worshipped stones, trees, idols, stars and spirits (Al-Shatti, 1977; Magzali, 1982). If anybody became diseased, he or she was referred to idols or to the healers of the tribe for help (Al-Haj, 1987).

Trade relationships with countries such as India, China, Egypt and Greece resulted in a classical medicine, whose practitioners were herb doctors, fortune tellers and faith healers (the faith healers were called Al-Khanah and Al-Arafeen) (Al-Haj, 1987; Al-Shatti, 1977; Caliph, 1984; Jingfeng, 1988). These healers treated people who were thought to be attacked by the spirits. The treatment was connected with magic. The healers and the people in the pre-Islamic period believed that diseases were caused by various supernatural powers or spirits (Al-Juhri, 1980; Al-Shatti, 1977; Caliph, 1984).

The pre-Islamic Bedouin believed that the spirits inhabited wells, rivers, springs and trees. The nomad felt at risk within a hostile and unstable world. Over the centuries, the nomads had learned self-reliance and developed ways of dealing with illness and injury: they were skilled in the use of desert plants, camels’ milk and honey. They believed in magic (Shr) and had magical beliefs about diseases (Al-Njaar, 1987; Magzali, 1982; Penelope, 1983, 1975). Many ancient approaches to treating disease survive today.

The Islamic period. Against such a background, the new religion of Islam offered faith in one God who was more powerful
than all the tribal gods or the innumerable spirits. The Koran itself is described as "a healing and mercy to the believers" (Koran, Surah 17, v. 17). "Illness" is said to be spiritual, and "those in whose hearts there is sickness" are called the hypocrites in Medina and suspected of secret plotting (Koran, Surah 5, v. 52).

The Muslim approach to all aspects of life, mental health included, are concisely expressed in a verse from the Koran and in the tradition Hadith. The Koran, Surah Al-Tuba, v. 51, states: "Nothing shall befall us save that which Allah has ordained for us. He is our protector. And in Allah then should the believers put their trust." In the Hadith we are told, "No disease Allah created, but that he created its treatment" (Al-Bukhari, 1974, p. 365).

The philosophy of traditional Bedouin medicine draws its strength from a reliance on one of the basic tenets of Islam: the belief in fate, that all things that happen to a person, both good and evil, are the will of God. According to the Bedouin, both health and illness are caused by Allah, through the natural and supernatural powers created by Him (Abu Rabia, 1983; Al-Krenawi, 1992; Ben-Asa, 1974). Therefore, people must accept their fate with strong faith, courage and great patience.

In the framework of the Islamic religion, the principal evil spirit, Iblis, is regarded as a power who acts in our world; his mission is to attack and seduce mankind. After the creation of man, Iblis had refused to submit:
God said, 'O Iblis, what is the matter with thee that thou wouldest not be among those who submit?' He [Iblis] answered, 'I am not going to submit to a man whom thou hast created from dry ringing clay, from black mud wrought into shape.' God said, 'Then get out hence, for surely, thou art rejected. And surely, on thee shall be my curse till the day of judgment.' Iblis answered, 'My lord, since thou hast adjudged me as lost, I will surely make evil appear beautiful to them on the earth, and I will surely lead them all astray.' (Koran, Surah Al-Hijr, v. 28-40)

One sees in this dialogue that, according to the Koran, there are spirits in the world which were punished by God and sent to the earth. According to Ibn-Taymeh (1957), the spirits are also tools in God's hands to punish the unbelievers (Al-Juhri, 1980). Iblis is thought to be more successful with women; they are believed to be more readily influenced by him than men are. He is regarded as the 'leader' of women, since Eve succumbed to his enticements, thus making her 'daughters' weaker and corruptible (El-Shamy, 1977). Ibn-Taymeh (1957) stated that women are the principal targets of Iblis; through women Iblis succeeds in achieving his goals by leading people astray.

In Bedouin society, women are considered basically weak, both physically and morally, making them vulnerable to Iblis' tricks. Muslims believe that "whenever a man encounters a woman Satan is also present" (Satan is the offspring of Iblis). Satan's task is to tempt the people into unacceptable behaviour (Al-Bostani, 1988; Al-Krenawi, 1992; Mass & Al-Krenawi, 1994). Similarly, Jewish-Moroccans in Israel believe that women are more vulnerable than men to the devil's attacks. This is because women are exposed to impure events during their lives, such as giving birth,
It is a small step from moral weakness to unscrupulousness, even treachery; hence Bedouins also consider women to be dangerous. Women are thought to be more familiar and adept with magic than men. Women use special beads, stones, or Saqwa (poison) against their husbands. According to my informant healer, the women pass these beads and stones from one to another. Bar-Zvi (1988) mentioned some of these stones, such as Sloh, a white stone the woman hangs on her body. This stone is "Tslab qalb al-Rajil" meaning "by this stone she will occupy her husband's heart." The woman uses such a stone where remarriage is contemplated, to keep the husband away from other women (Bar-Zvi, 1988). There have been a few reported cases where men died because of eating or drinking from these beads and stones. Bedouins believe that a man has to be cautious with his wife all the time (personal communication with amulet writer, Ali, 1994).

In the Bedouin world, from Riyadh in the south, to Mosul in the north, it was widely believed that certain tribal women possess special powers of casting the evil eye, of preparing Saqwa, poisons, and love potions for those who wish to purchase them, and are versed in the methods of Shr, witchcraft (Dickson, 1949). Women of African origin are also associated with witchcraft. Doughty (1936) reported a visit to Khibar, a predominantly black village of Ethiopian slave descent north of Medina. The witches were, by day, ordinary housewives but at night they caused their husbands to fall into a deep sleep from which they would not wake.
until the morning. Such women have power over men; as Doughty's host explained, "But though one knew his wife to be a witch, yet durst he not show it, nor put her away, for she might cause him to perish miserably" (p. 106). According to one of the female healers whom I interviewed, several men were dead because of what they called 'Saqwa' (personal communication with a Bedouin female fortune teller, 1994).

The Bedouin beliefs led to the development of a system to prevent, protect and treat people who are attacked by the spirits. The Prophet Muhammad called the Pre-Islamic healers Djaleen, which means "liars," and he warned the people against using them for treatment (Khan, 1986). The Prophet stated that treatment must be according to the Koran. Muhammad himself began to treat people who suffered from what we now call "mental illness" (Al-Ataar, 1989; Navdi, 1983), saying that these diseases are caused by Iblis and his assistants (Ashoor, 1987; Badawi, 1992). The Prophet further said that there are three types of spirits in the world:

1. The first type fly through the air;
2. The second type appear like animals (e.g., cats, dogs);
3. The third type stay in the earth and move from place to place.

Muhammad also warned Muslims about areas where spirits live, such as neglected places, and garbage dumps. He also stated that some of the spirits live among human beings (Al-Jamal, 1983; Al-Jzari, 1987; Ashoor, 1986; El-Shamy, 1977).

It is believed that God created the angels from light, human
beings from clay, and the Jinn from fire. The Jinn exist in different types, e.g., afarit, shayiatin, riyah (Boddy, 1989; Kennedy, 1967). The Jinn constitute a world of supernatural beings with power between angels and humans; their power is above that of humans but less than that of angels (Ashoor, 1989; El-Shamy, 1977; Ibn-Taymeh, 1957). Moroccans believe that the Jinn have no bodies, are like light, and may enter a room even though the door is closed; they are essentially invisible but can appear in various shapes (Crapanzano, 1973; Westermarck, 1926).

Muhammad's friends learned from him the skills and the techniques to treat people who suffered mental or physical illnesses. These kinds of treatment were called "prophetic medicine" (Al-Tibb an-nabawi). These types of treatment were passed from generation to generation (Al-Azhar & Al-Aoqdah, 1980; Al-Nasimi, 1984; Aomr, 1989; Salim, 1986; Sherif, 1972).

Islamic medicine has also been influenced by a movement called "Sufism" (Hamarneh, 1986). Muslims believe that Sufism, or, to give the proper appellation, Tasawwuf, has its spiritual origin in the teaching and in the personality of the Prophet Muhammad. It may have begun from the Prophet's states of ecstasy. The Sufis were probably called such because of their pure lives, pure hearts and spiritual elevation. Some say their name may have its origin in the term for wool (suf); but actually it came to them, most probably, because of other considerations. The Koran defined Ubad, or the subsequent Sufis, as "the servants of God who walk on the earth with polite courteous bearing; and who when they address the
ignorant people give reply to their salaam" (Koran, Surah Al-Furqan, v. 62). The Sufi is one who neither owns property nor is owned, i.e., one who is not in limitation. Tasawwuf is renunciation, i.e., guarding oneself against seeing other than God. The Sufi movement began at a time of neglectfulness (Gbor, 1938; Iqbal, 1971; Schimmel, 1975).

A person is composed of two elements, according to Sufi doctrine, the spiritual and the material. It is the material, with its limitations, which hinders the wayfarer in journeying towards reality. The purified Sufi aims to be absorbed into the absolute reality and thus be illuminated in its radiance; for body is falsehood, and the spirit, truth (haqīqa). The Sufi's quest has been to bridge the distance between himself and his God. This movement established rituals and ceremonies on the spiritual level to achieve a unity with God. An element of Sufi ritual is Dhikr (invoking God's name); the word literally means "to remember," and "to mention, utter," referring both to human mental activity and vocal communication. Dhikr as a vocal communication is often mentioned in connection with the worship of God, in the sense of mentioning God's name, praising, glorifying Him by invoking His name (Al-Ghazali, 1950). Such rituals as visiting saints' tombs (Awliya; singular, Wali) developed among this movement. The concept of Dervish (fāqeer, literally, poor man) also developed from the Sufi. From the 12th century, the Sufi movement began to be organized in different Turuq (schools of thought), and every school had a spiritual leader who was considered a holy man during
his life and after his death (Crapanzano, 1973; Gbor, 1938; Geertz, 1968; Lazaruz, 1980; Schimmel, 1975).

The etiological explanation, according to Islam, for what we call 'mental illness' is the interaction between human beings and supernatural powers, the spirits, sorcery and evil eye, particularly when the person is an unbeliever (Al-Krenawi et al., 1995; El-Islam, 1982; Eikelman, 1968; Haj-Yhiah, 1984; Tabarah, 1977). The treatment for such cases is God's words, belief in Him and practice of the Islamic pillars (Nagati, 1982). Mental illness is perceived by Muslim people and scholars as punishment from God for unbelief, evil thoughts and immoral actions (El-Islam & Abu-Dagga, 1992; El-Islam & Ahmed, 1971; Tabarah, 1977; Tlate & Adli, 1982).

Haj-Yhiah (1984), in his study of Muslim society in East Jerusalem, pointed out that the more religious people are, the greater the tendency to perceive mental illnesses as the result of "defective relationships with God." Hence the increased tendency to perceive illness as the result of "punishment from God." Furthermore, the more traditional people tend to perceive mental illness as God's will (fatalism) (Haj-Yhiah, 1984).

Contemporary Methods of Traditional Healing

Among the Negev Bedouin, there are traditional healers of various specialities, ministering to the physical and mental needs of the community. These include healers such as the Alaashp
(herbalists), the Al-Fataha (fortune tellers), the Dervish (who treat mental health and social issues), the Hawi (who treat poisonous wounds), the Kayy (who cauterize wounds), the Khatib or Hajjab (who use amulets to heal), the Mujjabir (who heal broken bones), and the Sheikh-Din or Moalaj Belkoran (those who treat using the Koran) (Al-Krenawi, 1992; Bailey & Danin, 1981; Clinton, 1982; Tal, 1981). The following study examined several such types, with a focus on mental illness issues: the Dervishes, the Khatib, the Al-Fataha, and the Sheikh-Din or Moalaj Belkoran.

**Dervishes.** The first stage of becoming a Dervish is to have received a Baraka (blessing, gift from God) in a manner legitimized by a well-recognized Dervish. This Baraka is bestowed on a person of positive qualities, a believer and religious individual. Once the Baraka has been received, the future Dervish must still be molded and trained extensively by an experienced Dervish before he or she can be recognized as a healer.

**Sources of the Baraka.** The Dervishes reported two main sources of their healing powers: inheritance and messages from God. The first source is said to be bestowed on them through the intervention of supernatural power mediated by angels, the messengers of God. Usually this is in the form of a dream in which angels teach techniques by which the spirits can be overcome, such as speaking the language of the spirits. The spirits are considered to be God's enemies as well as the enemies of all
mankind.

With the help of counsellors (senior Dervishes) new Dervishes acquire therapeutic skills and the rules of their craft, based on socially accepted cultural concepts. As one of the Dervishes commented:

This protection is not without conflict, however: We have to follow God's orders or the angels will attack us and stop protecting us from the spirits' deeds. I felt I have two minds. One mind said "Do this" and the other mind said "Do that."

The two minds this healer was describing belong to the angels and the spirits who continually pull him between good and evil.

The second source, inheritance, has also been observed in other cultures (Alegria, Guerra, Martinez, & Meyer, 1977; Torrey, 1972a). If one family member has healing power and Baraka, that person is perceived by the Bedouin as a saint; therefore, the entire family comes to be respected and feared. This process both facilitates the passing down of healing abilities through the generations and reinforces the classification of these families as holy. Although the Baraka often passes from generation to generation, it is not necessarily passed directly from father to son. The inheritance has been referred to variously as Ahl-Jed (the family grandfather was a known Dervish), Jediah (the Baraka stays in the family), or Sr (a secret from God, in the family).

The training period. Before training can begin, the receipt of a Baraka must first be recognized by an experienced Dervish. In order for this to happen, the initiate has to travel a long road of
spiritual and social struggle, usually involving mental suffering. In recounting her experience of receiving a Baraka, one of the females said:

After they [angels] appeared to me in my dream I became afraid, and isolated. I neglected my kids and my husband. The angels' message was also not to dress with fine clothing, especially the red color. That's because the spirits especially like red. I felt confused. They [My family] took me to the hospital and everybody in my tribe thought I was attacked by spirits, until my senior Dervish discovered that I had received Baraka.

Being chosen often leads to a decrease in social status of the family as they begin to look for a treatment from different healers, until one of the Dervish healers discovers that the person had received a Baraka from God. As one of the Dervishes remarked:

After the senior Dervish discovered that I had received the Baraka, he told me to tell my mother that God gave her farhaha (joy).

The senior Dervish takes the candidate under treatment. The senior Dervish becomes the therapist and later the supervisor, referred to as Am (uncle), indicating a quasi familial relationship beyond supervisor-apprentice roles. The initiate then is finally welcomed to the school of thought of the senior Dervish. With the transformation into a fully recognized spiritual healer, the new Dervish becomes a feared and respected individual in the community.

Dervishes regard themselves as the elite of traditional healers of Bedouin society. By virtue of the divine blessing bestowed upon them, they succeed in entering the mystical world beyond reason, and live at peace with both worlds simultaneously. This capability allows them to manage a dialogue with the spirits as well as to overcome them and expel them from the body. The
Baraka is also an ongoing resource for Dervishes. Throughout their learning and their professional careers, they continually use *rijal Allah al-Salhin* (invocation of saints, God, and the Prophet Muhammad), as they ask for help during treatment in treating mental illness and problems caused by *Iblis* (Satan) and his assistants.

*Schools of thought.* Among the Dervishes, there exist four *Turuq* (schools of thought), each with somewhat different principles. At the head of each school stands a spiritual leader, and every new Dervish has an instructor who helps in initiation into the school and its system. The new Dervish begins to work according to the system of his or her instructor. The group of Dervishes researched in this study belong to two of these schools of thought: *Al-Anemaat* and *Al-Jreraat*. Both are named after two eminent Dervishes, now dead.

The Dervishes considered themselves as therapists for what we call "mental health disturbances and problems." Because of the *Baraka*, they believe that they have the power to deal with the spirits and to discover what happened to the person who is sick. The Dervishes commonly determined a patient’s diagnosis without asking him or her about the symptoms; all they need is to examine a *Fad*, any item belonging to the patient, or to lay their hand on the patient's head. The Dervishes' first step was to describe the patient's symptoms; they often started with the physical complaints, such as weakness, pain in the chest, *Docah* (loss of consciousness), and other physical pains in the patient’s body.
Then they pointed out the non-physical complaints such as dreams, sleep disturbances, fear, anxiety. Sometimes they told the patient that he or she has been seeing figures that look like human beings, while sleeping or awake. According to my observations, the patients did not present their symptoms to the Dervishes. It is the Dervish's task to recognize the patient's symptoms. Such a situation often increases the patients' faith in the ability of the healers (Al-Krenawi, 1992).

**The Khatib or Hajjab (amulet writer).** This type of healer uses books from Egypt and Morocco. These old books were inherited from the healers' fathers, and they have been passed on from generation to generation. The son should have a basic knowledge of reading and writing and have a good character respected and accepted by the people. The teaching process includes how to use the books, and at what time to prepare the amulet; which Koranic verses should be written in the amulet; and other figures and numbers. Every issue related to the amulet has a different purpose. The essence of this craft is the books that the healer uses in his work. During his life, the healer allows his son to treat people under his supervision. When the healer dies, his son replaces him and becomes a healer. This type of healer often declares in later life which son will take over after his death and the Bedouin believe that the craft passes from father to son immediately after the father's death.

These healers are not organized in groups or schools of
thought; they work individually. However, they may consult each other and exchange information unofficially--related books or other references that they use in their work. The healers generally have few years of education.

When the patient arrived at the healer’s house, the healer asked the patient for his or her personal name and his or her mother’s name. In the next step, the healer converted the letters to numbers and divided these numbers by two. Then he opened the book that he uses for the treatment to the page corresponding to the number that he got. He started reading the patient’s symptoms. These healers read all the symptoms together, the physical and the non-physical; for instance, weakness, pain in the body, and dreams that cause fear of snakes and other animals. Symptoms include what the patient sees when awake, such as forms of human beings; in fact, these shapes are not human, they are spirits. After the healer told the patient his or her symptoms, he then moved to etiology, and later on to treatment. The symptoms, the diagnosis and the treatment all are written in the books.

*Al-Fataha (the fortune tellers).* Literally this phrase means to open something closed (this includes the person who comes for treatment); in other words, to expose the secret that the patient carries. This craft is inherited, as opposed to being passed on through supernatural intervention; since it occurs only among women, it is passed on from mother to daughter. Often the mother selects one of her daughters who has good relationships with
females in the tribe, is religious and of good character. By the
time the mother-healer has died, she has passed what she knows to
her daughter who will replace her after her death. During her
life, the mother teaches her daughter the basic principles of the
craft. One of the Al-Fatah's major diagnostic tools is being able
to read the coffee cups of others, an ancient tradition. In
addition, the mother teaches the daughter the techniques of dealing
with the diseases.

This group of healers are not organized in schools of thought;
every one of them works individually. However, they had good
relationships among themselves and they met sometimes and exchange
ideas about treatment methods. One of the healers said, "Abntalm
Mn Badhana," meaning "We learn from each other."

Their way of dealing with mental health problems is with a cup
of coffee. The patients do not say anything about their situation,
all they need to do is to drink the cup of coffee and to leave it
for a few minutes. After the patients drink the cup of coffee, the
healer takes it from the patient and puts it upside down. After a
few minutes, she takes it and looks at it carefully; every line and
figure is important and symbolizes something from the healer's
point of view. For example, if the coffee dregs form the shape of
a dog, then this connotes the symbolism of a friend; if the dregs
form a snake, this means Hamm (worries) -- usually it is inferred
to mean that somebody is doing a bad thing to the patient or trying
to hurt him or her. The shape of a deer means that the patient
should expect good news; eyes mean the evil eye, or as one of the
healers said, "When you see eyes that means the people's eyes focus on you, so you have to be cautious." A shape of a woman means that there is a woman who hates the patient and who has a plan to harm the patient -- or she has already done something against the patient, usually Amaal (sorcery). Trees are a symbol of hope; something good is going to happen. Also, the bottom of the cup is important; as one of the healers said, "If the bottom of the cup is distorted, this means there is a family problem."

Sheikh-Din or Moalaj Belkoran (healer according to the Koran).

These healers are educated and have academic degrees from Islamic Universities and colleges; they treat people according to the Koran.

The process of becoming a healer in this group. The healers need knowledge in Islam; a willingness to help those who have been attacked by evil spirits; training, based on reading various books; continuous reading of the Koran; and a pre-established period of apprenticeship under the supervision of a Koranic healer. These healers shall be discussed in this chapter, in several subsequent sub-headings, to follow.

The Psychological Insights of Islam

Islam is an all-pervading influence in the lives, norms, and frames of reference of the Bedouin patients and their traditional
healers. It provides a strong basis upon which mental illnesses and personal problems are constructed; how they are responded to; and how individuals perceive the entire social context of living.

The paradigm of Islamic psychology is essentially derived from the core of Islamic traditions, especially in the analysis of the Nafs, the self, and the means by which it can acquire its purpose, a state of unconditional tranquillity. Qalb, the heart, a non-material principle, is the essence of self and has predominant control of the life of an individual. The heart represents the whole human being in relation to Al-Dunya -- the immediate condition— and Al-Akhira -- the approaching reality (Hughes, 1978; Qutib, 1967). It is this essence which distinguishes human beings from all other created beings and constitutes the excellency which enables them to realize the truth. The heart is also the point of union between Jism, the body, and Ruh, the spirit.

In the Islamic order of creation, the heart is the non-material centre of the human organism, that which registers and reflects perception and consciousness. Changes can be initiated by an external or internal stimulus. It is on this plan that the essential functions such as the will, thinking and synthesis take place. Disturbance of these core functions constitutes a fundamental imbalance and disharmony within an individual. The heart is a centre of the organic whole of the psyche and soma that guides, directs and controls the human organism towards the realization of, and unification with, the truth (Ansari, 1992; Qutib, 1967).
The Koran affirms the belief in a hereafter as well as in punishment and reward mainly based on one’s adherence to the five pillars of the faith:

1. The "Shahada": the belief that there is no God but Allah and that Muhammad is His prophet;
2. Conducting the five daily prayers;
3. Paying alms to the needy;
4. Fasting during the month of Ramadan;
5. A pilgrimage to Mecca at least once in one’s lifetime if possible.

The most fundamental doctrine of Islamic faith is the "Shahadah": the faith expressed in the statement. There is no God but Allah and that Muhammad is His last prophet. By reading or reciting these words, Muslims testify to the oneness of the Creator and gratefully surrender to His will; they feel protected by God. This psychological feeling of security fosters a sense of empowerment in the face of difficulties and enhances a degree of emotional maturity and independence. It can be observed that these rites structure the daily life of Muslims in ways that bind them together in communal recognition of and surrender to God.

Islam has delineated very clear rules dictating behaviors and attitudes in all aspects of religious and secular life; rewards and punishments are specified accordingly. The Koran is the source of these laws, guiding the Muslims toward the fulfilment of their faith and protecting them from straying to the wrong path (Qutib, 1967). Psychologically speaking, the belief in reward and
punishment probably helps tame individual drives in the service of community welfare. If these drives are not regulated and positively directed, pleasure seeking might dominate and lead to an impulsive, selfish life filled with anxiety and overstimulation. That is not to say that Islam forbids all pleasures, but it forbids extravagance and excess, as mentioned in the Koran (Koran, 7, v. 32-36). One function of these social and religious laws is that they help the individual regulate his or her physical and emotional needs in the service of spiritual fulfilment. This in turn promotes group cohesiveness. The Koran says, "Thus have We made of you Umma [community] justly balanced" (Koran, 2, v. 142-143). The concepts of balance and community are closely linked, because a good Muslim is one who has succeeded, through real faith, in reconciling his or her drives with community law and welfare.

Islamic teachings aim at an ordered daily life including care for family and concern for the welfare of one's parents. From the Islamic point of view these actions are considered to have psychological aspects; besides being useful, they lead to balance in the Muslim personality (Najati, 1982). Further, the practice of prayer, meditation, and other forms of religious devotion reduces anxiety and increases the person's sense of well-being (Azhar et al., 1994). By following Islamic principles, it is believed that Muslims can achieve and enjoy the four ingredients of a healthy and balanced life: physical, social, mental, and spiritual health.
Righteous Living in Islam

Background. Islam is not only a code of theology but it is a guide to civilized, social living. Everything which affects human life is dealt with in Islam. Terms like "hygiene" and many others are modern, but such principles have been practised by Muslims since the advent of Islam. There are many verses in the Koran, and a great number of traditional teachings of the Prophet Muhammad, which give Muslims express advice on cleanliness of clothing, body and habit; regarding sniffing of water into the nose, cleaning of teeth, combing of hair. The requirements of Islam as to the ablutions that are essential prerequisites for prayer are an example of the wholesome directions which this religion embodies. Muslims clean and purify themselves, physically, spiritually and materially from filthy things, actions, thoughts and ideas. This protects a person from diseases and keeps him or her in good health physically and mentally (Qutib, 1967; Tabarah, 1978). Islam provides rules for social behaviour; for instance, it forbids prostitution, use of alcohol and narcotics. God said: "An adulteress and an adulterer, each one of them should be given a hundred lashes" (Koran, Surah 24, v. 2). And the Prophet Muhammad said, "Nobody commits adultery, while he is a believer at the time of commission" (An-Nawawi, 1982). These injunctions aim at promoting morality and stopping unlawful sexual activity. Islam at first advised its followers against consuming intoxicating liquor and later forbade them altogether from consuming it. God says: "O
you who believe, intoxicants and games of chance and sacrificing to stones set up and dividing by arrows are only an uncleanliness, and the devil's work; so shun it that you may succeed" (Koran Surah Al-Maada, v. 90).

The psychological and other causes of diseases were also recognized by the Prophet Muhammad. He warned against worry and is reported to have said: "Do not look too much at people suffering from elephantiasis." Also, he recommended that believers visit ill people; he stated that visiting supports the patients and brings them relief (Farsy, 1964; Najati, 1982).

The interpretation of dreams. According to the Prophet Muhammad (Hadith) there are three types of dreams: a) signs from God by His messengers (angels), this type of dream called in Arabic Roaeh (vision) which means to see things as in reality; b) signs from the spirits to cause the dreamer sadness; and c) daydreams that happen to the person during the day. From the Islamic point of view, if the person is a believer and practises Islamic principles, then in dreams he or she will see good things that bring relaxation and closeness to God (Al-Bostani, 1988). By contrast, the unbelievers in their dreams see bad things from the spirits which cause fear and worry. The Prophet Muhammad recommended that Muslims read verses from the Koran and mention God's name before going to sleep (Al-Bostani, 1988; Najati, 1993). The same method is recommended by the healers who treat "mental illness" among the Bedouin of the Negev (Al-Krenawi, 1992).
In Islam everything that a person sees in his or her dreams can be interpreted according to a symbolic system: for example, the egg means women; wood, unbelievers; pot, saving water, safety and protection from God; the mouse, a bad woman; snake, anger and fear from the future, dreams from the devil (the snake belongs to the spirits' side); star falling, someone will die; white and green clothing, the clothes of people in paradise and the colors of the angels (Messiri, 1984; Najati, 1993; Sherine, 1963).

There are two types of illness stated in the Koran: illness of the heart and illness of the body. The illnesses of the heart comprises two types: the first is suspicion and doubt, and the second desire, allurement and sin. In the first regard Allah said: "Their hearts are sick, and Allah has caused their sickness to intensify" (Koran, 2, v. 10). He also said, "Those whose hearts are sick and unbelievers say: What does God mean with this parable?" (Koran, 74, v. 31). So those who refuse to accept the criterion of the Koran and the prophetic traditions have the sickness of doubt and suspicion (Al-Azhar & Al-Aoqdhah, 1980). As for the sickness of desire and wantonness, an example is the sin of adultery.

The Koran also mentions physical illness, the health advantages of fasting, and the hygienic benefits of taking ablution. However, because this study deals primarily with mental illness, I will focus on mental and emotional problems and their treatment according to Islamic approaches. The next section will outline the treatment of "mental illness" by modern healers, based
upon the Koran.

**Treatment of mental illness by modern Koranic healers; Al-Ilaj BelKoran**

**Characteristics of Koranic healers.** In the Islamic world, there exists a movement of healers who treat people according to the Koran. This movement is recently increasing, and their treatments are legitimate according to Islamic scholars; this type of treatment has spread through all the Muslim communities around the globe (Al-Jzari, 1987; Ashoor, 1987; Bali, 1993). Al-Jzari (1987) has given some characteristics of these healers, called in Arabic, *Sheikh-Din* or *Moalaj Belkoran*:

1. The healer has to believe in God and practice the Islamic principles and the Prophet's tradition (*Hadith*).
2. The healer has to believe in the saints of Islam, in the Prophet Muhammad's treatment and in following it.
3. The healer has to believe that the Koran can influence the spirits.
4. The healer has to have knowledge of the spirits' world.
5. The healer has to know how the spirits enter the human body.
6. The healer has to be married.
7. The healer has to be a righteous person and not do anything which is forbidden by Islam.
8. The healer has to know the traditions which can influence
the spirits and also keep God in mind and avoid the spirits.
The same characteristics are given by Al-Daramdash (1991), and he added that healers have to know which chapter from the Koran to use in a given treatment.

**The stages of treatment.** The process of treatment has the following stages.

**First stage: Pre-treatment.** This involves creating the proper treatment atmosphere. The healer has to attend to several things before the treatment:

A. The healer has to remove all the pictures from the room where he treats. This action allows the angels to enter the room.

B. If the patient has hung an amulet, he has to put it in the fire.

C. The healer should take out all musical instruments from the room.

D. If the patient is wearing gold, it must be taken from the room.

E. The healer opens a conversation with the patient and family while he focuses on God's power. The healer shows them that everything happens by God's wish; the healer is a mediator between people and God.

F. The healer has to explain to the patient and the family
the difference between his treatment and the magical healers' Sahharin and Dajaleen, and to show them the treatment for mental illness and problems according to the Koran (Al-Daramdash, 1991; Al-Jzari, 1987; Ashoor, 1987; Bali, 1993).

**Second stage: Diagnosis.** In this stage, the healer asks the patient a few questions to determine the diagnosis; such as

A. Did you see animals when you slept; how many; was it the same animals or different ones?
B. Did you see animals following you while you slept?
C. Did you have bad dreams that frightened you?
D. Did you feel that you would fall down from a high place?
E. Did you feel that you were going somewhere that frightened you?

The goal of these questions is to find out how many spirits are inside the patient and which kind they are. For example, if the patient saw two snakes in the dream, that means that inside the patient are two spirits. Questions like those above are asked by the healer if the spirits do not speak through the patient's body; if the spirits communicate directly with the healer, then the questions are not necessary.

When the healer determines the diagnosis, he cleans himself -- since the spirits like impurity. He cleans his surroundings and asks the people in the room to clean themselves. This is according to the tradition (Hadith) "Al-Islamo Nazifon Fatanaazafu"--Islam is
clean, so clean yourselves (spiritually and physically) and your surroundings (Farsy, 1964).

If the patient is a woman, she has to cover her body, the healer can not treat a woman by herself, so her husband, father or brother has to stay with her during the treatment; others have to leave the room. The healer prays to God and asks help to overcome the spirits and expel them from the patient’s body.

**Third stage: Treatment.** This is the difficult stage for the healers because they face the spirits and deal with them. The healer puts a hand on the patient’s head and reads the first chapter from the Koran (Surah Al-Fatiha). He continues to read verses from other chapters, such as Surah, Al-Baqara v. 1-5; 163-164; 255-257, and Surah, Al-Jinn v. 1-9. The healer reads these verses in the patient’s ear, and this agitates the spirits in the patient’s body. This technique leads the spirits to communicate with the healer, or to leave. If the spirits leave there is no need to communicate with them, as the Prophet Muhammad said, "Do not hope to meet the enemy" (Salim, 1986). If the spirits initially refuse to leave the patient’s body, the healer communicates with them, until they leave the patient, or finally refuse to leave the patient’s body. In this case, the spirit is beyond the healer’s power.

*Signs to recognize spirits during the treatment process.* The healers use the following signs to recognize spirits:
When the patient closes his or her eyes or covers them.

B. There is a strong shock in the body, or in the hands or legs.

C. There is shouting and crying.

D. The spirit says his or her name.

When the spirit appears, the healer communicates with it and wants to know information about the spirit's background, such as which kind of spirit, religion, sex, the reason for the attack or entry into the patient's body. Also the healer asks him if there are other spirits inside the patient and their location in the patient's body. The healer wants to know if the spirit works alone or with a magical healer--Sahr (sorcerer). When the healer recognizes a spirit, the healer tries to convince him or her to become a Muslim (Al-Jzari, 1987; Bali, 1993).

The healers' movement is gaining adherents in the Islamic countries. This movement will likely be increasing more and more among the Islamic world, because many Islamic people are returning to religion. If one becomes a religious person, one has to accept what the Prophet said and did and to act according the Koran.

From the Islamic Arabs' point of view, a person consists of two factors, a material and a spiritual/emotional factor (Qutib, 1967; Tabarah, 1977); those who practice Islamic principles--obedience to God's will and the Prophet's traditions--achieve a good relationship with God; they thereby balance the two sides of themselves, secure good social relationships, and are protected from diseases. Hence Islamic healers follow the Koran and support
their patients in practising Islamic principles.

Al-Issawi, a Muslim psychologist, in his book, Islam and Psychotherapy (1988), stated that the Muslim therapist has to encourage his/her patients to believe in God and His prophet Muhammad and to practise Islamic principles. This leads the patients to safety, relaxation and closeness with the Creator. He also asks patients to purify themselves by prayer, which means by water, and Al-Issawi used the term "water therapy." What he practised was a combination of modern psychotherapy and Islamic religion. Other Islamic psychologists and scholars have reported that this combination works and that the patients found relief from their problems (Al-Bostani, 1988; Nagati, 1993, 1982).

Such integration of the modern and the traditional system is increasing in the Islamic world. The integration of Islamic spiritual approaches in the therapy of drug addiction has been pioneered in Egypt and Saudi Arabia (Abu El Azayem, 1987; Baasher & Abu El Azayem, 1980).
Summary

Above all else, as this chapter has indicated, the aforementioned aspects of Bedouin society provide the prism through which the Bedouin experience, construct, and respond to mental health problems.

In summary, it should be noted that the Bedouin have undergone a long period of domination by several successive occupying regimes, they have long developed a tendency to rely on their own, indigenous modes of helping. But westerners would perceive the Bedouin to be a traditional, tribal society based on patriarchal, hierarchical, and strongly socially coded modes of organization. And in like regard, there has been a sophisticated, complex structure of traditional healing which continues to assist Bedouins with a variety of physical, mental, and psychosocial problems; these need to be fully comprehended.
Chapter Three

THE RELATIONSHIP BETWEEN TRADITIONAL AND
MODERN HEALING: A REVIEW OF THE LITERATURE

Introduction

The present chapter examines the theoretical underpinnings of the two systems of helping, the traditional and the modern. It finds that there are more similarities than differences; and that there are many common psychotherapeutic factors in both systems, among them ventilation, catharsis, and elements of individual, family, group and community social support.

Modern psychology and psychiatry have drawn attention to the mental and emotional condition of human beings. In therapeutic practice, the psychological and psychiatric approach supplies techniques of intervention to reduce pain and conflict (Rogers, 1961; Sandner, 1979; Wellwood, 1983). Traditional beliefs regarding the meanings and causes of illness have been relegated to the realm of religion (Bromberg, 1975; Jung, 1984). One mode for resolution in orthodox psychology is analysis; in religion, it is meditation or contemplation (Campbell, 1972; Jung, 1984).

It should be noted that the following terms are used throughout the dissertation, and therefore merit definition at the outset.

Compartmentalization occurs when different types of healers are believed to be competent to treat different types of

Competition occurs when practitioners of different systems are believed to be competent to treat the same type of illnesses (Press, 1969).

Complementarity occurs when different types of practitioners are consulted concurrently to deal with different aspects of the same problem. The biomedical physician, for example, may be utilized to cure the symptoms of a disease and the traditional healer to treat its underlying, perceived spiritual, moral, or social causes (Garrison, 1977).

Exploitation occurs when patients tend to utilize a particular type of practitioner not because they believe he or she is the most competent to deal with the problem, but because they wish to demonstrate something about themselves, such as their social status or cultural identity (Press, 1969).

Integration is defined as that process whereby cooperation between traditional healers and modern psychiatrists are seen as possible, and whereby the two kinds of practitioners could help each other in their respective spheres of practice (Incorporated on the basis of Razali, 1995. See also Lambo, 1978; Rappaport & Rappaport, 1981).

And similarity is that state where there are mutual resemblances between two or more mental health systems.

The Roots of Psychology, Psychotherapy and Psychiatry

An accurate account of the origins and development of medical
psychology (Zilboorg, 1941) would naturally find many connections with religious and magical practices of traditional cultures (Bynum, 1983). From his search for the roots of the discipline, Calestro (1972) concluded: "... psychotherapy is the bastard progeny of a long tradition of neo-religious and magical practices that have risen up in every unit of human culture" (p. 83). Practitioners of psychological treatment have felt compelled to defend it against suspicions that it still trafficked in what Alexander and Selesnick (1966) term "... old demonological concepts..." (p. 4) and so have paid comparatively little attention to actual resemblances to the religio-magical practices from which psychological therapy originated. Some historians however, have noted these similarities (Alexander & Selesnick, 1966; Bromberg, 1975; Calestro, 1972; McDonnell, 1975; Zilboorg, 1941).

Mental health is defined by social standards (Trotter, 1981). Each culture has techniques for evaluating and sustaining mental health concordant with group norms. Since the world has a diverse population, cultural issues influence professionals' attitudes in the field of psychological health care (Campbell, 1972; Levi-Strauss, 1963a; Sandner, 1979). It has been found, for instance, that the more a similarity of understanding exists between the healer and patient, the greater the possibility for successful treatment (Trotter, 1981, p. 173).

On the other hand, many healing traditions throughout history have had psychological components (Campbell, 1972; Jung, 1956;

It is a fact that the beginnings of psychoanalysis were fundamentally nothing else than the scientific rediscovery of an ancient truth; even the name catharsis (or cleansing), which was given to the earliest method of treatment, comes from the Greek initiation rites. (Jung, 1933, p. 35)

Psychology or more particularly, psychological therapy, attempts to aid an individual to function within his or her society. Heritage and cultural background influence what is considered illness, how it is to be treated, where the healing can occur, and who will administer the treatment (Sandner, 1979). There are common factors, unifying principles among all people with respect to physical/mental/spiritual aspects in human experience and life overall (Pelletier, 1977). Yet, as Ruth Benedict reported,

A chief of the Digger Indians... Ramon broke in upon his descriptions of grinding mesquite and preparing acorn soup. "In the beginning... God gave to every people a cup, a cup of clay, and from this cup they drank their life... They all dipped in the water... but their cups were different. (1960, p. 33)

Although all people share common concerns, attempts to influence run up against particular racial, social or cultural interests when specific characteristics are discounted or overlooked (Benedict, 1934; Geertz, 1973).

If one does not know about cultural influence, it is easy to misdiagnose or mistreat (Chiu, 1994; Murphy, 1982). Some cultures may view depressive or anxiety symptoms as a bodily and spiritual phenomenon (Al-Issa, 1982, 1970). Cultural views also affect how a patient defines the problem and the expectations a patient brings
in seeking help, which results in relative accessibility of patients to different forms of psychotherapy (Frank, Hoehn-Saric, Liberman, & Stone, 1978). Similarly, there are different types of healers (Salzman, 1984), types which can also be understood as related to cultural differences. Salzman's models include a) the wise, magical healer possessed of spiritual values and wisdom who is accepted by the patient with "faith and spiritual conviction"; b) the skilled, detached scientist, who does not depend upon charisma; and c) the expert-partnership relationship in which the healer is an understanding person who "guides and encourages" growth (p. 104).

Explanation and manifestation of mental health problems differ from culture to culture (Al-Issa, 1982; Good & Good, 1986; Marsella, 1993; Wallace, 1961). Also, in many traditional societies, syndromes are described which are specifically related to culture and religion (Obeyesekere, 1970). Rakc (1982) pointed out that people in Western countries want to know from what disorder they suffer. In contrast, people from traditional societies are interested in finding out why they suffer. From a time that far predates the beginnings of scientific medicine and psychology, human beings have sought, and to their satisfaction, found healing from many varieties of human disease, in religious contexts. The history of every religion is laced with tales of miraculous healing (Smart, 1976; Smith, 1958). Founders and reformers of religions, saints, shrines, relics and rituals are all surrounded with reports of cures calculated to perpetuate faith in
their continuing healing powers (Van der Leeuw, 1963). It may be that most of the people in the history of the world who have sought healing have searched in a religious context.

In all societies, religious approaches tend to exist side-by-side with naturalistic treatment of ailments with medicine. Yet in Western countries, scientific medicine is clearly distinct from, and has largely replaced, religious healing. It is different elsewhere. For example, many people, including traditional healers in India, do not distinguish clearly between religious healing and medical treatment, be it treatment based on traditional systems indigenous to its culture or on Western, scientific medicine. When an average Indian person consults a Western doctor or an Ayurvedic physician, he or she may choose one or the other for pragmatic reasons of effectiveness, custom or convenience; in any case, the person may concurrently seek religious healing (Fernando, 1991).

It should be noted that in India, there is a convention of traditional healing, based on the Ayurveda, which centres largely on the patient's entire physical, psychological, and metaphysical aspects (Srinivasan, 1995). The Ayurvedic notion of a healthy person is pervaded by ideals of moderation, control and responsibility. The maintenance of good health is considered to be inseparable from deliverance from disease. It is contrasted, in treatment, from the western psychotherapeutic notions of "self" and "introspection" (Kakar, 1982). Among the Ayurveda, there is no systematic theory of 'mind' and 'mental' processes as there is in Western thought, although some forms of therapy for 'restraining
the mind' derive from the various schools of yoga. In addition, there is 'purification' by, for example, purges and enemas, and 'pacification' that tranquilizes, counteracts depression and strengthens the nerves (Kakar, 1982).

Murdock (1980) reported on 186 cultures with respect to how they referred to mental health problems. Among these cultures, many emphasize that supernatural powers are the causes of disease. For instance, some studies have pointed out that people from Morocco, Yemen, Iraq, Iran and other Arab countries believe that the reason for mental health problems is some supernatural power (spirits, evil eye). They seek treatment for their problems (which we might call "psychological") from people in their own communities, such as Rabbis, Moris and other healers (Arieli, 1970; Bilu, 1978, 1977; Bilu & Witztum, 1993, 1994a; Hes, 1964; Palgi, 1961; Shilon, 1968). Lambek (1993), in like manner, provided evidence of the significance to a traditional Muslim population of Islamic religion, cosmology, and possession in the context of mental health issues.

Suffice it to say, then, that mental health workers have to be aware of the patient's cultural background. This enables them to deal with their problems effectively and to use traditional techniques and rituals during the therapeutic sessions. One assumption is that it is most beneficial for the therapist and the patient to belong to the same culture. This leads to better communication and understanding of the patient's needs, since both use the same language, the same proverbs and cultural symbols (Al-
There are relationships between aspects of traditional healing and a number of areas of psychological investigation that have received attention. Five of these areas are now briefly discussed.

First, mental health workers attempting to provide services to those in cultural settings that do not, in any way, share the Western scientific world-view have experienced considerable difficulties and limitations in their ability to deliver effective, acceptable treatment (Draguns, 1975; Kiev, 1968). The use of native healers in conjunction with Western medical delivery systems and techniques has been introduced in a number of settings with good effect (Al-Krenawi et al., 1995; Martinez, 1977; Ruiz & Langrod, 1976a, 1976b; Schwartz, 1985; Wessels, 1985). Such cross-cultural experience demonstrates that the role of the meaning system of the sufferer is extremely important in the etiology and cure of the problem. The meaning system may function with similar efficacy in religious healing settings (Nelson & Torrey, 1973).

Second, in Persuasion and Healing, Frank (1973, 1974, 1975) has presented religious healing as an example of the various factors at work in any relationship involving interpersonal influence. Drawing from diverse instances of religious healing
Frank, in his search for non-specific factors at work in all psychotherapeutic relationships (see also Strupp, 1973a), concluded that the common underlying complaint in most mental health problems and many physical ones is demoralization, and that all forms of effective therapy must deal with this issue. They do deal with it, often indirectly, through means which they share with all forms of healing: a confidence-inspiring, socially sanctioned patient-healer relationship; a ritualized setting; a mutually accepted rationale or myth explaining illness and cure, i.e., a shared world-view; a task or ritual legitimized by the myth. Frank’s theory offers one plausible model for conceptualizing the dimensions of religious healing.

Third, because it is a factor to be accounted for in every therapy-outcome study (Strupp, 1978), the placebo effect has received increasing attention in medicine as well as in psychotherapy research (Adler & Hammett, 1973). The placebo is used as a suggestive treatment which is similar to that used by traditional healers. A placebo, in present times, may consist of water, sugar capsules, and/or a host of vitamin therapies used today for almost any disease (Josepe, 1978, p. 3). For example, patients have reported the wonderful relief they experience from severe headache, where the treatment was nothing more than routine and suggestion (Josepe, 1978). In fact, most medications and treatment until the twentieth century were placebos; so the history of medical treatment can be characterized largely as the history of the placebo effect (Shapiro & Morris, 1978). The placebo effect,
until recent years was almost completely neglected as an object of study per se (Josepe, 1978).

Today the focus has shifted from giving resentful attention to the placebo effect as an unwanted and confounding element in research to interest in the effect in its own right as a potential key to understanding human self-healing capabilities. Shapiro and Morris, for example, stated: "... much can be learned about psychotherapy from study of the placebo effect" (1978, p. 369). Similarly, whatever can be understood about the workings of the placebo effect may help to clarify the seemingly analogous phenomenon of religious healing. Yet healing cannot be explained simply in terms of placebo reactions. As Frank pointed out, "The major conclusion to be drawn from studies of the placebo effect is that its simplicity is only apparent" (1974, p. 151). The continuing research illustrates that it is "... a multidetermined phenomenon influenced by many different factors and processes" (Shapiro & Morris, 1978, p. 372). What is being learned about these factors and processes has implications for understanding how religious healing works.

Fourth, the psychoanalytic notions of inexact interpretation (Glover, 1955), flight into health (Oremland, 1972) and transference cure (Fenichel, 1945; Strupp, 1973b), which are used to explain certain sorts of rapid recovery in a psychotherapeutic setting, may have implications for understanding religious healing (La Barre, 1962). "Inexact interpretation," for example, refers to an incorrect or partially correct attribution of meaning offered by
the therapist. Under such interpretations the distressed person is led to reformulate the meaning of the symptoms in terms of the healer’s world view; a certain satisfaction and peace are derived that lessen the inner anxiety, facilitate ego functioning and culminate in the disappearance of the symptoms (Glover, 1955). Likewise, in discussing how transference cures explain what is called "faith healing," Fenichel notes,

Christian science and other institutions or sects which promise health and magical protection as a reward for faith and obedience may, due to their history and surrounding awe, achieve better and quicker cures than many scientists. (1945, p. 562)

The receptivity to dependency that underlies the transference relationship (Strupp, 1973b) may also be the psychological basis for belief in God and religious healing (Van der Leeuw, 1963). Further, the mechanisms of spontaneous remission (Bergin & Lambert, 1978) may also illuminate the religious healing process. All of these notions, however, have proved difficult to operationalize and test and are consequently not easily applied to research on religious healing.

Fifth, researchers in psychology and social psychology have looked extensively at the power of groups in the lives of their members (Nixon, 1979; Yalom, 1975). In contemporary cultures much attention is being given to the impact of religious and quasi-religious cults on individuals who come in contact with them (Etemad, 1978; Freedland, 1972). Since a large proportion of religious healing takes place in a group setting, the ways in which groups can influence the thought and behaviour of their members can
be brought into play to cast light on the dimensions of religious healing in the context of a group.

In sum, the widespread phenomenon of religious healing is closely linked with the roots and the contemporary concerns of psychology, yet it has received insufficient attention in psychological research. There are commonalities between religious healing and particular therapeutic factors that have been the subject of modern psychological investigation.

For some investigators the religious healing phenomenon provokes questions about parallels between the various forms of traditional and non-traditional healing practices and offers a key to understanding the common underlying structures which account for the way all healing change takes place (Calestro, 1972; Devereux, 1958; Ehrenwald, 1977). Realization that religious healing appears to be analogous to the placebo effect (Calestro, 1972; Frank, 1973) has made the study of religious healing significant to the burgeoning placebo literature (Brody, 1980, p. 139). Similarly hypnotism and suggestive treatment may also be elucidated through a better understanding of religious healing (Evans, 1967; Frank, 1973; Matheson, 1979). Insofar as religious healing is an instance of interpersonal interaction based on suggestion, persuasion or influence, it holds implications for all therapeutic techniques based totally or partially on these factors.
Significance of the Problem

Although the evident lack of interest in investigating the phenomenon of religious healing (Capps, Ransohoff, & Rambo, 1978) might suggest that it has little significance for scientific psychology or psychiatry or for the mainstream interests of twentieth century western culture, analysis of the dimensions of traditional healing reveals the opposite. From intrapsychic processes to sociocultural matrix, the questions generated by the claim of religious healing touch on some of the most substantial issues in the social and medical sciences.

The connection of religious healing with ritual reincorporation into a community of belief (Frank, 1973; Levi-Strauss, 1963a) has wider implications. Supposing that the proliferating need for psychological therapy is indeed related to the experienced breakdown of a sense of community (Frank, 1978), then the renewal of a sense of belonging found in the group setting of religious healing may bear lessons for contemporary society (Bellah, 1970; Berger, 1969). Understanding the influence of the religious healing group (Lebra, 1974) can help explain the continuing viability of folk-psychiatry (Harwood, 1977; Ruiz, 1976).

Writing on psychosomatic medicine and the mind-body relationship, Frank (1975) stated,

In recent years Westerners have started to pay more attention to the so-called holistic concepts of illness and healing held by most of the rest of the world, which views the human as a psychological unity... (p. 78)
Interest is being given to the effects of psychological stress on the incidence of cancer and other health problems (Cummings, 1977; Garfield, 1979; Tansey, 1980). Because claims are made for cure of physical symptoms and diseases through religious healing, investigation of such healing may potentially help to identify and enlist the natural healing processes within the human psychophysiological system (Brown, 1977; Cousins, 1979) and to understand the body-mind relationship (Smith, 1975).

**Studies in Cross Cultural Psychiatry and Anthropology**

Growing recognition of the importance of cross-cultural psychiatry and medical anthropology for understanding any healing process has stimulated a significant amount of work in these disciplines relevant to a psychological understanding of traditional healing. Kleinman (1980) has described a hypothetical process in patients and healers in the context of culture by which culturally sanctioned healing rituals can be understood to bring about real, significant changes in a variety of problems by means of relabelling. Central to this understanding is the distinction between disease, a malfunctioning of biological and/or psychological processes, and illness, the psychosocial experience and meaning of perceived sickness (Kleinman, 1980, p. 72). This distinction is intended to suggest the artificiality of attempting to distinguish clearly between physical and psychological healing; although disease and illness can be easily separated at the level
of psychological constructs, at the level of lived reality they interact and interpenetrate in a complex interrelationship (Kleinman, 1980, p. 75). Any relabelling, reattribution or meaning shift that takes place at the level of the illness can produce not only healing of the illness but also, through the complex processes by which mind and body mutually influence each other, healing of the disease itself. Hence it is essential to recognize the irrelevance and impossibility of effectively distinguishing between physical and psychological healing, to acknowledge the importance of meaning shifts that become possible through the power of religious-cultural rituals in a group setting, and to appreciate the fact that healing includes biological, behavioral, sociocultural and psychological aspects, i.e., meaning.

Medical anthropological investigations of indigenous healing, reviewed in various surveys (Cf. Bourguignon, 1976; Kiev, 1972; Prince, 1976; Umoren, 1990; Waldman, 1990) and in anthologies of accounts of quite diverse healing phenomena (Cf. Singer, 1977) regularly emphasize the common elements in many examples of healing. The literature on the Hispanic "Curandero," for example, consistently points to the function of the healer in maintaining or facilitating the regaining of psychological, social, historical and spiritual equilibrium (Harwood, 1977; Kiev, 1968; Krassner, 1986; Sherman, 1975). Despite the advances in western medical science, the only fully satisfactory medical approach seems to be one which encompasses the whole person in the context of his or her culture (Ackerknecht, 1943; Araneta, 1977; Torrey, 1972a). Whether it be
in areas as diverse as Japanese healing cults (Lebra, 1974), West Indian pentecostal (Kiev, 1964b), East African folk psychotherapy (Rappaport & Dent, 1979) or others, one is forced to note common underlying therapeutic elements and the seeming effectiveness of the traditional treatments. The elements recognized as common across varied cultural forms generally coincide with Frank’s (1973) enumeration.

As a group, the cultural psychiatry studies repeatedly emphasize that the efficacy of folk healing is rooted in the power of the group based on the shared meaning system of the social network. Modification of the meaning attached to certain sets of symptoms can trigger endogenous healing mechanisms which lie at the root of all healing processes. Guilt, alienation, tangled relationships, fear, self-doubt, loss of hope, and low morale are recognized, even by scientific medicine, as etiological factors in many diseases, whether they are manifested in predominantly psychological or physiological ways (Horowitz, 1976; Pelletier, 1977). The power of the healer to deal effectively with these factors arises from shared, culturally determined meaning systems (Bourguignon, 1976; Levi-Strauss, 1963b) Kiev (1964a) concluded,

*The manifestations of native healing... evince certain parallels with Western psychotherapy showing how... a patterned interaction of a patient, a helper and the group in a framework of a self-consistent assumptive world can promote healing.* (p. 29)

Studies of the global phenomenon of shamanism suggest that the shaman’s power to heal is largely derived from the respect and recognition accorded him because he represents and speaks for the
social group in his functions of assigning meanings and causes to disease, conducting appropriate symbolic rituals that produce emotional arousal in the client and, by all of this, raising expectations, enhancing morale and restoring hope (Eliade, 1964; Lewis, 1971; Sandner, 1979). Religious and cultural healing rituals in all cultures are connected with powerful emotional experiences and temporarily altered states of consciousness in group rituals (Durkheim, 1915; Goodman, Henney, & Pressel, 1974).

To conclude, the similarities and analogies between the modern and traditional systems have been extensively, if incompletely, investigated. Socioemotional and meaning issues are addressed by both modern and traditional methods. We can observe in the traditional system how patients express their emotional difficulties, and how they are listened to, and one is often reminded of the psychological techniques utilized in the modern system. In fact there is evidence that in some instances traditional systems can be more attuned to patients' needs than the modern.

Ritual and Psychotherapy

Definitions

The present section analyzes the concepts of ritual, types, symbols, communication codes and traditional healing rituals. There is an analysis of the psychotherapeutic elements that healing rituals contain. Several healing rituals were chosen from the
literature in order to show their therapeutic components. In addition, this section will demonstrate the therapeutic significance that has been attributed to rituals in Western therapies and interventions.

A ritual (or rite) embodies a holistic form of healing that incorporates psychological issues, physical condition, spiritual beliefs and cultural patterns (Campbell, 1972). A powerful ritual contains elements that bring forth a conscious realization of the source of illness and a strategy for healing or wholeness which initiates a transcendent experience (Beane & William, 1975). When one is conscious, the mind and the senses are fully and intentionally engaged. Rituals unite the mind with the action and form of an experience (Campbell, 1972).

Spiritual experience is an aspect of ritual (Eliade, 1957; Halifax, 1982). The sacred takes one beyond oneself, yet gives a sense of connection to everything (Metzner, 1986). According to Eliade, rituals contain symbols that are enacted; that perform, modulate, and transform (Beane & William, 1975, p. 164). Denzin (1974) defined ritual as

a conventionalized joint activity given to ceremony, involving two or more persons, endowed with special emotion and often sacred meaning, focused around a clearly defined set of social objects, and when performed confers upon its participants a special sense of the sacred and the out of ordinary. (p. 272)

The Encyclopedia of Psychology (1984) cited many authors who agreed on the following points.
Rituals may be performed... for purely magical, mystical or religious reasons, so as to gain some control over or mark the uncontrollable, often occurrences in the natural world, transmissions of the group's moral code, or the existential certainties of birth, death and the life-cycle transitions from status position to status position within the group's social structure... rituals are also enacted for the emotional effects... the performance bestows upon individuals. (p. 246)

Authors from divergent disciplines are of the opinion that rituals are of essential importance in all human life. The anthropologist Mary Douglas (1966), for example, has stated that humans, as social animals, are ritual animals. She argued that if ritual becomes suppressed in one form, it will crop up in other forms, and this will occur more strongly the more intense the social interaction. Friendship cannot exist without the rites of friendship. Social rituals create their own reality; ritual is more to society than words are to thought. It is possible to know something and be unable to express it verbally, but it is impossible to have social relations without symbolic acts (Douglas, 1966, p. 62).

Rituals consist of stereotyped, symbolic acts or interactions. People can express their ideologies, opinions, values, norms, and emotions via those symbolic acts. In performing a ritual, people simultaneously contribute to the sanctioning or perpetuation of the social system of which they are a member.

Types of Rituals

There are many types of rituals that can be performed on various occasions. I will only deal extensively here with those
rituals that may be of importance to a psychotherapist or family therapist; that provide models of use in therapy. The following types of rituals are among those distinguished in the literature:

**Transition rituals.** The original term is *Rites de passage*. Van Gennep (1960) used this term for rituals that mark all types of transitions experienced by individuals and also by groups during their development; examples are marriage, birth, and death. These transitions are often experienced as crises, hence some authors (Chapple, 1970; Turner, 1969; Warner, 1959) also speak of rituals for life crises.

**Healing rituals.** These are also called "rituals of affliction" (Turner, 1964, 1968) or "rituals for misfortune" (Wilson, 1957). These refer to 'ordinary' transitions in the individual or family life cycle that are improperly made or not made at all. When problems arise, a special, ritualistic treatment may be necessary. Healing rituals can be compared to transition rituals, however they are less standardized. For example, much more attention is devoted to the unique characteristics and needs of those people directly involved than is the case in the "ordinary" rituals of transition. The rationale of this type of ritual is to solve specific problems. Furthermore, healing rituals change the disturbed relations between the participants and provide the opportunity to express anger and other completely or partially suppressed emotions (Al-Krenawi & Graham, in press).
Healing rituals are to be considered as a special type of transition ritual (Turner, 1969; Warner, 1959). They are geared to steer the persons and their environment safely through the crisis period and to restore "ordinary life." The situations in which healing rituals are required often have an even stronger crisis character than the normal transitions.

Telectic and intensification rituals. The term "telectic"--introduced by Firth (1973)--originates from the Greek and means taking off the old and putting on the new; something that also characterizes the rituals mentioned before, but which is reserved by Firth for arrival and farewell: the acts undertaken when someone arrives or leaves.

Rituals of intensification more broadly, are the collective ritualistic activities of a group (Chapple & Coon, 1942; Coon, 1972), activities that coincide with the changes in the natural surroundings of the group, such as the alternation of day and night and the succession of the seasons. They directly influence the entire group, not just one group member. The latter is more the case with transition rituals.

Other types of rituals. Besides these three types of rituals, one encounters rites of reversal in the literature. These in fact, are not a separate type but a form of ritual that occurs both in transition rituals as well as rites of intensification.

In rites of reversal, certain roles are reversed during a
festival or a "state of exception" (cf. Rigby, 1968; Turner, 1969). In certain Bantu tribes, for example, the women dominate the men one day of the year. The men are subjected to various teasing. Sometimes the women do the men's jobs and wear men's clothing. Gluckman (1954) speaks of rituals of rebellion: rituals in which those who are in a lower or unfavourable position can express their justifiable anger against those who are better off, without having consequences for the existing social order. In fact, the rite of reversal actually confirms the existing social structure.

Van Gennep's (1960) division of rituals into three main headings--preliminal, liminal, and postliminal--may be important in determining the value of rituals. The term "liminal" is derived from the Latin "limen" meaning threshold. Van Gennep viewed the process of change in terms of stepping over a threshold. Major thresholds in an individual's life may include birth, entering school, puberty, marriage, and death. Much of our life is taken up with crossing thresholds, and many cultures have developed rituals to acknowledge these changes. Turner (1969) stated,

The first phase (of separation) comprises symbolic behaviour signifying the detachment of the individual or group either from an earlier fixed point in the social structure, from a set of cultural conditions (a "state"), or from both. During the intervening "liminal" period, the characteristics of the ritual subject (the "passenger") are ambiguous; he passes through a cultural realm that has few or none of the attributes of the past or coming state. In the third phase (reaggregation or reincorporation) the passage is consummated. The ritual subject, individual or corporate, is in a relatively stable state once more, and, by virtue of this, has rights and obligations vis-a-vis others of a clearly defined and "structural type." (p. 95)
The preliminal stage is one of relative equilibrium as a crisis is approached. The state of crisis lies in the liminal stage, and the postliminal stage marks the re-emergence on the other side.

Symbols in Rituals

There are various definitions of "symbol." Firth (1973) viewed a symbol as a type of sign. According to Firth, a symbol is referred to where a sign has a complex series of associations, often of emotional kind, and difficult to describe in terms other than partial representations. The aspect of personal or social construction in meaning may be marked, so no sensory likeness of symbol to object may be apparent to an observer, and imputation of relationship may seem arbitrary. (Firth, 1973, p. 75)

Symbols appear in rituals in different forms: as objects, acts, or words (formulas). Some rituals consist of acts where symbolic objects are manipulated. There are also rituals that mainly consist of symbolic acts without the presence of objects. An example of such an act is kneeling during a religious ritual.

The symbols that are used in rituals--objects, acts, or words--have more than one meaning. They are multivocal (Turner 1967, p. 50). Multivocal symbols are also called "condensed symbols"; according to Douglas (1973), they have a variety of precise meanings that remain implicit in the performance of a ritual. Sapir (1934) asserted that symbols have a strong emotional quality, that is, they transfer their meanings on the emotional
level. They can also have a normative and an ideological charge. Condensed symbols--just as techniques that bring the organism into a state of excitement--evoke strong emotions. This aroused energy is then connected to the norms and values that belong to the ideology. Those involved aim their wishes and desires toward the task at hand, through which an integration of emotions, values, and norms can take place (cf. Gluckman, 1975, p. 16).

Symbol, an integral ingredient of ritual, brings the abstract into form (Turner, 1969). Personal and universal symbols represent a thought, feeling or experience. Symbols are part of the reality of the psyche. They communicate to the unconscious by relaying information between levels of awareness that the intellect might not otherwise connect, or know how to utilize (Jung, 1956).

In rituals, symbols offer an avenue for organized expression (Campbell, 1972). In the use of symbols, concerns are externalized in physical or tangible form (Geertz, 1973; Levi-Strauss, 1963a). This creates a connection between the unconscious and conscious awareness through experience. A catalyst for transcendence, a healing ritual moves the psyche purposefully, often by-passing the rational mind and its resistance (Campbell, 1972). Ritual facilitates healing through a radical integration of form and experience (Eliade, 1957).

Symbolic communication during a ritual may be very abstract. The healing symbols may seem simple, but their meaning is extremely complicated. As Wallace (1966) observed, ritual symbols may "refer to extensive and complex ideas of value, structure, and
transformation, whose verbal statement requires considerable time. Consequently, the symbolism of ritual is often obscure, since it refers to intentions and beliefs that are complex and, in part, unconscious (p. 273). In other words, the meaning of ritual symbols is polyvalent and thus communicates several messages simultaneously to different levels of the conscious and unconscious mind.

A healing experience produces a dynamic state of transformation or catharsis (Jung, 1933; Metzner, 1986; Turner, 1969). In an individual, this is shown through physical condition, quality of emotional integration, patterns of thought and spiritual insight (Pelletier, 1977; Progoff, 1956). In all healing, there is an attempt to create order from chaos (Lewis, 1971). The healing process and its results become manifest externally to immediate relationships and the world at large (Campbell, 1972).

Rituals and Communications Codes

Insofar as rituals are communicative, they depend on communication codes. Communication codes can be described as principles that regulate the selection and organization of the exchange of messages (Bernstein, 1974). Codes restrict the type of selection and combination of messages (and with this, types of behaviour) that are admissible within a certain context (Wilden & Wilson, 1976). Characteristic of these codes is that they are known but are not necessarily consciously realized and do not need
to be consciously recognized.

Bernstein (1974, 1976) has distinguished the so-called restricted (or non-verbal) language code and the elaborated (or verbal) language code. Communicating according to a restricted code means that there is a relatively high degree of predictability regarding what and how a person will communicate in a certain situation. The structure of communications is relatively simple and lacks nuance. Communicating according to a restricted code also involves the use of a restricted number of condensed symbols. Their meanings remain implicit. Many of the meanings can be communally shared. But besides this, new meanings can be described by familiar gestures in concrete situations, and a familiar symbol can be experienced in new ways. Rituals, it should be emphasized, rely strongly upon the non-verbal, restricted codes of language (Van der Hart, 1983).

Traditional Healing Rituals

Munn's (1973) observation that traditional healing rituals appear to consist of two stages is invaluable for therapeutic purposes. During the first stage, the presenting problem is relabelled; the second stage involves the prescription of a ritual to resolve the newly relabelled problem.

In life within a traditional tribal society, situations occur in which conflict, threat, tension, disintegration, become dominant, for whatever reason; these situations may be expressed in
the form of illness of individual members. The illness is the symptom that somewhere—on whatever level or levels—the ecological balance is disturbed. As the Navaho Indians say: "To be sick is to be fragmented. To be healed is to become whole, and to become whole one must be in harmony with family, friends and nature" (Fields, 1976, p. 13). Although other traditional cultures have typically not viewed illness from quite such an all-encompassing ecological perspective, numerous cultures do perceive illness as being more than an isolated physiological dysfunction. According to Zulu culture for example, "whites have failed to see that in Africa a human being is an entity.... not divided up into various sections as the physical body, the soul and the spirit" (attributed to a Zulu medical practitioner by Buhrman, 1984, p. 32).

The extent to which the society perceives the illness as an ecological imbalance permits the healer to work on many levels in the attempt to restore ecological balance. Because a traditional society perceives its environment from an ecological perspective it is accepted that visible imbalances in one form, such as illnesses, can be related to imbalances in other forms, such as social tensions. The healer, for example, might not directly treat the patient but attribute the source of the patient's problem to the infighting and dissatisfaction which exists within a village.

Traditional healers are regarded as experts in their cultural traditions; hence any interpretation which they attach to an illness or phenomena will invariably be closely aligned to the social reality of the culture. If the patient accepts the new
interpretation for his or her problem, there is an explanation of the problem which is compatible with the social reality of the culture. It is thus possible to posit the establishment of a new balance between the patient's ideational structure and the environment. As long as the healer is regarded by the society as the custodian of cultural beliefs and attaches a meaning to the patient's illness which is in accordance with these beliefs, then the healer can be described as fulfilling an ecological function, even if that is not how the healer would describe it (Van der Hart, 1983).

When illness or other signs of disintegration occur, an adequate diagnosis must be made. Sometimes that is not so difficult, as in this example (from Levi-Strauss, 1963a): An Indian woman in South America had serious difficulties with childbirth; the midwife had to ask for the help of a shaman, which he gave. However simple the diagnosis would perhaps be in Western terms, his treatment showed that he took dysfunction into account on many psychobiological levels.

In other cases, the issue is much more complex and has still more dimensions. A ritualistic psychotherapy (described by Jilek, 1974) is applied by Indians on the northwest coast of North America. The patients for whom this healing ritual is intended have many kinds of psychosomatic complaints, or are characterized by acting-out aggressive behaviour—for instance, alcohol and drug abuse. Both cases concern, according to the Indian leaders, are the so-called "spirit illness," which Jilek labels an underlying
anomic depression. To make this diagnosis of spirit illness, it is necessary to become acquainted with the total social and cultural context in which these Indian patients are living.

Ritual treatment of the Ndembu (from central Africa) with economic, social, psychological and psychosomatic complaints has been discussed in detail (Turner, 1964, 1968). Turner demonstrated that an assessment of the entire ecological system takes place and that the social factors are especially important.

From the macro perspective, Simpson's (1970) and Lewis's (1971) research has demonstrated that ceremonial possession affords benefits to the wider social group by tightening social structure and promoting cohesion. Simpson enumerated the latent consequences of ritual possession as: (1) the establishment of interaction between the individual and the community, (2) the recognition of the individual's role in the cult, (3) the satisfaction of sharing esoteric traditions among group members, and (4) emotional release from the ordinary functions of life. In fact, the group and the community in the ritual, both offer help to the individual and legitimize the ritual (Ward, 1984). Often the ritual roles and symbols are based on community cultures. This situation indicates to us the influence of the community on the ritual, and its effect at the individual level.

Hindus have historically placed great value on ecstatic trance and development of supernatural powers through austerity (Fadiman & Frager, 1976). In addition there has been a traditional predisposition to compel the gods to fulfil requests through
extreme practices of self-discipline and self-mortification. Gaitonae (1961) has argued that these techniques are therapeutic in themselves and that there is a strong link between ritual systems of anxiety reduction, and understanding deeper psychological forces. So too have other traditional societies, including the Tamang, a Tibeto-Burmese speaking people, the largest, single, ethnic group in Nepal Petter (1978); and the Zar of Ethiopia (Messing 1959) and some traditional Puerto Rican peoples (Koss 1975). These and later investigations have highlighted group psychotherapeutic components of traditional approaches to socioemotional problems.

Rituals themselves, as Kiev argues (1972), provide emotional catharsis, by allowing the patient to ventilate aggression and frustration, provides "a sense of renewal and an improved capacity for dealing with reality" (p. 42). Furthermore, catharsis has remained an important aspect of psychoanalysis from its inception. As Freud (1924) wrote, "The cathartic method... in spite of every extension of experience and of every modification of [psychoanalytical] theory, is still contained within its nucleus" (p. 194).

Psychotherapists should rethink rituals as therapeutic techniques. The theory and investigations in this area open a doorway for further research; they help us gain more information about the effectiveness of ritual and its implications for psychotherapy. The next section deals with rituals in Western therapies and interventions.
A search for writers who describe rituals as a psychotherapeutic tool was made through numerous books and articles. Types of psychotherapy thought most likely to mention rituals were examined. This section contains information and examples from psychoanalysis, existential, Jungian, and strategic psychotherapies; interventions in social work as well as cross-cultural and pastoral counselling.

**Systems of psychotherapy.** Rituals have played a role in several types of therapeutic intervention.

**Psychoanalysis.** Freud (Breuer & Freud, 1955) viewed religious and social rituals negatively as based on guilt. But maladaptive, ritualistic behaviour on an individual, clinical level was of most interest to Freud. Since Freud, psychoanalysts speak of day-to-day habits such as greeting as adaptive rituals (Erikson, 1966), while other types of ritual—e.g., compulsive handwashing—are seen as maladaptive.

More recent psychoanalysts have taken a different stance. Siggens (1983) asserted that the psychoanalytic process can be viewed as a ritual. She gave an example of a patient who experienced the death of a loved one and feared that the strength of grief would prove intolerable. The therapists helped the client work through the grief. She concluded by stating, "the ritual of
the psychoanalytic setting provides a regular predictable form which maximizes the freedom of thought and feeling in the analysand that is necessary for the work of the psychoanalysis itself." (p. 2)

In at least one case, a ritual was suggested by none other than Freud himself (Breuer & Freud, 1955). It appears in his report of the treatment of Fraulein Elizabeth Von R., but it is not called a therapeutic technique. Freud suggested to Elizabeth that she visit her sister's grave. He did not however, explain the reason(s) for this intervention. The suggestion moreover, might appear to conflict with Freud's negative view of religion. He considered some religious manifestations as psychopathological: people, in his view, adopt religion out of unconscious dependence on a parental figure. When they become mature, they become more independent (Freud, 1927; Siggins, 1983). Yet clearly, Freud, at the very least, felt that religious dependence could be utilized in therapy.

Existential psychotherapy. The philosophical framework of existential psychotherapy stresses the importance of ritual in human life. Yet there is little evidence of rituals being utilized as a therapeutic framework. This lack may be due to the fact that existential therapists tend not to emphasize interventions. The authentic, committed relationship between therapist and client is seen as the major tool for growth (Keen, 1978; Valle & King, 1978). Such quasi-friendship may, of course, have ritual elements.
Existential thinkers (Becker, 1973; Keen, 1978; Sartre, 1971) view neurosis as a human condition. Becker (1973) suggested that "the only thing that can 'cure' it [neurosis] is a world-view, some kind of affirmative collective ideology in which the person can perform the living drama of his acceptance as a creature" (p. 158). This has been accomplished in the past through societal, myth-ritual complexes which channelled obsessions. "We might say it places creative obsession within the reach of every man; this is precisely the function of ritual" (Becker, 1973, p. 199).

Becker added that rituals automatically provide safety and meaning to life and allows some aspects of existence to be experienced in manageable "bites." Becker concluded by lamenting the fact that the cure for neurosis may be clear, but the way to "prescribe" the cure is not. He said, "For one thing, [the therapist] cannot get living myth-ritual complexes... on a prescription form from the pharmacy. He cannot even get them in mental hospitals or therapeutic communities" (p. 159). Becker stopped just short of proposing that since rituals are man-made, they can be developed by therapist and client.

Zuesse (1983), like Becker, stopped short of advocating that rituals be utilized in psychotherapy. He viewed rituals as producing a self-alienation which, paradoxically, could spur an individual to grow psychologically. According to him, in order to participate in a ritual, an individual "must accept a limited role which is merely complementary to other roles; one gives up the intention to be self-determined" (p. 41). The absurdity or
The paradox of rituals is that individuals move toward sanity as they experience this self-alienation. For it is only by experiencing the known structure that individuals can fully see themselves as they really are: finite, bounded, and completely interrelated with the world. Knowing and accepting who one is, one can grow and be healed.

Yalom (1980) came closer to advocating the therapeutic use of rituals. To assist clients in moving deeper into their existential condition and the issues surrounding it, Yalom offered a number of suggestions including guided imagery, psychodrama, and other encounter techniques. He also briefly touches on ritual, although he does not expressly use that label. He said, "Simple milestones such as birthdays and anniversaries can be useful levers for the therapist. The [existential] pain elicited by these signs of the passage of time runs deep" (p. 172). Yalom further stated that the therapist can utilize naturally occurring important times in a client’s life or may contrive such situations.

Jungian psychotherapy. Jung (1966) stated that one of the most difficult tasks of the psychotherapist is helping the adult to grow up. The adult entering psychotherapy is given the "chance to shed all the fragments of egg-shell still adhering to him from his childhood days, and to withdraw the projection of the parental images from external reality" (p. 96). He made the point that, prior to the advent of modern psychotherapy, societies attempted to facilitate and ease the transition from childhood to adulthood.
through the use of rituals at puberty, marriage, death, and birth. The rites "are probably designed in the first place to avert the psychic injuries liable to occur at such times; but they are also intended to impart to the initiate the preparation and teaching needed for life" (Jung, 1959, p. 97). Jung believed that religious rituals, e.g., baptism, confirmation, Bar Mitzvah, and funerals, have the same purpose. He viewed orthodox rituals however, as a poor tool, one too frequently "congealed in a rigid, often elaborate, structure of ideas" (Jung, 1959, p. 473). The rite loses richness and aliveness and ends up stifling participants. Jung did not speak about rituals as a psychotherapeutic framework.

Since his death, some Jungian-oriented writers have taken a second look at rituals. Some (Campbell, 1972; Mattoon, 1981) have suggested that rituals are still important; although not advocating rituals in therapy, they believe that rituals can be made more therapeutic. Campbell (1972) argued,

A ritual is an organization of mythological symbols; and by participating in the drama of the rite one is brought directly in touch with these not as verbal reports of historic events, either past, present, or to be, but as revelations, here and now, of what is always and forever. Where the synagogues and churches go wrong is by telling what their symbols "mean." The value of an effective rite is that it leaves everyone to his own thoughts which dogma and definitions only confuse. (p. 918)

Campbell and Mattoon, agreeing with Jung that rituals assist the individual to grow to adulthood, advocated the development of meaningful rites. Mattoon (1981) was especially concerned with the current trend to do away with rituals. "The lack of transitional
ceremony remains, however, and may account for some the enthusiasm of many young people for entering religious cults or joining their peers in the use of mind-altering drugs" (p. 172).

**Strategic psychotherapy.** Strategic therapists work towards understanding patterns of communication and rules of the individual or family. They then introduce an intervention in an attempt to break old maladaptive patterns. It is believed that a new adaptive pattern will likely emerge. Reframing and paradoxical intervention are commonly utilized techniques, and ritual interventions are often given as homework assignments.

Various strategic therapists (Friedman & Pettus, 1985; Haley, 1973; Palazzoli et al., 1978; Van der Hart et al., 1988) have openly advocated the use of ritual in psychotherapy. The Milan group, in their book *Paradox and Counterparadox* (Palazzoli et al., 1978) devote an entire chapter to an example of a family ritual. They define family ritual as "an action or series of actions, usually accompanied by verbal formulas or expressions which are to be carried out by all members of family" (p. 95).

By acting out the ritual, rather than talking about their problems, it is believed that the family will perceive themselves as a cohesive whole and naturally move into more adaptive ways of relating. The authors stress that a ritual should be specifically designed for the family that will enact it. "The intervention of a ritual always requires a great effort from the therapists, first an effort of observation, and then a creative effort, since it is
unthinkable that a ritual proven effective in one family can be in another" (p. 97). Rituals in strategic therapy are developed by the therapist without consultation with the client.

Friedman and Pettus (1985) have described a ritual to assist a family that were unable to allow an adolescent member to separate naturally. The family had become enmeshed in mutual dependency and triangulation. The family was Jewish and consisted of a father, a mother, a fourteen-year-old, and the perceived problem child, a sixteen-year-old son, Sam. Sam exhibited many ritualistic behaviors—such as touching objects twice—which severely restricted his normal functioning. The therapists clarified that the family was in a state of unresolved grief about the death of a child from the father's previous marriage. The daughter had been killed in a car accident at age eighteen. The parents were not about to "lose" another child by allowing Sam to experience normal adolescent separation and differentiation.

The therapists prescribed a ritual which was to be enacted by Sam and a Rabbi who was close to the family. Sam was to "meet with the Rabbi for one-half hour each week at which time the Rabbi would 'prescribe' a series of prayers ('ordeals') for Sam to recite each morning. He was to say each two times" (p. 200). The ritual was designed to relieve Sam's expressed guilt and to change his ritualistic behaviour into more appropriate, socially acceptable behaviour.

While Sam was undertaking this ritual, the family continued to see the therapists for a number of sessions: Sam's ritualistic
behaviour did not go away completely, but it was greatly reduced, and a few years later he moved out of the family home. The therapists believe the ritual accomplished its purpose by allowing Sam to disengage somewhat from the enmeshed family situation.

**Pastoral counselling.** Religions have traditionally relied heavily on rituals to deliver their spiritual messages and to work through spiritual problems. Counselling that incorporates a religious or spiritual dimension is termed "pastoral counselling." It is surprising, given the interest religions have in ritual, that only in recent years has ritual been viewed as a psychotherapeutic technique in pastoral counselling (Gordon & Gordon, 1984; Griffith, 1983; Renner, 1979).

Renner (1979) argued that rituals in counselling can provide a psychological and spiritual anchor to assist an individual who is in danger of disintegrating. He gave the example of Maree, who with her fiance', had gone to him for premarital counselling. On the morning of the wedding day, her fiance' was killed in a car accident. At Maree's request, Renner met her frequently over the next few days to provide support and counselling in her grief. Maree wanted to view the body of her loved one, and expressed the desire to place a ring on his finger. In clarifying this request, both the pastor and Maree agreed that the ring ceremony would symbolically represent all that the relationship had meant.

The ritual consisted of the pastor viewing the body first and then explaining to Maree what the deceased looked like. Then the
pastor and Maree together approached the body. Maree placed the ring on his finger, talked briefly to him about their love, kissed his head, and then indicated that she was finished. The pastor said a prayer and they left together.

Social work. The art of social work as a human service profession rests on all of the human sciences, and it is that foundation which provides an understanding of person as a biopsychosocial, cultural, and spiritual organism (Joseph, 1988; Teicher, 1958). Since social work deals with the person as a total organism, we cannot afford to abdicate our rightful responsibilities as social workers by demanding that social scientists construct a ready-made system for intervening effectively with troubled persons in our society.

One of our goals as social workers is to help the client to further his or her welfare. That means that the social worker has to consider all the resources that exist in the client's community. The traditional healers and the rituals that the community uses in case of crisis are sources for treatment. The social worker should use them as resources and cooperate with the traditional services which exist in the community to gain the treatment goals. Social workers should take into account the client's belief systems and his or her religion; knowing these factors helps the social worker understand the client's problems.

Historically, social work has been significantly influenced by the Christian and Jewish religions. Theological teachings,
religiously committed individuals and sectarian organizations have contributed to the formulation of social work concepts, principles and values, the creation of social-work educational institutions. Religious ideas from Christianity and Judaism have also informed the development of social-work values and ethics (Canda, 1988; Young & Ashton, 1956). Biestek's (1957) exposition of social casework which emphasizes compassion, love, understanding and acceptance is perhaps the best example of the infusion of essentially religious notions into social work.

Whatever the condition and fate of ritual today, it is clear that the form of ritual has considerable power. Families themselves consciously or unconsciously use the ritual mechanism to preserve, to adapt, to change, or to avoid change. Thus social workers need to learn how to capture and more effectively use rituals in their interventions with families (Abramowitz, 1993; Al-Krenawi & Graham, in press; Frey & Edinburg, 1978; Gutheil, 1993; Laird, 1984; Schindler, 1993; Wolin & Bennett, 1984).

Cross-cultural counselling. With the increasing numbers of immigrants, often from Third-world countries to modern countries, such as the United States, Canada, and Israel, psychotherapists will likely find themselves dealing with clients from very different cultural backgrounds and lifestyles. In recognition of this situation, the Counselling Psychologist, in 1985, published an entire issue on cross-cultural counselling. Important therapeutic principles in this type of therapy include understanding and
accepting the client's definition of health, as well as the client's perceptions of the world, upbringing, and life experiences (Ibrahim, 1985; Suinn, 1985). To use these tools effectively, therapists must recognize the ways in which their own perceptions differ from those of their clients. Aguilar and Wood (1979) emphasized that in order for a ritual to be effective it needs to be experienced as meaningful by the patient. Therefore, the therapist must treat it with respect, solemnity, and mysticism. The ritual also needs to be flexible enough to change when necessary to meet the individual's needs.

*How rituals may assist in counselling.* Both Renner (1979) and Rando (1985) viewed rituals as an important adjunct to the counselling process, not a substitute for it. Renner stated, "Ritual gathers the fragments that have surfaced in the counselling sessions and dramatizes them and gives them concrete form. Counselling adds free flow of sorrow in grief, but ritual provides it with form, whereby it's channelled toward wholesome creative ends" (p. 172).

Rando (1985) argued that rituals can be powerfully therapeutic because they necessitate the behavioral expression of thought and feeling. This "acting-out" moves the client from passivity, helplessness, and emptiness to integration as an actor in the grieving process. Rituals, being a right brain activity, touches the unconscious more quickly than verbalization. This mind/body congruence also enhances the working through of such issues as
Both Renner and Rando agree that rituals need to be meaningful for the patient and full of feeling but not overly dramatic. Renner stated that some familiar traditional elements, such as the Lord’s prayer for a Christian, make the ritual more effective, and both counsellors agree that the parts of a ritual must be congruent with its purpose.

In summary, many schools of psychotherapy—e.g., Freudian—implicitly use ritual. Newer approaches, such as strategic and paradoxical therapy explicitly use ritual. Social work, especially its cross-cultural subspecialisms, has begun to look with more favor upon rituals as part of a consideration of cultural context. All such approaches may ultimately help us understand more about the healing effects of ritual.

Integration Between the Modern and Traditional Mental Health Systems

Introduction

This section deals with the similarities and differences between the modern and traditional systems in treating "mental illness." It shows that there are therapeutic components in traditional healing systems which are similar to those in the
modern. The healer or shaman appears to act as a therapist in Western terms, and it is arguable that the techniques utilized by healers are similar to those used by psychiatrists.

There are differences between the two systems; for instance, interpretations of symptomatology and the ways psychiatrists and traditional healers determine diagnoses. Often healers are familiar with their patients' background and share the same world view. In contrast, psychiatrists, particularly those working in traditional societies are generally not familiar with their patients' background and do not share the same world view. Traditional healers and their patients believe that diseases are caused by supernatural powers, such as spirits, sorcery and the evil eye. The psychiatrists' or mental health practitioners' perceptions of the disease, on the other hand, are scientific; the cause of the disease or the problem is thought to be internal rather than external, that is, within the patient or the family dynamics.

The Similarities Between the Two Systems

Historically, there is a connection and analogy between modern psychiatry and traditional healing. Modern psychiatry is based on what existed in traditional cultures, including so-called spiritual treatment by religions and healing rituals (Bilu & Witztum, 1994a; Bromberg, 1975, 1937; Nelson & Torrey, 1973; Prince, 1981, 1976; Wallace, 1958). Levi-Strauss (1963b), for instance, stated that
the goals and methods of psychoanalysis in Western culture are best understood by comparing them to those of shamans and sorcerers in other cultures.

Shamans have been regarded by some anthropologists as suffering from various types of neurosis, personality disorder or psychosis, but, according to Jelik and Todd (1974) their image in Western thinking is changing. Western investigators have characterized their healing and psychotherapeutic activities (Kiev, 1964a; Seguin, 1973; Torrey, 1972a). Folk healers have been found to use techniques such as suggestion, persuasion, and manipulation, which are similar to those used by psychiatrists (Ruiz & Langrod, 1976a). Murphy (1973) pointed out that folk healers could be as effective as medical practitioners for certain types of disorders in certain cultural settings. He stressed the important part played by cultural beliefs in emotional conflicts.

Although the term "shaman" refers specifically to a type of Siberian healer, it has a more generic connotation referring to a role-complex undertaken by indigenous healers who use "magical," nonscientific modes of treatment. Every cultural group has its shamans, such as Haitian handguns, Navaho hand-tremblers, West Indian obeah men, and Western faith healers. It is not surprising that some shamanistic practices are similar to scientific therapy, e.g., the use of psychopharmacological agents, psychodrama, catharsis, abreaction, environmental manipulation, suggestion, and direct ego support (Kiev, 1964a). Some shamanistic procedures, such as exorcism, bandaging, and magical tricks like sucking out
evil spirits, may prove effective if the patient and others in the culture have faith in the healer's abilities. Such manipulations raise positive expectations which may show an important impact on the outcome of treatment (Marica, Rubin, & Efran, 1969; Rappaport, 1972). Tantam (1993) stated that both psychotherapy and exorcism seek to make something socially useful from feelings, such as aggression, that were previously antisocial. Frequently, shamans are able to mobilize family, social network, and community support for the patient (Al-Krenawi, 1992; Al-Krenawi et al., 1995; Al-Krenawi & Graham, in press; Heilman & Witztum, 1994; Rappaport & Simkins, 1991; Speck & Attneave, 1973). Because the patient's family occupies a central position in the traditional healing treatment, it appears that there are elements of family therapy in this system (Hajal, 1987).

Murphy (1964) noted that the effective shaman calls on an entire system of beliefs that are widely held and emotionally accepted by a cultural group. The healer then dramatically performs the curing ceremony in a group context, and awes the group by his or her extraordinary powers. In so doing the shaman may act as an agent of a spirit and actively involves the patient in the treatment by prescribing specific activities (Csordas, 1990; Krassner, 1986; Wessels, 1985).

Although there are some similarities between the shamanistic complex and psychiatric modes of therapy, there are also differences (Prince, 1964). Despite demonstrated placebo effects in treatment, psychiatrists are not true shamans in modern garb,
and it is doubtful that psychiatrists are merely using magical procedures. There is, however, an element of ritual in psychiatric or psychotherapeutic treatment (Serlin, 1993).

Likewise traditional healing rituals also contain several types of psychotherapeutic components, at the personal, family and group levels. Leighton and Leighton (1941) pointed out the variety of therapeutic factors involved in the performance of the healing: the powerful influence of suggestion, the air of optimism about eventual cure, the diversion and participation of the patient during preparation and performance of the ritual. These investigations concluded that the Navaho healer provides "a powerful suggestive psychotherapy which can certainly aid states of anxiousness and render the physically ailing better able to bear his illness" (p. 515). They also advocated collaborative work between healers and Western practitioners. Moreover, contemporary mental health practitioners have begun to evaluate the individual within his or her family, considering the healing ritual as a psychotherapeutic technique on several levels, individual, group, family and community (Al-Krenawi & Graham, in press; Atkinson, 1987; Gorelick, 1987; Kennedy, 1967; Koss, 1975; Messing, 1959; Palazzoli et al., 1978; Pearson, 1987; Perlmutter & Sauer, 1986; Rando, 1985; Schindler, 1993; Serlin, 1993; Skultans, 1988; Ward, 1984). The rituals integrate parts of the self and bind individuals with their communities and histories (Hoch-Smith & Spring, 1978).

The treatment ritual in both systems appears to be similar
from the patients' perspectives. When the disease emerges the patients seek help from both the healer and professional; often they are accompanied by family members. Both practitioners -- the traditional and modern -- are perceived to have authority. The professional has knowledge and skills to treat the disease based on education and experience; and the healer has the supernatural power to expel the disease from the patient's body based on religious/magical and temporal experience. At the initial help-seeking stage, the patients in either system expects their both practitioners to treat the disease.

Bankart et al. (1992) discussed two interrelated traditions as they are reflected in contemporary and traditional approaches to psychotherapy in Japan. The first uses various meditational and self-focusing instruction sets whose common goal is to facilitate the slowing down, deepening, and clearer focusing of sensory and interpersonal awareness. The second focuses on physical self-regulation and autonomic self-control through exercises that foster enhanced voluntary control over physical states and processes. Eastern philosophy offers a set of practices that help the individual overcome the inherent selfishness of his or her isolated experience. The goal of such work includes recognition of gratitude to important people in the patient's life, rediscovery of the joy of meaningful work, and the experience of a unifying cosmic consciousness.

The psychiatrist and the healer have authority and power. The psychiatrist has the knowledge and skills; the profession itself
gives him/her power, prestige and status: he or she can use medications, injection and psychotherapy. The healer has a supernatural power, which likewise gives him or her social status, authority, and power, including the ability to heal people. The supernatural power makes the healer an important person, which leads to high status and respect from the people in the community (Al-Krenawi, 1992; Bilu, 1978; Crapanzano, 1973; Frank, 1973; Meyer, Blum, & Cull, 1981; Rappaport & Dent, 1979; Torrey, 1972a, 1972b).

The Differences Between the Two Systems

Symptomatology. Psychiatrists determine a diagnosis according to the patient’s symptoms as stated in authoritative sources. Usually psychiatrists do not consider the cultural effects; often they use the apparently universal descriptions given by the Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R) (American Psychiatric Association, 1987). Thus psychiatrists determine the patient’s diagnosis according to symptoms as they are understood in Western culture; psychiatric categories reflect Western values (Al-Krenawi et al., 1995; Aviram & Levav, 1981; Bilu & Witztum, 1993; Chiu, 1994). Many psychiatrists make diagnostic mistakes when they do not consider the patient’s background, religion and belief systems (Bilu & Witztum, 1994b; Chiu, 1994; Jayasuriya, 1988; Larson, Patterson & Blazer, 1986; Schwartz, 1985; Witztum et al., 1990).
Wallace (1961) has argued that symptoms of mental disorder vary, depending on the cultural context of the victim. Sometimes the patterning of these symptoms is so unlike Western clinical portraits as to suggest that a new mental disease has been discovered. Familiar examples may be cited: amok and latah in Southeast Asia; piblokto among Eskimo, and arctic hysteria among northern Siberian peoples. Even within Western society, Opler has demonstrated, the symptoms typically exhibited by members of such ethnic groups as Irish and Italian in New York City, are sharply different: For instance, Irish male schizophrenics tend to be quiet and withdrawn, and their Italian counterparts tend to be noisy and aggressive (Opler & Singer, 1956).

Bedouin patients often express their emotional difficulties by bodily complaints e.g., they say Colo Bojja, or "the pain swims in my body" (Al-Krenawi, 1993; Al-Krenawi, 1992). The Bedouin also explain their emotional difficulties by proverbial expressions. The proverbs reflect the patients' subjective feelings, indicating a level of abstract thinking as in Western medicine (Nguyen, Foulks, & Carlin, 1991). Similar processes were described by Abad and Boyce (1977), in their analysis of Puerto Rican patients expressing their difficulties by physical complaints; these patients apparently described hallucinatory experiences (pseudohallucinations).

Bazzouï (1970) reported that the average Iraqi patient describes depression as a sense of oppression in the chest, a feeling of being hemmed in, or in other cases, a hunger for air.
The chest, head, and abdomen are frequently considered to be the core of the patient's troubles, and he or she employs phrases such as, "My heart feels like a cold, dark room on a winter night," and "My heart is dead." Western-trained psychiatrists who examine the heart and offer reassurance that nothing is wrong to Middle Easterners who report "heart distress" cannot help their patients because they fail to understand the culturally shared schema of emotional distress symbolized by this expression (Good, 1977). If psychiatrists do not pay attention to the cultural dimensions, this leads to misdiagnosis and incorrect treatment (Bilu & Witztum, 1993, 1994a, 1994b; Budman, Lipson & Meleis, 1992; Chiu, 1994; Gomez, 1982; Leff, 1981; Lefley, 1986; Meleis & La fever, 1984).

A Philippine anthropologist has described how the people of a particular village saw or heard fairylike spirits in nearly every tree and pitied him because he was blind to these (Jocano, 1971). A Senegalese psychiatrist has asserted that quasi-hallucinations are so frequent in his country that they should not be used for diagnostic purposes; he further pointed out that the cultural traditions in Senegal encourage everyone to have ideas of reference (Sow, 1978, quoted by Murphy, 1982).

Underlying the recent interest in the cultural variations of symptomatology has been the question of whether the present psychiatric classification system could be universally applied in the diagnosis of mental disorders. Since the DSM system is based on symptoms of patients from Western cultural backgrounds, it may be inappropriate for use with patients from other cultures (Al-
Issa, 1977, 1970; Marsella, 1980; Minuchin-Itzigsohn, Ben-Shaol, Weingrod, & Krasilowsky, 1984). In order to distinguish between culturally normal and abnormal symptomatology, it is necessary to become acquainted with the behaviour, values and the belief system of the cultural or ethnic group (Bilu & Witztum, 1993; Littelwood & Lipsedge, 1989; Slattery, 1987).

Schwartz (1985) argued that the treatment of mental and emotional disorders needs to be based in the world view of the people being served. Western diagnostic systems and rational psychiatry models are not effective where people conceptualize differently; imposing psychiatry may be a form of cultural imperialism (Schwartz, 1985). In many traditional societies, syndromes are described which are specifically related to culture and religion: "Illness and its symptoms are expressed in a religious idiom shared by the community as a whole" (Obeyesekere, 1970, p. 97).

One may compare Eastern and Western concepts of self within the context of the healing process. The works of Kakar (1982) and Kohut (1978) illustrate differences in how mental illness is expressed and treated in India and the United States. It is proposed that cultural variances in the way that illness is expressed and treated relate to differences in culturally determined myths of the self. In India, the self is conceived as fluid and interdependent; in the West, self is conceived as more solid and autonomous. The therapeutic methods employed by the Western-trained psychoanalysts and psychotherapists make use of the
Western construct of self. Likewise, in India the shaman heals in accordance with the myths available (Florsheim, 1990).

In defining a symptom it is necessary to make a distinction between form and content. Symptoms in psychiatric conditions are what the patients tell you about their abnormal experiences. The form of a symptom comprises those essential characteristics which distinguishes it from other, different symptoms (Leff, 1981). Such content is best understood by healers from the patient’s culture.

*Etiology.* With respect to etiology, psychiatrists, in effect, say to the patient, "Something is wrong with you"; for instance, during earlier life something happened in one of the developmental stages. That is why the person has a problem. An example would be an overly-dependent adult; it might be that proposed person never learned to become independent of the family. Such a message is largely based on an internal locus of control. In contrast, traditional healers believe that something from outside causes diseases or problems; this indicates an external locus of control (Azevedo, Prater, & Lantum, 1991; Foster, 1976; Shilon, 1968; Young, 1976). Bilu (1977), in his study of Jewish-Moroccans in Israel, pointed out that more than half of the problems consist of a mixture of mental and somatic symptoms assumed to be caused by demons (evil spirits, black magic and the evil eye). These powers are believed to cause what we call "mental illness" (Bilu, 1985; Crapanzano, 1973; Hes, 1964; Rappaport & Dent, 1979; Sharp, 1994).
In sum, psychiatrists try to cure phenomena believed to be supernatural by natural means and approaches, whereas healers use methods more closely related to the patient's perception of causative factors.

*Modes of communication.* Traditional healers communicate in the same terminology that their patients use; psychiatrists working within different cultures do not always do the same, thus jeopardizing identification and development of a therapeutic alliance. Psychiatrists in unfamiliar settings often need the help of translators during the treatment process. In contrast, the healer understands nonverbal communication, a common means of communicating among traditional communities, such as Hispanic migrants (Krassner, 1986). Psychiatrists tend to place greater value on verbal expressions, thus causing serious identification problems, as well as limiting the therapeutic approaches used. For example, these patients are not considered suitable for psychotherapy but rather for somatic therapies such as chemotherapy. Such an approach to treatment appears to be symptomatological; the primary problem or conflict remain and the complaints about bodily distress continue.

The psychiatrists emphasize the diagnosis and, in cure, an internal locus of control ("You are responsible for taking the medication"). In a traditional system, the healer tries to increase the patient's faith that there will be improvement in the situation by the supernatural power on which the healer relies.
The healer’s message increases the patient’s expectation from the treatment because the supernatural powers involved are God, religion and saints who are empowered by God (Al-Juhri, 1991; Frank, 1973; Geertz, 1968; Rappaport, 1972; Sharafeldin, 1983; Torrey, 1972a, 1972b).

In sum, it is often assumed in the West that classification of mental illness should be based on the following: symptomatology, etiology and prognosis. Yet an etiological determination is often not made for mental illness, and prognostic classifications are speculative. Thus most classification of mental illness has been based primarily on symptomatology, sometimes augmented with demographic and other data. In Scadding’s terminology (Scadding, 1967), the defining characteristic of most psychiatric disorders has usually been their clinical syndrome. Underlying illness, disease, or dysfunction is generally not known. Where psychiatrists label patients under supposed categories of mental illness, based on symptoms, the failure to consider cultural and religious factors may undermine diagnosis and treatment (Budman et al., 1992; Slattery, 1987).

When a traditional patient refers to Western psychiatry for treatment, that does not mean that the patient changes his or her perceptions regarding diseases and medicine. These patients bring to the modern systems their belief systems and ways of decoding the psychiatrist’s messages. Yet they still express their difficulties in their own way. Hence there is considerable potential for miscommunication with practitioners (Creyghton, 1977). Waxler
(1976) reported that Sinhalese village patients who were referred to the psychiatric treatment did not change their traditional beliefs about the cause of mental illness. Beliefs in demonic possession, ghosts, planetary influence, and witchcraft are all used by families with modern values and middle-class status to explain the strange behaviour of their mentally ill family member. She pointed out that Western medicine is also used by everyone, in somewhat different proportions perhaps, but always as a first or second choice (Waxler, 1976).

A problem which could emerge during such treatment is that belief in a supernatural power does not play a part in most psychiatrists' practices (Ruiz & Langrod, 1976a). Thus there is a contradiction between the patient's belief systems and the psychiatrists' or practitioner's approach (Comaroff, 1978; Daie et al., 1992; Schwartz, 1985; Sharp, 1994; Shuval, 1970).

The Utilization of the Modern and Traditional Mental Health Systems

The consensus of the literature is that the failure of mental health facilities to accommodate to the needs of traditional populations is a major factor in their underutilizing modern health systems (Casimir & Morrison, 1993; Keefe, 1979). The lack of bilingual or multilingual mental health workers has been considered primary (Reeves, 1986). The mental health system also fails, quite often, to identify the patients' diseases (Acosta, 1979). The role of ethnic and cultural factors in diagnosis, treatment,
and service utilization in mental illness have been proposed as important variables (Casimir & Morrison, 1993; Chang & Lin, 1994; Kagawa-Singer & Chang, 1994). Another important factor is that the traditional people seek help from the traditional healing system in their communities (Razali, 1995).

The utilization of the traditional healing system is expected to be quite prevalent in ethnic minority communities. Research on refugee and immigrant groups has documented a strong tendency for members of these groups to continue to rely on traditional medicine and healing methods, and to underutilize mainstream services (Eisenberg, Kesser, Foster, Norlock, Calkins, & Delbanco, 1993; Kilic, Rezaki, & Gater, 1994). This is especially true in the area of mental health, possibly due to cultural barriers, stigma, and unavailability of services (Fabrega, 1991; Higginbotham, Trevino, & Ray, 1990; Sue & Morishima, 1982).

It should be noted that researchers have reported that most Southeast Asian refugees are unfamiliar with Western mental health concepts (Kinzine, 1985; Lin & Masuda, 1983), and are still deeply influenced by a multitude of indigenous cultural beliefs and practices that significantly affect the symptoms presentation, conceptualization, and help-seeking behaviour (Chang & Lin (1994). Chang and Lin (1994) have reported that Asian Americans show a tendency to use traditional herbal medicine and traditional healers. Chinese medicine is often used in addition to, or in combination with Western medicine (Lin & Lin, 1978). The Chinese in New York City’s Chinatown showed a high prevalence of "shopping
around" for medical care (Chan & Chang, 1976). This involved not only visiting different physicians within the Western medical system, but also sequential or simultaneous use of Western and traditional Chinese medicine (Chan & Chang, 1976).

**Dual and Multiple Use**

In spite of the different messages regarding mental health problems, several studies have shown that, in some communities, the patients refer to modern psychiatrists or physicians in the primary health care centres and to traditional healers simultaneously (Ademuwagun, Ayoda, Harrison, & Warren, 1979; Bilu, 1978; Hes, 1964; Lambo, 1978; Palgi, 1981; Shuval, 1970). Kapur (1979) conducted a study in rural India. He found that the majority of the village consulted both modern health practitioners and traditional healers for their psychiatric symptoms. There was no relationship between age, education, social class and the rate of referral to traditional healers.

The utilization of two different systems of treatment may cause cultural dilemmas among some of the patients; the treatment may confuse the patients because they get different explanations of their disease or problem. On the other hand, they may profit from utilizing both systems. According to Rommanucci-Schwartz (1969) this pattern, going from modern practitioners to traditional ones, designates an "acculturative sequence" in which the degree of acceptance of modern medical practices by traditional segments is
indicated. While this sequence attests to the dominance accorded to medical resources, it also points to the actual failures of modern medicine and psychiatry, which contribute to the maintenance of the traditional alternative (Bilu, 1985).

In sum, it is common in many societies in which indigenous and Western healing systems coexist to tend to have different expectations regarding the various systems and either to choose different types of healing specialists for different types of problems or to utilize them simultaneously, each to deal with a different aspect or symptom of the same problem (Benoist, 1975; Garrison, 1977; Jahoda, 1961; Woods, 1977). Each system may thus adapt to the presence of the others, thereby preventing direct competition between them. On other hand, as a result of competition, the importance of systems may diminish and new medical roles, "emergent roles," may result from the interaction (Landy, 1974).

The Integration of Mental Health Professions and Traditional Healing

Rappaport and Rappaport (1981) proposed a model of integration between Western health and traditional healing systems. They stated that traditional healing is a distinctly different system that has a different model of disease and that operates within a different world view. Despite perceived clashes in values between
the traditional and Western systems, differences in their manipulation of expectancy, and the degree to which the systems differ in healer charisma, the authors "concluded that Western and traditional systems are complementary and should be constructed to function alongside another" (p. 774).

Moreover, Rappaport and Rappaport suggested that integration is possible: an analogy is treatment of psychosomatic illness in the West; this can provide a model for integration. In case of organic symptoms the patient is treated by medication; subsequently, the physician, recognizing "underlying emotional difficulties," refers the patient to a therapist. This integrated model would entail that the scientific specialist treats the organic symptom and then the traditional healer treats the emotional problem. Systematizing this model would ensure that the best of both systems is utilized (Rappaport & Rappaport, 1981).

Lambo (1978) embarked on an innovative experiment in Nigeria to set up a psychiatric facility that incorporated the tribal medicine men. He established a treatment centre in the rural town of Aro and fashioned it as a "therapeutic milieu." The plan was ingenious and was ahead of its time in both Africa and the West. The rationale was to create a treatment program in the context of natural, Nigerian village life with the full participation of the inhabitants. Lambo incorporated the local medicine man into his structure and used the shaman in a consulting fashion. This inclusion of the shaman was a critical part of the plan as both Lambo and other writers (Rappaport, 1977) have identified the
traditional healer as a vital transmitter and caretaker of African culture.

A recent study conducted by Heilman and Witztum (1994) demonstrates how a third party may assist in enabling healers to overcome patients' feelings of "cultural distress" and discomfiture and how such intermediaries may assist the therapists to be "culturally sensitive" in their use of psychiatric methods. This study focused on how psychiatrists collaborate with traditional healers (Rabbis) from the patient community; the treatment was effective and brought the patients relief and cure. The authors recommended that to effect change one must be open to using all sorts of resources, including those that stem from the culture and heritage of the patient, such as Rabbis, holy men, spouses, parents and traditional healers. The authors concluded with an argument for increased openness and flexibility in the practice of psychotherapy, particularly in cross-cultural encounters. Similarly Wessels (1985) reported on the effectiveness of combined modern and traditional treatment for the same patient.

Edwards (1986) examines psychiatric patients in South Africa who used traditional Zulu healers and modern clinical psychologists. While the two treatment models worked from different theoretical orientations, they were in significant agreement as to both diagnosis and treatment. Patients perceived both traditional and modern practitioners as being more or less equally helpful.

In spite of the competition and the contradiction between
modern and traditional systems, there is a way of coexistence, especially in terms of psychiatric problems (Barbee, 1986 Bilu et al., 1990; Bravo & Grob, 1989; Chi, 1994; Garrison, 1977; Heilman & Witztum, 1994; Ikema & Hitoshi, 1979; Lambo, 1978; Lin et al., 1990; Meketon, 1982; Prince, 1981; Razali, 1995; Rudy & Thomas, 1983; Ruiz & Langrod, 1976a; Shukla, 1980; Suryani & Jensen, 1992; New, 1977; Wessels, 1985; Yoder, 1982). Ogunremi (1987) proposed that the mental-health-care delivery system should be integrated into the general health care system in Nigeria and that the expertise of traditional healers, herbalists, and religious groups should be channelled into the health-care delivery system. A similar approach was advocated by the first Jewish-Ethiopian psychiatrist in Israel; he called for integration between the modern and traditional mental health systems for the treatment of the Ethiopians in Israel (Amit Reicher, Yedioth Ahronoth, July 9, 1994, pp. 18-19).

Traditional healers continue to exist as vital and respected mental and social helpers in Muslim and other societies around the world (Shukla, 1980). In 1993, Islamic scholars proclaimed the theological validity and social purpose of traditional religious healing (Al-Ataar, 1989; Al-Jzari, 1987; Al-Sharqawi, 1992; Bali, 1993; Badawi, 1992). Some outcome research, as well, has demonstrated that traditional healing has comparable success rates to modern psychiatric interventions, namely 70% (Bilu, 1978). Bilu's study also indicates that the patients who were treated in both systems were satisfied with both modern and traditional
treatments.

In sum, both modern and traditional mental health systems exist side by side in several societies around the world; often patients in the modern system refer to the traditional system without telling their mental health workers. However, there is a process of integration developed by the patients themselves without the intervention of mental health workers. Therefore, it is time to rethink how to integrate both treatments; it is particularly important that modern practitioners become more culturally sensitive in dealing with the patients’ belief systems and their traditional healing systems. In this matter Sidel (1973) stated that one of the principles mental health professionals learn from indigenous neighbourhood health workers is

minimization of the social distance between primary care health workers and those they serve, one form of which has been called deprofessionalization.... (p. 742)

As a professional social worker with an indigenous people, I am in general agreement with the position of Torrey (1972a) who stated:

The techniques used by Western therapists (in the field of psychiatry) are on exactly the same scientific plane as those used by witch doctors... The reasons we have failed to see this in the past is that we have confused our technology with our techniques, in other words, whatever goes on in a modern office must be science, whereas what goes on in a grass hut must be magic. (p. 74)

Finally, it should be noted that the literature does not distinguish between two aspects of "integration": firstly, as it occurs when patients use both traditional and modern systems; and secondly, as it occurs when modern practitioners and/or traditional healers use the two systems. Usually, the literature’s frame of
reference is towards this second aspect of the term, as described above. But, as this dissertation shall point out, it is important, as well, to incorporate the first part of the concept of "integration" -- that is, the patients' experience of it.

Summary of the Literature Review

There are two central trends in the attitude of psychology to religion, and they contrast sharply. The first, represented by Freud, considers most religious manifestations as psychopathological. In contrast to this view, others (e.g., Jung, Frank) consider religiosity as an expression of the development and consolidation of the personality, and believe that it can help people cope with their problems. But as has been argued, in considering traditional populations, surely the less negative view of religion ought to be embraced; if religion is an important part of a patient's frame of reference, then surely it ought to be incorporated in the theory of mental health practice, as well as in assessment and treatment (Kushilevitz, 1989).

It is important, then, for mental health professionals to avoid seeing religion as a superstition of tribal societies, or as a placebo effect in the cure of so-called "psychosomatic" patients. From the Islamic point of view, if a person is religious, his or her psychological state is in balance. And if he or she is not religious, that means that the person lives in imbalance (Al-Qbudi, 1989). And in most traditional societies, religion is an integral
part of traditional healing systems (Shilon, 1981; Umoren, 1990).

For a traditional culture in particular, rituals are a key entry into the symbolic universe of a patient. Traditional healers understand this point implicitly; they use words, phrases, and proverbs from the patient's culture, discernable to both patients family, and community. It must be emphasized that social workers, by virtue of their own training, also have a repertoire of comparable -- but radically different -- symbols (Kim, 1995; Lum, 1986). But, particularly since culturally sensitive practice has become such a high priority, is it not time for social workers to grapple with the use of rituals in the context of practice (Al-Krenawi & Graham, in press; David & Erickson 1990)? This would provide entry into the patient's social and psychosocial environments, to assist the social workers to appreciate family dynamics, and to incorporate natural helping networks in any treatment plan (Azhar et al., 1994; Fay, 1982; Kelley & Kelley, 1985; Speck & Attneave, 1973; Waltman, 1986).

Professionals in the field of mental health also need to learn from the healers, especially the terminology used when labelling and "classifying" the severity of mental disorders. We will benefit by understanding our patients and in determining which needs can be fulfilled by the traditional healer and which not (Al-Krenawi et al., 1995; Hes, 1975; Razali, 1995).
Chapter Four

THE RESEARCH QUESTIONS

Introduction

This study uses qualitative methodologies to explore and analyze patients' perspectives of dual concurrent use of modern and traditional mental health systems and the factors that influence their decisions to use either or both systems. It is important to note that there are few studies dealing with the issue of mental health in the Bedouin society; and that the present thesis is the first to examine the dual use of both systems among the Bedouin of the Negev, Israel.

Particularly important, as the preceding chapters have emphasized, is the perception of the patients themselves in the experience of dual use of the two systems. Few studies, it should be emphasized, have delved into this most important issue. As well, the dissertation compares the perceptions of the traditional healers with those of the psychiatrists. The dissertation also provides a forum in which the perceptions and experiences of patients can be compared with those of their respective psychiatrists and healers. But beyond this, the dissertation also sheds light on what are the specific patterns of dual use by the Bedouin patients. It also examines how gender and Bedouin culture
influence this same process of utilization.

The Research Questions

The central research question is: What are the patterns of dual use of modern and traditional mental health systems by the Bedouin of the Negev? This central question leads to subsidiary questions related to the two systems involved in the treatment of these patients. Areas considered were etiology/explanation, diagnosis, symptomatology, prognosis, and course of treatment.

The questions related to the patients. The investigation addressed the following questions about the patients:

1. What factors are taken into account by those who are referred to a mental health clinic in deciding whether to use both the modern and the traditional systems, as opposed to only one or the other?

2. How is dual use of both systems experienced by the users and their significant others? What strategies are employed by dual users to manage their use of both systems?

3. What patterns of dual use are seen, and how do they reflect differences with respect to gender, class, degree of biculturality, life history or other factors?

4. What are the patients’ perceptions of the diagnosis, the etiology of the disease or problem, and the prognosis? How do the patients perceive the two systems?
5. How do the patients understand the treatment process in each system; and how do they manage the differing treatments in the two systems?
   5.1. Do they experience conflict because they are treated in two different systems?
   5.2. How do they perceive their psychiatrist-patient and healer-patient relationships; how do these relationships reflect awareness of Bedouin culture?

6. What are the patients' reasons for utilizing each system, and what are the perceived advantages, disadvantages and effectiveness of each system?

7. What are the patients' reasons for utilizing both systems concurrently?

8. What are the implications of dual use for mental health practitioners in multicultural settings?

**Subsidiary questions about the two systems.** The following subsidiary questions were considered:

1. What are the diagnoses from the psychiatric and traditional healing systems (terminology)? How do the psychiatrists and healers perceive the patients' diseases or problems?

2. What are the etiological explanations from the healers' and psychiatrists' points of view?

3. What are the treatment techniques and prognoses in each system? How do these techniques reflect awareness of Bedouin culture?
4. What are the psychotherapeutic elements within the cultural and religious healing rituals?

5. How do the healers and psychiatrists view each others’ systems?

6. In each system, how does the practitioner involve the patient’s family, relatives and community in the treatment process?

7. Do the healers and psychiatrists handle females and males differently in the treatment encounter? What are these differences based on?

8. How might the two systems be integrated in mental health and social work practice?
Chapter Five

METHODOLOGY

An Ethnographic Approach

The following dissertation follows one branch of qualitative research methodology: ethnography. This methodology is chosen due to the complexity of the research topic, the paucity of previous studies concerning the Bedouin population, and the lack of research dealing directly with mental illness in this society. Ethnography by definition is descriptive. In anthropology it means, literally "a picture of the way of life of some interacting group..." (Woods, 1985, p. 52).

Faithfulness to a culture as it is found is the guiding principle of ethnography, and immersion in the culture under study is the general strategy towards this end (Woods, 1985). Ethnographers compile a rich database that supports an analysis revealing the many interrelated variables that create peoples' respective realities (Brooks, 1994; Glik, 1988; Katakura, 1977; Meyer, 1992; Trotter & Chavira, 1980).

In addition, it should be emphasized, an important part of the research is its cross-cultural dimensions. As Carstairs (1965) has pointed out, there are great advantages in limiting cross-cultural studies in such a way as to keep the group compared within one national, linguistic, political and geographical framework. In this case, the group is limited to the Bedouin of the Negev; and
the cross-cultural aspect is the two types of mental health systems.

Beyond this, the dissertation may be conceived as a case study -- that is, it focuses on one hospital, a finite number of patients, traditional healers, and psychiatrists. On this basis, as will be demonstrated, the case study is a prism through which one can begin to contemplate broader issues related to the dual use of mental health systems in Bedouin society.

Through interviews of patients, healers, and modern practitioners, and through participant observation of the healing rituals and observations of modern practices, it is possible to obtain rich and authentic data (Brooks, 1994; Glik, 1988 Psathas, 1973). It also should be noted that the patients' medical files were made available for additional consultation, having received the consent of the patients and their psychiatrists. Also, various modes of traditional and modern healing technologies -- medications, medical books, Holy books, amulets -- were periodically examined. The files provided the researcher with the modern system's diagnoses; sometimes, these were corroborated by the psychiatrist. In the traditional system, in contrast, diagnoses were revealed by the patients themselves, and/or their families; those traditional healers who were interviewed also were obviously able to provide the diagnoses. In addition, two Arab psychiatrists who had treated some of the initial patient population, were interviewed once. It should be noted that this
entire process of data collection took place over a three month period.

The ethnographic approach was chosen for the following reasons. First, the researcher intended to learn about patients' subjective feelings from their points of view; these included their perceptions of the disease, what they believed were the causes of their disease, and the patients' reasons for deciding to utilize one system or both systems simultaneously, and the strategies by which utilization took place. Second, using the ethnographic approach the researcher could describe and analyze what occurred in both systems.

The qualitative approach allowed one to learn about the subjects and to understand the phenomenon of dual use. Qualitative methods helped to understand the modern and the traditional healers' ways of dealing with mental illness, their diagnoses (terminology), prognoses, ideas about etiology, and their treatment processes. Qualitative research, as outlined by Berg (1989, p. 6), "properly seeks answers to questions by examining various social settings and the individuals who inhabit these settings." He suggests that qualitative researchers are interested in how humans arrange themselves and their settings and inhabitants of these settings make sense of their surroundings through symbols, rituals, social structures, social roles, and so forth. (p. 6)

Marshall and Rossman (1989, p. 11) offered a similar definition of qualitative research:
that entails immersion in the everyday life of the setting chosen for study, that values participants' perspectives on their worlds and seeks to discover those perspectives, that views inquiry as an interactive process between the researcher and the participants, and that is primarily descriptive and relies on people's worlds as primary data.

According to Finch (1986), an important focus in qualitative research:

- is upon the meanings which people attribute to their actions, and the processes by which such meanings are constructed, negotiated and shared in the course of human interaction...
- Qualitative research...[sees] the task of social research as uncovering the meaning of social events and processes, based upon understanding the lived experience of human society from the actors' point of view. (p. 7)

Qualitative research, as argued by Lincoln and Guba, operates from a naturalistic paradigm. Such a paradigm assumes that realities are "multiple, constructed, and holistic" (1984, p. 37); that they must be studied in the context in which they occur, and that the goal of research is to achieve some level of understanding, rather than prediction and control. Goldstein (1991) stated that qualitative procedures cannot be prespecified in detail, nor do they often allow exact replication, for the intent of the research is not to prove, but to "discover, explain, or interpret ... at the outset what appears to be obscure, perhaps ambiguous human events or situations" (p. 104).

As well, since the proposed research questions are somewhat new, an exploratory approach was considered to be the best method of inquiry. To find out the participants' subjective, feeling experiences, one should go beyond the questions. Sometimes the present subjects talked about issues which were not mentioned by the researcher. However, this helped to understand the patients
difficulties and the healers' experiences in treating so-called "mental illness." Neuman (1991) described the goals of exploratory research to include development of a well-grounded mental picture of what is occurring; generation of many ideas and development of tentative theories and conjectures; and formulation of questions and refinement of issues for more systematic inquiry.

**The Setting (The Clinic)**

The psychiatric clinic at the Soroka Medical Centre has a catchment area of nearly 200,000 inhabitants, including the 80,000 Bedouin of the Negev (Al-Krenawi et al., 1994). I was one of those who planned to open the psychiatric outpatient clinic for the Bedouin, and when it was established in 1981, I became the coordinator of the "Bedouin clinic" until 1992. I am the first and the only Bedouin psychiatric social worker. The Bedouin clinic is open for one day per week and mainly receives patients who are referred by general practitioners or family physicians working in the community, primary-care clinics in the area, the emergency room in the Soroka hospital, and by private physicians. Some of the Bedouin patients came to the psychiatric system on other days during the week; the psychiatrists often invited patients for treatment on other days, if the patients spoke Hebrew.

There are no services that provide psychological counselling or psychotherapy for the Bedouin society in the Negev except the psychiatric clinic in Soroka. In Bedouin schools, there are no
counsellors, social workers or psychologists. Also there are no psychological services in the Bedouin community, such as marriage counselling, psychological services for children and youth. Therefore, the Bedouin are not familiar with such systems (Haidar, 1991). Today there are ten Bedouin social workers, all of them working in the social welfare services. The social services are perceived by the Bedouin as an institution providing instrumental support. Unfortunately there is a stigma attached to these services, reinforced by the workers who focus on instrumental support rather than emotional and psychological problems.

The clinic is located in a separate area, in its own building. The clinic building consists of several offices for the practitioners, and a general office. All the clinic activities and the waiting rooms are close to the general office, and from there I was able to observe the patients as well as the psychiatrists in the clinic. The psychiatric clinic is close to other departments and clinics, such as the gynaecological department, paediatric department and heart clinic. Thus, the patients have the opportunity to visit relatives who are hospitalized, or to meet friends and relatives in the general hospital.

The staff of the psychiatric clinic included 15 psychiatrists; 8 of them were Israelis, 5 males and 3 females. One was a Romanian male; 6 were Russians, 3 males and 3 females. There were six psychologists; five were Israelis, three males and two females. One female had recently immigrated from Argentina. There were four social workers, all of them Israeli females. There were two
nurses; both were female, one Israeli and the other Russian. The two secretaries were both Israeli females. Some of the clinic staff worked part time, therefore some offices are shared by two employees.

The Sample

This section deals with the three types of subjects. These are the Bedouin patients, psychiatrists and traditional healers. The research sample was drawn from the Bedouin patient population who were treated simultaneously (of their own volition or the family's choice) in modern psychiatric and traditional healing systems.

Patients

I interviewed the Bedouin patients at the psychiatric clinic in the Soroka hospital. After I gained their trust and acceptance, I interviewed them by semi-structured interviews in Arabic. During the interviews I tried to show empathy, acceptance and respect to the patients; I sought their agreement to participate in the study.

In the case of the Bedouin patients, it is culturally impractical and potentially harmful to the quality of data collection to introduce a signed form providing consent to participate in the study. Unlike those of us in the Western world, the traditional Bedouin perceives "the word" (Kalmah) to be synonymous with consent and is suspicious of signed documents. To
paraphrase a Bedouin saying, "If the Bedouin give you their word, this means that they agree to what you suggest to them." But to introduce the prospect of a signed form would be to put into question the integrity of the Bedouin patient's word; to unnecessarily evoke the Bedouin's suspicion of the research project itself; to introduce a climate of suspicion between the researcher and subject; and to create an asymmetrical relationship between the researcher, who is literate, and the subjects, many of whom are illiterate. Only by following what is acceptable culturally and by obeying the rules of the Bedouin society, is it possible to create a sufficient climate of trust to enable the accurate acquisition of data (Sebai, 1981). The Bedouin patients' permission was therefore only obtained orally.

Verbal consent from the Bedouin subjects was gained in the following manner: I first introduced myself, explained that I have no connection with any agency in Israel, and then proceeded to outline my research goals: to promote knowledge about how patients are treated in the modern and the traditional systems; and to understand how the two systems might better treat Bedouin patients. Then I said to them that their participation in the study is completely voluntary and anonymous. For the Bedouin patient, I emphasized that participation in no way affected the patient's relationship with the Bedouin community, the healer(s), the psychiatric clinic, or any aspect of treatment which was to be received.
Gaining the patients' consent was also complicated because of Bedouin cultural rules regarding gender. A strange man has no right to communicate with a female who is not his relative. The Bedouin culture fully enforces the separation between male and female, this custom being based on the Koran and the tradition (Al-Bostani, 1988; Al-Radi & Al-Mahdy, 1989; Mass & Al-Krenawi, 1994). Thus to avoid a conflict with the Bedouin canon, I always addressed, first, the males who accompanied the female patients, or the old females who accompanied the young females when male family members were not available.

In addressing the males, I would ask for permission to interview the female; I explained my research goals. If the patient was a young female, I emphasized that she would be like my sister (aocti). They usually agreed to my proposal, but thought that I was an employee in the clinic.

The term "research" was strange to them, and I tried as much as I could to make the idea understandable. When I was allowed to meet a female patient, I explained to her what I was doing, asked for her consent, and explained why I addressed her relative in the beginning and not her. I assured her that everything she said would be secret and that nobody could find it out, neither her relatives nor the doctors (psychiatrists). In addition, I said to her that she had the right not to participate in the study and could leave whenever she wanted.

I divided the female patients into three categories: a young woman (single or married) whom I called aocti (a sister); an older
woman (at the approximate age of menopause) whom I called khalti (an aunt from the mother's side); an old woman whom I called jadah (a grandmother). These cultural terms avoided suspicion in terms of the encounter between male and female. By such terms, I established familial relationships with the female patients which helped in gaining their trust and consent to participate in the study.

I faced several difficulties in dealing with the female patients. They had high expectations from the researcher; even after my explanation of the study, they still thought that I was an employee in the clinic and that I could help them with their illness. Their families often spoke to me, sometimes asking what I thought about the patient's situation. Such situations led me to explain over and over to them what I was doing. My former clients came to my office, wanting to talk to me about their situation, and asking if I was back at work. Males who accompanied the female patients spoke to me, asking about the patients' disease; another expected me to help him by talking to the doctors, or providing a letter to social services about the patient's situation. During the interview with the females, I respected their perceptions regarding the disease, and anything they mentioned even if it seemed irrelevant to the study. I tried to build good relationships with them and with their relatives who accompanied them.

Throughout the research course, I walked a very thin lines: On the one hand, I heard the woman's problems with her family or
her husband. And on the other hand, I had to keep in touch with the male who accompanied her; otherwise he could intervene and stop the interview and the treatment in the psychiatric clinic. So I sought to convey respect to both sides, the female patients and their male relatives. Further, I tried to be in good relationships with the men in order to allow me to interview the patient's healer, and to participate in and observe the healing rituals. When patients and families arrived at the clinic, I talked to them and asked what I could do for them; often they showed me letters to read. After I finished the interview with the female, I accompanied the family to the psychiatrist's office. I also explained to them where they could get medication. By obeying the Bedouin cultural rules and respecting the patients and their belief systems, I obtained good collaboration from the female patients and their relatives.

With the male patients, I routinely spoke to them directly and asked for their consent to participate in the study after I explained the research goals to them. This group of patients also had expectations of the interviewer: to help them and to talk to the doctor. I tried to show respect and acceptance for everything they said or mentioned. The Bedouin people should be considered sensitive; if you hurt them emotionally, they will never come back.

Based on my experience with Bedouin patients, they do not like the formal roles which separate them from the official employees of social service systems. So I treated them as friends, and I even used the term "Shaab" (friends) during the interview. I tried to
establish close relationships with them by talking to them while they waited for the treatment, asking about their situation, giving them direction if it was needed. Some of them invited me to their homes, and I visited them. By doing this, I created close relationships with them, and they really felt like friends; they became flexible about the time of the ritual that they planned to do; they phoned me and told me when and where they were going to do the rituals. We went to the Gaza Strip in my car, and to the revered saints' tombs; I spent a night with a few patients in Nebi-Musa (a holy place to Muslims, near Jerusalem). We ate together and discussed several issues not related to the study. I tried to feel what they were doing. Such a situation led them to trust me and to tell numerous details about their lives. Even after the interview and the participant observation was completed, they kept in touch with me, telling me about their situations.

In selecting the twenty patient subjects, I had initially interviewed all the new referrals to the psychiatric clinic before the initial contact with the psychiatrist. The next interview was done a week after the first psychiatric contact. Thus I followed the new referral patients, regardless of their diagnosis, until a final sample of ten male and female dual users was obtained. After consent was obtained, the patient was invited to join the study.

The specific criteria for selection of the final sample of dual users of both systems were as follows:

1. Patient is a new user of the psychiatric system;
2. Patient is not psychotic;
3. Patient has decided to be treated by a traditional healer in parallel with the psychiatric treatment. According to the patients, his or her diagnosis is actions or influences of spirits, such as Hariah, meaning anxiety; or Mlmus, meaning the devil touched the person and caused him or her fear; or Nufs mn Al-Jinn, air from the Jinn. These patients were not considered by the healers to be actually possessed by spirits or devils (Al-Krenawi, 1992; Graham & Al-Krenawi, in press).

One notes as an aside, that the traditional, diagnostic categories of the Bedouin are similar to folk categories that have been observed by psychiatrists, anthropologists and psychologists in Southeast Asia, among the Malays; among the Sarawak; among the Serer of West Africa; the Hamadsh of Morocco; the Jewish Moroccans in Israel; in Egypt, Saudi Arabia, Algeria, Iraq, Sudan and Bali (Al-Issa, 1990; Al-Juhri, 1991; Al-Sibaie, 1989; Bazzoui & Al-Issa, 1966; Beiser, Burr, Ravel, & Collomb, 1973; Beiser, Ravel, Collomb, & Rgelohoff, 1972; Bilu, 1978; Boddy, 1989; Crapanzano, 1973; Dean & Thong, 1972; El-Islam, 1982; Schmidt, 1968; Wallace, 1959; Westermeyer, 1979). These folk categories exhibit some similarities to the modern psychiatric categories, psychosis and neurosis, or major and minor mental disorder (Al-Krenawi, 1992; Dean & Thong, 1972; Manson, Shore, & Blum, 1985; Simons & Hughes, 1985; Westermeyer, 1979).
Description of the Sample

Early in the research period, 60 patients (the "initial sample") were interviewed, regardless of their diagnoses, in order to select a sample. It should be noted that all had some sort of experience with both modern and traditional healing systems; that is to say, all had at one time been treated by a psychiatrist, and all had been treated by a traditional healer. Of the 60, there were 37 females and 23 males; there were neurotics and psychotics. At the next stage, the research focused on patients who were diagnosed as suffering from neurotic disorders and/or adjustment problems. This smaller group of 20 patients, the final sample, was followed by the researcher during the course of their concurrent treatment in both systems -- the modern and the traditional.

Thirty patients (50%) in the initial sample left the psychiatric system and turned to the traditional healing system, private doctors, and/or psychiatrists in the Gaza Strip and West Bank. Because these patients were not concurrent users, they were excluded from the final sample; Thirty patients remained in touch with the psychiatric system; these included neurotic and psychotic persons. The main point of the study focused on a subset of those who remained: Bedouin patients who utilized both systems concurrently. These have been called the final sample. Information about those excluded from the final sample is given first.
Patients in the Initial Sample Excluded from the Final Sample: Dropouts

In the initial sample of new referrals to the psychiatric system, 30 dropped out of the treatment in the psychiatric system after one or two sessions. The characteristics of these patients and their reasons for dropping out are now discussed. The patients can be grouped as follows, according to their patterns of mental health system utilization and the distinctive social/psychosocial reasons for making utilization choices.

First group. The first group comprised five patients who quickly turned to the traditional healing system. All were above the age of 55 and illiterate. One of this group said after the second session, "The doctor gave me medication and it does not help; she [the doctor] refused to do a medical examination." This patient kept saying, "What kind of treatment is this 'Haki' (talking)?" This group of patients expected the psychiatric system to be a system like the primary care centre where doctors were doing blood tests and examinations. When this did not occur in the psychiatric system, they became confused.

From my observation of the encounter between the psychiatrists and these patients, these patients typically presented many symptoms, including weakness in the whole body, Diag fe Alsadder (pressure in the chest), pain in the heart and in the stomach. They often described the pain as starting from the legs and going
up to the head. From their cultural point of view, these patients believe that proper treatment is carried out thus: the doctor examines the body and touches where the pain is located; the doctor then treats the location of the pain. One of these patients, for instance, asked the doctor to give her an injection in her stomach to remove the pain.

From the researcher's point of view, since the Arab language tends to be overemphatic and hyperbolic (Prothro, 1955), it is expected that individuals will exaggerate in their verbal communications; otherwise they will not be taken by others to mean what they say, especially in cases of disease. Therefore, it should not be surprising that patients and their relatives exaggerate their verbal reports of pain. Moreover, patients may act out their complaint in keeping with their verbal emphasis on suffering.

These patients were very active during their encounters with the psychiatrists. They often looked at the doctor while they spoke and pointed where the pain was located in their body. One of the patients took the (female) psychiatrist's hand and put it on her chest, to make sure that the doctor identified where the pain was located. The way that these patients described their symptoms was very interesting; sometimes it was even difficult for me as a Bedouin to understand what they meant when they spoke of their difficulties. For example, one of these patients said to the psychiatrist, "Shie Abemsakneh Mn Rejlijah Wa Abetlah Ala Sadrieh Wa Beqaf Fe Raqabati La Ind Rassi wa Behoom Ale" (meaning "Something
catches me from my leg and goes up to my chest and stops in my neck and later in my head; it leads me to be dizzy"). These patients described their symptoms as something alive, and similar to objective things in reality. From my point of view, the patients were more active than the younger patients for cultural reasons. Their age gave them advantages in communicating with others that young females did not have. Their diagnoses in the psychiatric system ranged from depression to conversion reaction. In contrast, in the traditional system their diagnoses were Amaal (sorcery), Hariah (anxiety) and Nfas mn Al-Jinn (air from the spirit).

Second group. The second group of patients were unmarried women who terminated the modern treatment system and consequently turned to the traditional system. These consisted of 10 unmarried female patients. They often were accompanied by two or more members of their families. The families soon realized that the clinic treated mental illness, after they contacted patients who were in the clinic and talked to the psychiatrist. The families then wished their daughters to leave the psychiatric system. The patient's family, for instance, often said, "This clinic is for Maganin (crazy people). Our daughter is not crazy." The families of these patients often responded very angrily when they realized that this system treated Maganin. After one session, these families left the clinic and never came back; such families never consulted their daughters. One father, after he asked me which
this was, said to his daughter, "Let's go, this is not for you," and tore up the psychiatrist's prescription.

The age of these patients ranged from 16 to 20 years old. Their average education was 6 years. None of them held a job, and all came from large families. Five of them were True Bedouin, three Flahin Bedouin; and two Abid Bedouin. For this group, the decision about which system to utilize was taken by the patient's family. The treatment of unmarried female patients in a psychiatric facility was viewed, by the families, as a source of stigma. Thus, when the families realized that the clinic dealt with mentally ill patients, they decided to leave immediately and turn to the traditional system. This occurred more with the True Bedouin and the Flahin Bedouin, than the Abid Bedouin. During the course of research, all the unmarried females from the True Bedouin social group left the psychiatric system after one session; the families even refused to allow the patients to take medication. Such a matter was a concern also of the Flahin Bedouin and the Abid Bedouin, but it was emphasized more with the True Bedouin. During the observation of their encounter with the psychiatrists, members of the second group appeared to be very passive, and their relatives were very active.

The main symptoms presented by these patients were somatization, breathlessness, headache, poor sleep and low appetite. Their diagnoses in the psychiatric system were adjustment disorders, depression, anxiety and conversion reaction including hysterical paralysis. In contrast, their diagnoses in
the traditional system were Amaal (sorcery), Hariah (anxiety), Milmush (touched by the devil) and Mhas sodh (evil eye). Because of the families' involvement and the psychiatrists' lack of familiarity with the Bedouin culture, there were several problems in terms of the communication. Such problems will be discussed later on.

As stated, these patients never argued with what their families decided for them. Throughout the interviews I felt that these young females suffered emotionally and socially; such a situation was clear from their responses and the somatization that they presented. In addition, some of them described their lives as "Adhaab Wa Dowamah," suffering and confusion.

There were several reasons why the patients' families decided to leave the psychiatric system. They were, firstly, the Bedouin attitudes toward the mentally ill; the families' perceptions of mental illness as caused by supernatural powers; the desire not to expose the families' secrets or plans to outside persons; and contact with a psychiatric system could adversely influence the daughter's marriage opportunities (Keating, 1987; Okasha & Lotailf, 1979; Sellick & Goodear, 1985).

Third group. The third group of patients were married women, and the only wives to their husbands, who terminated the modern health utilization. They numbered 6 in total. Their ages ranged from 20 to 31. All were housewives, and only one of them did not have children. They represented two social strata in the Bedouin
society: two were True Bedouin and four were Flahin Bedouin. Often these patients came to the clinic accompanied by their mothers or sisters. They complained about pain everywhere in their body, and never mentioned psychological problems, underlying the somatization. The psychiatric diagnoses included conversion reaction, depression, anxiety state and psychosocial problems. In the traditional system, all of these females were diagnosed as having been affected by Amaal (sorcery). When I spoke with these females individually, I realized that the main problems behind the complaints were marital. This group of patients left the psychiatric system for two reasons. The first reason was disappointment with the treatment; after they took medication for one week and saw no improvement in their situation, they became angry and disappointed with the psychiatrist's medication. The second reason was that often these patients met other patients in the clinic and heard information about the clinic; however, when they realized that the clinic treated Maganin, this led them to leave the clinic immediately. One of these patients said during the interview with her, "I have enough problems without being in this treatment. What if my husband knows that I am crazy?" For cultural reasons, these patients understood that if they were to go into psychiatric treatment, they would indirectly provide their husband with evidence against them. In other words, the husband would have a reason to marry a second wife.

Bazzoui and Al-Issa (1966) pointed out that when a Muslim wife becomes mentally ill, her husband is encouraged to take a second
wife who will look after the household. In contrast, if the husband falls mentally ill, the wife will continue her previous tasks while serving her sick husband. So too in a Bedouin context. If the husband’s family believed his wife was mentally ill, he would be encouraged to remarry. Female patients therefore were afraid of divorce and loss of their children. In my opinion, this was a very strong reason why these female patients left the psychiatric system. These female patients often expressed their marital problems by saying "Maksaar Raqbatı Gher Al-Aolad" (Just the children break my neck). This saying means that they suffer emotionally and have marital problems, but because of the children they felt hopeless (Al-Krenawi, 1993; Mass & Al-Krenawi, 1994).

Fourth group. The fourth group included 6 male patients who were wealthy or belonged to wealthy families and employees in public services. Their ages ranged from 24 to 40. Their average amount of education was 12 years. This group of patients, after the first meeting with the psychiatrists, often decided to leave the modern system for Arab psychiatrists in the Gaza Strip and East Jerusalem. There were several reasons. One was the stigma. As one of them said, "Here [in the clinic] everybody knows me and I have to wait and talk to people, I do not want anybody to know that I am in such treatment." The second reason was that these people were wealthy, so they could pay for a private doctor. The third reason, as one of these patients pointed out, an Arab doctor understands exactly what you mean when you talk to him.
These patients felt uncomfortable when they saw me in the clinic. During the interviews, they talked about their success in their business and how well they were doing economically. They presented several symptoms to the doctors such as confusion, headache, breathlessness, sleep disturbances and pain in the whole body which made them weak physically. One of these patients was diagnosed as mentally retarded; he was 18 years old and was accompanied by his family. This family believed that the doctor in Gaza may understand the patient’s situation better than the doctors in Soroka. The diagnoses for this group in the psychiatric system included depression, posttraumatic stress disorders, personality disorder, and mental retardation. In contrast, they were diagnosed in the traditional system as Mlmush, Amaal, Hariah, Jinn Ahamar (red devil).

Fifth group. The fifth group were 3 patients who decided to refer to the traditional healers after they were disappointed with the psychiatric system. Their ages ranged from 25 to 42. All were religious people and working as labourers. Their average amount of education was 7 years. They belonged to two social strata, True Bedouin and Flahin Bedouin. These three patients were diagnosed in the psychiatric system as paranoid schizophrenia, personality disorders and depression. In contrast, their diagnoses in the traditional system were Ammal, Mlmush and Darbaat Blaad (attack from the spirits inhabiting the earth).
It should be noted that the issue of stigma was very strong among the educated patients. They attempted to convince me that they had nothing serious, and they even wondered why the GP referred them to the psychiatric clinic.

Patients Excluded from the Final Sample due to Severe Disorders; Psychotics

There were 10 patients who were excluded from the final sample because of the severity of their problems. These included 8 diagnosed psychotics and 2 diagnosed neurotics; there were six females and four males; four of these females were married and had children, and two were unmarried. Three of the six were the first wives to husbands who were married to second wives. One was a second wife, and her husband was married to three wives. The four married females were illiterate, and their ages ranged from 28 to 48. The unmarried females had 3 and 4 years of education respectively, and the average age was 17 years old. This group of patients represented the three social classes, two were Abid Bedouin, one Flahin Bedouin and one True Bedouin. The unmarried females belong to the Abid and Flahin Bedouin.

Both the unmarried females were diagnosed in the psychiatric system as psychotics, and they were always accompanied by their families. One of them was hospitalized for one week, and her parents stayed with her during the hospitalization process. Moreover, the parents of these two patients often came to the
psychiatrists took the medication for their daughters and reported the patient's situation. However, the communication in these cases was done through the patients' families and psychiatrists, while the patients stayed at home. Both of these patients were diagnosed in the traditional systems as suffering from severe problems such as Darbaat Blaad (attack from the devil inhabiting the earth). According to the traditional healers (Dervishes), these diagnoses were considered severe, in fact, states of "possession" where spirits had remained in the patient's body. These spirits were called by the healers "Marrad." Al-Shidabi (1989) described this type of spirit as dangerous, rigid and not easily treated. This type of spirit is mentioned in the Koran (Surah Al-Nesa, v. 117).

The male patients in this group were married; their ages ranged from 20 to 50. Two were diagnosed as psychotics, and two as neurotics. They belonged to two social groups, the Abid Bedouin and Flahin Bedouin. Those who were diagnosed psychotics were religious, and the neurotics were partly religious. The psychotics were illiterate, and of the neurotics, one had 7 years of education, and the other had 9. None of the psychotics were employed and they had no occupation. The neurotic patients thought the psychiatric system was the best for them; they worked as drivers in the Jewish settlements (Kibbutzim). Because of family pressure, they went to traditional healers in addition to the psychiatric treatment. But when they felt improvement after the medication, they left the traditional systems and focused on the modern treatment.
They used the modern system, but still practised traditional rituals; they thought that to be fully cured from a disease or problem, one should do a ritual to end the disease. The ritual was done by them and their families. In my opinion, these patients lived in two worlds at the same time; they worked and spent most of their time with people from modern society, such as Kibbutzim. On the other hand, they had their own Bedouin families, who have different perceptions regarding diseases or problems, especially mental illness issues. They stated that it is safer to stay under the supervision of the doctors. Also, their friends from the Kibbutzim recommended to them to stay in treatment in the psychiatric system. All eight patients who were psychotics utilized both systems, the modern and the traditional, concurrently; they also used the social services system for instrumental support.
The Final Sample

The characteristics of those in the final sample (n=20), concurrent users of both systems, are now set out.

Demographic Information, Male Patients

Table 1.

Names and years of birth of the male patients (pseudonyms used)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hamad</td>
<td>1971</td>
</tr>
<tr>
<td>2. Freeh</td>
<td>1954</td>
</tr>
<tr>
<td>3. Saed</td>
<td>1973</td>
</tr>
<tr>
<td>4. Taleeb</td>
<td>1968</td>
</tr>
<tr>
<td>5. Aref</td>
<td>1965</td>
</tr>
<tr>
<td>6. Muhammad</td>
<td>1973</td>
</tr>
<tr>
<td>7. Al Imrani</td>
<td>1964</td>
</tr>
<tr>
<td>8. Abdullah</td>
<td>1970</td>
</tr>
<tr>
<td>9. Majed</td>
<td>1970</td>
</tr>
<tr>
<td>10. Aoadh</td>
<td>1964</td>
</tr>
</tbody>
</table>

There were 10 male patients; their ages ranged from 24 to 40. We can see that the majority of the male patients were under the age of 26.
Table 2.
Social class and years of education of the male patients

<table>
<thead>
<tr>
<th>Social class</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. True Bedouin</td>
<td>6 years</td>
</tr>
<tr>
<td>2. Flahin Bedouin</td>
<td>15 years</td>
</tr>
<tr>
<td>3. Flahin Bedouin</td>
<td>9 years</td>
</tr>
<tr>
<td>4. Flahin Bedouin</td>
<td>12 years</td>
</tr>
<tr>
<td>5. True Bedouin</td>
<td>8 years</td>
</tr>
<tr>
<td>6. Abid Bedouin</td>
<td>5 years</td>
</tr>
<tr>
<td>7. True Bedouin</td>
<td>10 years</td>
</tr>
<tr>
<td>8. Abid Bedouin</td>
<td>10 years</td>
</tr>
<tr>
<td>9. Flahin Bedouin</td>
<td>7 years</td>
</tr>
<tr>
<td>10. Abid Bedouin</td>
<td>None</td>
</tr>
</tbody>
</table>

The table shows that the patients who belong to the Flahin group had more years of education than the True Bedouin. The Abid patients had less education than the other two groups. Generally speaking, roughly 7 years of education represents an elementary level; 12 years, roughly, would represent a high school education. The data in this table are supported by Ben-David (1994); he found that the Flahin Bedouin have become more educated than the two other groups in the Bedouin society.
Table 3.
Male patients' relationship status; number and gender of children

<table>
<thead>
<tr>
<th>Relationship status</th>
<th># of children</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Single</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2. Two wives</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>3. Two wives</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4. One wife</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5. Separated</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6. Single</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>7. One wife</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. One wife</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9. One wife</td>
<td>2</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>10. One wife</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Eight of the 10 male patients were married, and two of them had married two wives. The reason for their second marriage, according to them, was that they wanted boys. For instance, patient number 2 was a teacher; he said, "I have just one daughter from my first wife, and I cannot live like this .... there was pressure from my family to get married to a second wife." He said, "Believe me, I did that just because I need boys." Number 10 had just gotten married. For all male subjects, the number of children ranged from 2 to 7; there were 17 girls and 9 boys.
Table 4.

Place of living and type of house

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Village</td>
<td>House and tent; he lives with his family</td>
</tr>
<tr>
<td>2. Village</td>
<td>House and tent</td>
</tr>
<tr>
<td>3. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>4. Village</td>
<td>House and tent; he lives with his family</td>
</tr>
<tr>
<td>5. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>6. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>7. Village</td>
<td>House and tent</td>
</tr>
<tr>
<td>8. Village</td>
<td>House and tent; he lives with his family</td>
</tr>
<tr>
<td>9. Village</td>
<td>House and tent; he lives with his family</td>
</tr>
<tr>
<td>10. Outside the villages</td>
<td>Hut</td>
</tr>
</tbody>
</table>

Six of 10 lived in Bedouin villages, and the rest lived outside. One can see from the table that even those who lived in the Bedouin villages used modern houses as well as tents. One can conclude from the above that there is a tendency to use both the modern houses and the traditional tent-dwellings.
Table 5.

Work and occupation, and religion

<table>
<thead>
<tr>
<th></th>
<th>Occupation</th>
<th>Religious Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Unemployed</td>
<td>Religious</td>
</tr>
<tr>
<td>2.</td>
<td>Teacher</td>
<td>Partly religious</td>
</tr>
<tr>
<td>3.</td>
<td>Unemployed</td>
<td>Religious</td>
</tr>
<tr>
<td>4.</td>
<td>Unemployed</td>
<td>Partly religious</td>
</tr>
<tr>
<td>5.</td>
<td>Unemployed</td>
<td>Partly religious</td>
</tr>
<tr>
<td>6.</td>
<td>Factory employee</td>
<td>Partly religious</td>
</tr>
<tr>
<td>7.</td>
<td>Unemployed</td>
<td>Religious</td>
</tr>
<tr>
<td>8.</td>
<td>Unemployed</td>
<td>Religious</td>
</tr>
<tr>
<td>9.</td>
<td>Unemployed</td>
<td>Religious</td>
</tr>
<tr>
<td>10.</td>
<td>Unemployed</td>
<td>Partly religious</td>
</tr>
</tbody>
</table>

Eight of 10 did not work because of their diseases or problems. According to them, they cannot work or function because of the influence of the disease. Four of them had no occupation; the others who had occupations complained that their ability to work was affected by the disease. It is important to note that the 2 who were working did not work all the time; according to them it depends on their health situation. Throughout the research period they often asked the psychiatrists to request sick leave for them.

All of the 10 were religious to differing degrees; there were two groups: one group was religious and practised all the Islamic principles; they said they regularly practised the principles, such as praying. The second group, on the other hand, became religious after the disease started. They considered themselves partly religious, and they routinely prayed, especially every Friday, the holy day.
Demographic Information, Female Patients

Table 6.

Names and years of birth of the female patients (pseudonyms used)

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Namah</td>
<td>1948</td>
</tr>
<tr>
<td>2. Noof</td>
<td>1940</td>
</tr>
<tr>
<td>3. Tmamm</td>
<td>1972</td>
</tr>
<tr>
<td>4. Hadrah</td>
<td>1950</td>
</tr>
<tr>
<td>5. Sabah</td>
<td>1975</td>
</tr>
<tr>
<td>6. Nozzah</td>
<td>1977</td>
</tr>
<tr>
<td>7. Amnah</td>
<td>1966</td>
</tr>
<tr>
<td>8. Rajaa</td>
<td>1957</td>
</tr>
<tr>
<td>9. Mleeha</td>
<td>1953</td>
</tr>
<tr>
<td>10. Salmi</td>
<td>1950</td>
</tr>
</tbody>
</table>

The ages in the female group ranged from 17 to 46. The table shows that both young and old females used both systems.
Table 7.
Social class and education of the female patients

<table>
<thead>
<tr>
<th>Social class</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. True Bedouin</td>
<td>None</td>
</tr>
<tr>
<td>2. True Bedouin</td>
<td>None</td>
</tr>
<tr>
<td>3. Flahin Bedouin</td>
<td>4 years</td>
</tr>
<tr>
<td>4. True Bedouin</td>
<td>None</td>
</tr>
<tr>
<td>5. Abid Bedouin</td>
<td>7 years</td>
</tr>
<tr>
<td>6. Flahin Bedouin</td>
<td>5 years</td>
</tr>
<tr>
<td>7. Flahin Bedouin</td>
<td>6 years</td>
</tr>
<tr>
<td>8. Flahin Bedouin</td>
<td>None</td>
</tr>
<tr>
<td>9. True Bedouin</td>
<td>None</td>
</tr>
<tr>
<td>10. Abid Bedouin</td>
<td>None</td>
</tr>
</tbody>
</table>

The table shows that there were patients from the three social classes. Four True Bedouin, 4 Flahin Bedouin and 2 Abid Bedouin; the Abid are considered a minority in the Negev Bedouin society comparable to the True Bedouin and the Flahin Bedouin. Of the 10, 6 had no formal education, and the rest of the group had a few years of education which enabled them to read and write basic Arabic.

The True Bedouin women were without education and unable to read and write; that is because of their year of birth. In their time, there was no chance to go to school, even for a few years. At present, girls are commonly sent to school by their families for a few years; when they reach the age of 12-13, their education is stopped by their families.
Table 8.

Relationship status and the number and gender of children

<table>
<thead>
<tr>
<th>Relationship status</th>
<th># of children</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Married</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>2. Separated</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>3. Married</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4. Widow</td>
<td>9</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Engaged</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Engaged</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Married</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. Married</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>9. Married</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>10. Separated</td>
<td>8</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Five of the 10 were married; 1 was a widow, and 2 were engaged. Two reported that they lived separately from their husbands, which means they lived with their own families and were waiting for somebody to intervene to help them return to their marital homes. The number of children ranged from 3 to 10, 34 girls and 21 boys. The total number of children was 55, an average of more than five per woman.
Table 9.

The number (in order) of the patient among the husband’s wives

<table>
<thead>
<tr>
<th>Number</th>
<th>Total Wives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number four</td>
<td>7</td>
</tr>
<tr>
<td>2. Number one</td>
<td>2</td>
</tr>
<tr>
<td>3. Number two</td>
<td>2</td>
</tr>
<tr>
<td>4. Number one</td>
<td>2</td>
</tr>
<tr>
<td>5. Engaged</td>
<td>0</td>
</tr>
<tr>
<td>6. Engaged</td>
<td>0</td>
</tr>
<tr>
<td>7. Number one</td>
<td>1</td>
</tr>
<tr>
<td>8. Number one</td>
<td>1</td>
</tr>
<tr>
<td>9. Number one</td>
<td>3</td>
</tr>
<tr>
<td>10. Number one</td>
<td>2</td>
</tr>
</tbody>
</table>

The table indicates the difficulties that Bedouin women face, such as the remarriage of their husband, or the differences in the age between the husband and his wife. In case number 3, the wife was 22 years old; she got married at age 18. Her husband today is 52 years old. Another point is the arrangement of marriage, such as the case of number 5. It must be mentioned that many of the women reported that their husbands were older than they were. In case number 1, the wife is 46 years old and her husband is 80 years old. Living under such circumstances clearly affects the Bedouin female emotionally and psychologically, and is probably one reason the number of females in the psychiatric system is greater than the number of males. Al-Issa (1990) reported that among the reasons why Muslim women in Algeria suffer were family stresses and polygamy; these factors are related to mental illness among

Table 10.
Place of living and type of house

<table>
<thead>
<tr>
<th>Place of living</th>
<th>Type of house</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Village</td>
<td>House and tent</td>
</tr>
<tr>
<td>2. Outside the villages</td>
<td>Tent and hut</td>
</tr>
<tr>
<td>3. Village</td>
<td>House and tent</td>
</tr>
<tr>
<td>4. Outside the villages</td>
<td>Tent</td>
</tr>
<tr>
<td>5. Village</td>
<td>House and tent -- she lives with her family</td>
</tr>
<tr>
<td>6. Village</td>
<td>House and tent -- she lives with her family</td>
</tr>
<tr>
<td>7. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>8. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>9. Outside the villages</td>
<td>Hut and tent</td>
</tr>
<tr>
<td>10. Outside the villages</td>
<td>Tent</td>
</tr>
</tbody>
</table>

Four of 10 live in Bedouin villages, while six live outside. Those who live in the villages use two types of dwelling concurrently, the modern and the traditional.
Table 11.
Work, occupation and religion

<table>
<thead>
<tr>
<th>Job</th>
<th>Occupation</th>
<th>Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Housewife</td>
<td>No occupation</td>
<td>Religious</td>
</tr>
<tr>
<td>2. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>3. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>4. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>5. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>6. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>7. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>8. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>9. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
<tr>
<td>10. Housewife</td>
<td>==</td>
<td>==</td>
</tr>
</tbody>
</table>

According to Bedouin rules none of the women held a job or paid occupation outside the home. All reported that they are religious. They practised the Islamic principles and commonly mentioned God during the interviews and the observations. There were a few females who belonged to the Abid (Bedouin) who worked in the Jewish settlements along with contractors from the same tribes.

The Psychiatrists

In attempting to gain access, there were several barriers to these groups that might not be found in other populations, firstly the psychiatrists expected me to translate the patients' statements and even to intervene during the observation of their encounter
with the Bedouin patients. One of the psychiatrists said: "What do you contribute to the clinic? You have to do something."

I had worked in the psychiatric clinic in the Soroka Medical Centre in the city of Beer-Sheva from August, 1981 to July, 1992. I know the staff of the psychiatric department, and this made it easy for me to gain staff acceptance. Thereby I was able to get the patients' and the psychiatrists' consent to read the patients' files. I assured the head of the clinic that no real names (or identifying characteristics) of the patients or of the psychiatrists would be published in my study.

I met with all the psychiatrists in the clinic and explained my research goals; I said that for three months I would stay in contact with them and with the patients they were treating. There were several psychiatrists I did not know, and the majority of them were Russian. The head of the clinic, however, was interested in my area of study; he supported my position among the psychiatrists and asked them to collaborate with the research. Some psychiatrists whom I knew from the past supported me and encouraged the Russian psychiatrists to collaborate with me. The latter did collaborate with me, but they asked questions about the patients and for my clinical opinion, I did not answer their questions; I stated that I was a researcher, not an employee.

I explained my research goals to the psychiatrists, and gave them the consent form to sign as an indication that participation in this research was completely voluntary and anonymous (Appendix D). I also signed a document prepared by the head of the service
indicating that no real names of the patients or the psychiatrists will published in the study (Appendix E).

In general, all the psychiatrists who treated the Bedouin were ready to help and collaborate with me throughout the research period. In addition, the staff of the general office in the clinic were very helpful, gave me office space, and sent all the new referral patients to my office before contact with the psychiatrists and the other patients. The main secretary routinely phoned me if I was away from the clinic to inform me that there was a new patient in the emergency room. My office was next to the main office in the clinic. When a new patient arrived at the clinic, the main secretary routinely referred him or her to my office, or she called me to the office and pointed out that there was a new case. All in all, I got very good collaboration from the clinic staff.

I met with the general practitioners who work with the Bedouin community in the primary health care clinics. I explained to them about my research, and that I would work at the psychiatric clinic in the Soroka hospital; I gave them the schedule of which days I would be at the clinic. I had worked with these general practitioners in the past, and this helped the collaboration; they referred patients to the psychiatric clinic in accordance with my schedule.
The Psychiatrists' Background

There were seven psychiatrists who treated Bedouin patients in the psychiatric system at the Soroka hospital (see Table 12).

Table 12

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
<th>Academic credential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russian</td>
<td>Male</td>
<td>M.D. Russia</td>
</tr>
<tr>
<td>Russian</td>
<td>Male</td>
<td>M.D. Russia</td>
</tr>
<tr>
<td>Russian</td>
<td>Male</td>
<td>M.D. Russia</td>
</tr>
<tr>
<td>Russian</td>
<td>Female</td>
<td>M.D. Russia</td>
</tr>
<tr>
<td>Russian</td>
<td>Female</td>
<td>M.D. Russia</td>
</tr>
<tr>
<td>Romanian</td>
<td>Male</td>
<td>M.D. Romania</td>
</tr>
<tr>
<td>Ashkenazi</td>
<td>Female</td>
<td>M.D. Italy</td>
</tr>
</tbody>
</table>

All the psychiatrists graduated from countries outside Israel, and lacked experience with either Israelis and/or Arabs. This was particularly true of the Russians psychiatrists, who were themselves recent to Israel and experiencing their own acculturation adjustments.
Traditional Healers

Gaining the healer's consent was accomplished as follows: I had already established good relationships with the patients and their relatives. So the patients were ready to allow me to interview the healers who treated them and to participate and observe in the treatment process and the rituals that they planned to practice. Various steps were taken to gain healers' acceptance: During the interviews I was aware of the cultural canon, and used forms of address that reduced Bedouin suspicions about meetings between male and female (Al-Bostani, 1988; Al-Krenawi, 1993; Mass & Al-Krenawi, 1994; Najati, 1993).

With the traditional healers in the Bedouin society, I showed respect for what they did or said. I used religious words during my meetings with them and called them Sheikhs, or Hajj; these are religious distinctions. I respected the healers' treatment methods during the meetings with them (Abdul-Rahman, 1991; Al-Krenawi, 1992). Ottman (1991) points out that it is very important to show respect for the informants, especially when dealing with such sensitive matters, for Arabs, as healing. In this case, the researcher belonged to the other side of medicine (modern); the healers perceived the doctors of the modern system as laughing at their treatment and not respecting them. To avoid these suspicions, I showed respect and believed in what the healers did or said. For similar reasons to those given for patients, it was not culturally appropriate to seek written consent from the
healers. My assurances were valid and my word about confidentiality was a matter of honor. Further, I emphasized that participation would in no way affect their relationship to the Bedouin community, the individuals they treat, or their status as healers. The subjects were asked if they understood and agreed to the above-mentioned conditions; only after obtaining consent did the interview proceed. It was also emphasized that termination of the interview, at any point, would in no way affect them (as stated above).

There were four types of healers with various approaches and specialties: Dervishes, amulet writers, fortune tellers and Sheikh-Din or Moalaj Belkoran. The first group of healers, the Dervishes, considered themselves as treating what we call "mental illness." Some of these Dervishes I knew from an earlier study (Al-Krenawi, 1992), so they were ready to allow me to interview them about patients who had already given consent. One of the Dervishes said, "I see you came back; you like our treatment." I tried to show respect for what he said.

All the male Dervishes started to talk about their ability to cure patients and about the saints that they invoked during their treatment. All were ready to collaborate with me after I explained my study to them. They tried to prove to me that their treatment was more effective than the modern system. One of the Dervishes said, "all the patients came to me and by the power of God they were cured"; he kept saying, "the modern system cannot do like we do. We have a power from God (Baraka)."
Through the initial contact, I mentioned God and the Prophet Muhammad, as they did. I spoke to a well-known Dervish among the Bedouin who had helped me during my study in 1992. He was ready to do that again. One of the male Dervishes hesitated, but the other Dervishes talked to him about me, and he agreed. I assured them, however, that I would keep everything secret; no names would be used and therefore nobody would be able to identify them. It is worth mentioning that the patients themselves helped through this process; they spoke to the healers and said that they agreed to my presence during the treatment.

With the female Dervishes, it was completely different. I usually addressed the female Dervish’s husband, asking for his permission to allow me to interview his wife and to observe what she was doing. However, as in my study of 1992, I was accompanied by my wife; I assured the Dervishes’ husbands that my wife would stay with me throughout the interview; I also emphasized to them that their wives, the Dervishes, were like my sisters. Mostly they agreed; one man was not sure that the woman who was with me was my wife: I did not argue, and I assured him that she was my wife; then he agreed.

I took my wife with me to illustrate and to prove to the husbands of the Dervishes that I was serious, and my goal was the study, not anything else. After the husbands gave their consent, my wife and I entered the house where the Dervishes treat the patients. I explained my study to them, and I assured the Dervish and the patients who were present in the Dervish’s house that all
of them were like my sisters. The patients talked to my wife about what I was doing and sought to obtain information about me. The presence of my wife led them to be open with me, and even patients who were not part of the study talked to us about their situations.

The amulet writers, the second group, were all male; there are no females in this craft. These healers were interested in what I was doing; they raised questions about the psychiatric system and why I was interested in their treatment. They talked about their ability to treat mental illness. These healers gave names of patients who were treated by them and were cured. They mentioned cases and names, including people whom I knew from the tribe. They tried to prove to me and to the other patients who were present that they succeeded where the modern system had failed. I showed respect for what they said or did. They also told me about their profession and how difficult it is; if you are not familiar with the books, you can harm yourself. They were ready to collaborate and to show me what they doing.

The third group was the fortune tellers, who were all females; to avoid problems and clash with the cultural canon, I first approached their husbands, asking for consent to allow me to interview their wives. I was accompanied by my wife. After the husbands gave their word, my wife and I entered the house, and I explained my study to the healers. It is important to note that all of the patients of these healers were females. My wife's presence helped a lot; the female patients came close to us and talked openly about their problems and difficulties.
The healers who treat according to the Koran, the fourth group, were quite different. All of these healers were male. When I met them and presented my study, they became interested and talked about the power of the Koran in treating mental illness. They were ready to share and collaborate with me about everything; they gave me books to read about such treatment. All of these healers were literate; they were ready to allow me to record the treatment process. With one of the healers, I spent a day recording a number of cases that he treated. These cases were possessed by the Jinn or affected by the Jinn's actions. The healers tried to show me what the Koran can do to the spirits. One of them said during the interview with him, "Look what the words of God do." He kept saying that he had several cases treated by the modern system, and none of these cases was cured until they came to him. Another healer said, "We are tools in God's hands, we worship Him and serve His servants." With this group of healers, I had no problems gaining consent; moreover, they were ready to allow me to do everything I needed in order to show to the modern system the power of the Koran.

The Backgrounds of the Healers

The backgrounds of the healers by type, gender, ethnicity, and class are summarized in Table 13. The table shows that there were female and male healers. Among the Dervishes, there were three males and two females. Amulet writers included no females; this
craft requires basic knowledge of reading and writing. These healers believe that their craft is dangerous and that females could not risk it. The fortune tellers were all female; the Bedouin consider this craft for women, not for men. Fortune tellers have low status among the healers, allegedly because they deal with the spirits' activities and not with the spirits directly. I believe that the other healers considered the fortune tellers as having low status because the craft is all female. These female healers, however, are respected by the society, perhaps because people fear their supernatural power.

Among the Sheikh-Din, there were two Arabs from Gaza and two Bedouin from the Negev. They perceived this craft as only for males. According to them, a female cannot confront the spirits because the spirits can influence her. A female is more vulnerable to the spirits than a male because of perceived weaknesses in her life and body: giving birth, blood; her voice and body openings -- all of these issues are considered as vulnerable to the spirits (Al-Jzari, 1989; Bali, 1993; Bilu, 1978; Boddy, 1989; Grotberg, 1990; Kennedy, 1967).
Table 13

<table>
<thead>
<tr>
<th>Type of healer</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Social class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dervish</td>
<td>Male</td>
<td>Bedouin</td>
<td>True Bedouin</td>
</tr>
<tr>
<td>Dervish</td>
<td>Male</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Dervish</td>
<td>Male</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Dervish</td>
<td>Female</td>
<td>Bedouin</td>
<td>True Bedouin</td>
</tr>
<tr>
<td>Dervish</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>Male</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>Male</td>
<td>Bedouin</td>
<td>Abid Bedouin</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>Male</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>Male</td>
<td>Bedouin</td>
<td>True Bedouin</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>Male</td>
<td>Bedouin</td>
<td>Abid Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>True Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Abid Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>Female</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>Male</td>
<td>Arab</td>
<td>Arab</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>Male</td>
<td>Arab</td>
<td>Arab</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>Male</td>
<td>Bedouin</td>
<td>Flahin Bedouin</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>Male</td>
<td>Bedouin</td>
<td>True Bedouin</td>
</tr>
</tbody>
</table>

The education of the healers, summarized by type is given in Table 14. The table shows that only one of the Dervishes had four years of education, enabling him to read and write in Arabic. The amulet writers had few years of education, ranging from five to eight years. All the fortune tellers had no formal education at all, as were the two female Dervishes. By contrast, three of the
Sheikhs had academic credentials, and one of them had a college diploma. Their education was in the Islamic religion.

There was competition between the three types of healers, Dervishes, Khatib and the Sheikhs. The three groups considered the fortune tellers as a female craft and generally no one talked about them, for good or bad. The female Dervishes, however, respected the fortune tellers; one said, "Every one of us is doing his or her job, and the rest of the cure is from God." The issue of competition arose recently when the new healers, Sheikhs, emerged and called for the treatment only according to the Koran; they called all other healing, sorcery.

All of the Sheikhs considered themselves scholars in Islam. Every healer had his own books, so in case he did not know how to deal with any problem, he could look it up. The Sheikhs severely criticized all the other healers, and called them liars; they believed that the other healers -- especially the amulet writers -- were sorcerers who deliberately sought money in collaboration with evil spirits.
Table 14

<table>
<thead>
<tr>
<th>Type of healer</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dervish</td>
<td>4 years of education</td>
</tr>
<tr>
<td>Dervish</td>
<td>None</td>
</tr>
<tr>
<td>Dervish</td>
<td>None</td>
</tr>
<tr>
<td>Dervish</td>
<td>None</td>
</tr>
<tr>
<td>Dervish</td>
<td>None</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>5 years of education</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>5 years of education</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>8 years of education</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>6 years of education</td>
</tr>
<tr>
<td>Amulet writer</td>
<td>7 years of education</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Fortune teller</td>
<td>None</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>B.A., University of Al-Azhar</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>B.A., University of Al-Azhar</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>B.A., Islamic University-Gaza</td>
</tr>
<tr>
<td>Sheikh-Din</td>
<td>Diploma, Islamic College</td>
</tr>
</tbody>
</table>

The Sheikhs routinely asked the patient if he or she had used other healers. If the patient did, they asked for the amulet, and later on, threw it in the fire. The Sheikhs did not care if the patients visited the Dervishes for treatment, but they reminded these patients to accept treatment only by the Koran.
The Dervishes and the amulet writers, in their turn, talked about the Sheikhs; they said that the latter do not know anything about the treatment of the spirits. The amulet writers talked against the Dervishes; by seeing them, it cannot accomplish anything except to lead one astray.

In spite of the competition between these groups of healers, the patients are not part of the argument, and they generally do not know about this competition. Members of these groups generally did not say anything in front of the patients about the other healers; the exception was the healers who treat according to the Koran. From my point of view, the four groups of healers treat the same illnesses; however, every group tries to protect and advance his or her social status/vocation as far as possible.

Table (13) shows that the healers represent the three social classes among the Bedouin society. Thus the traditional healing system treats all human beings, not one particular social class.
Through interviews, I followed the treatments in the psychiatric clinic and in the traditional healing systems: I kept in touch with the patients, psychiatrists and the healers who treated these Bedouin patients. It is significant to note that when I arrived at the Soroka Medical Centre to begin the present investigation, the administration, employees and the psychiatrists who were in "Kubat Holim," the health insurance institution of the General Federation of Labor in Israel were on strike. Soroka Medical Centre belongs to this organization. The psychiatrists were on strike for two weeks and the social workers for more than one month. Because of the strike, the psychiatric clinic was closed for two weeks. In that period, I interviewed several prospective patients, before they contacted the psychiatrists. Thus, for 15 cases, I started the research at that time.

The process of interviewing the patients was done in the outpatient psychiatric clinic at the Soroka Medical Centre. With the patients' and the psychiatrists' consent, I observed the treatment encounter, and after the observation the psychiatrists were interviewed about the patients. It is important to mention that I had the opportunity to observe the encounter between some of the patients and the psychiatrists twice. In addition I was able
to observe what occurred in the psychiatric system, among the patients as well as among the psychiatrists.

Next, the research moved to the traditional system; I observed and interviewed the folk healers who treated the patients; I systematically investigated the encounter between the healers and patients, including participant observation of the healing rituals.

The data were collected through semi-structured and open-ended interviews with the initial referrals and the final sample selected for the study. An initial interview of on average one hour was undertaken with the 60 patient total. The 20 patients from this initial sample of 60 were interviewed, in addition to this, at least one other time, for on average one hour. Many of the 20, it should be noted, were interviewed for varying lengths of time beyond this as well. It also should be noted that some of the 40 who had been excluded from the initial sample, were interviewed a second time; and some, as well, were encountered in subsequent participant observations of traditional healing systems.

The questionnaire was translated into Arabic and then compared to the original English copy. The comparison was done to make sure that the two copies were similar and that no important details were lost during the translation process. I did the translation from English into Arabic; I tried to stay as close as I could to the Bedouin dialect. A comparison between the questionnaires was done by an expert in the Arabic language (Appendix A).

The research instruments dealt with several issues; firstly, the background of the patients who simultaneously utilize both systems;
their perceptions and explanations of their problems or diseases -- subjective experiences; their strategies of managing the use of both systems. Secondly, it tapped the perceived advantages and disadvantages and the effectiveness of each system from the patients' perspectives. Thirdly, it considered the similarities and the differences between the systems in terms of etiology, diagnosis, symptomatology, prognosis, and treatment.

The instrument (Appendix A) was divided into two parts, part one being done before contact with the psychiatrists. This part first gathered demographic information, such as birth date, gender, social status, relationships status, education, place of living, job and degree of religiosity. Additional information included perception of the problem or disease, the referral path to the psychiatric system, the patient's familiarity with the diagnosis from the GP, the patient's familiarity with the psychiatric system; use of traditional healers, consultation with the patient's family since the problem emerged, and the patient's expectations of the psychiatric treatment.

Part two of the instrument was administered after the patients had contact with the psychiatrists. This part included information about the psychiatrists; diagnosis, symptoms, treatment, understanding of the patient's difficulties by the psychiatrists; the relationships, improvement in the patient's situation, and informal help in the psychiatric system.

Data were also collected on the continuation of the treatment in the psychiatric system, and utilization of the traditional
healers; this included information about the traditional healers and the diagnosis, symptoms, treatment, suggestions from the healers; the relationships with the healers, and the path of referral to the healers. In addition, this part included information about cultural and religious healing rituals, and the patient's family involvement in performance of the rituals, and the effectiveness of the rituals according to the patient's experience.

In addition, the patients were asked to explain which treatment they considered more effective, the modern or traditional; how they used both systems simultaneously, the way they perceived the two systems, and their way of managing the treatment of both systems. Patients were asked about gains from each system and which type of treatment was more appropriate in their view.

The interview with the psychiatrists was done in Hebrew and took about one-half hour. The issues that were covered by these questions were translated into Hebrew (Appendix B). The instrument included information about the psychiatrists, such as gender and ethnicity. Additional information included patients' diagnoses, etiological explanation, prognosis and the treatment approach; the relationships and the difference between the treatment of educated and other patients, and the difference between males and females during the treatment. Further questions addressed the psychiatrists' familiarity with the Bedouin culture, such as rituals and religion, and their difficulties in dealing with Bedouin patients because of cultural differences. Lastly,
questions were asked about the impact of the traditional treatment on the psychiatrist’s treatment.

The questions to the healers were translated into Arabic (Appendix C); the length of the interview was about one hour. This procedure gathered information about the healers’ gender, social status, and the type of practice. In addition, questions addressed the following issues: the patients’ diagnosis, causality of the disease or the problem, prognosis, relationships between the healer and the patients; the difference between educated and uneducated patients, the difference between males and females in treatment; lastly, the impact of the psychiatric treatment on the healer’s treatment. It is noted that the researcher speaks three languages fluently -- Arabic, Hebrew and English -- which made it easy to communicate with the patients, healers and the psychiatrists.

Participant Observation

A naturalistic approach requires the researcher to become intimately, but non-intrusively involved with the people he or she is trying to understand. The approach is carried out where they live and requires establishing relationships based upon empathy and trust. Hammersley and Atkinson (1983) defined naturalistic inquiry as follows:

To participate covertly and overtly in people's lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact, collecting whatever data are available to throw light on the issues with which he or she is concerned. (p. 2)
Glancy (1986) has stated that participant observation is useful for studying the context of recreation participation and could be valuable in leisure study and in developing grounded theory associated with freedom, expressiveness, meaning, and motivation in leisure.

I used the participant observation method when cultural and religious healing rituals took place (Fetterman, 1989; MacCall & Simmons, 1969). The length was about two hours, depending on the location of the ritual. The aim of this technique was to experience what these patients practice and determine which types of psychotherapeutic elements the rituals contain. These questions were addressed: At the individual level, how does the patient express negative feelings regarding his or her problem, ("venting")? How does the patient communicate with the healer or a saint's tomb (saint's soul) during the ritual performance? Is there any helping group throughout the ritual? Does the patient's family or extended family take part in the ritual performance? What are the emotional and instrumental supports that the patient gets from the community (tribe)? Do the healer and the patient focus on the same things when the ritual takes place? Do the other patients who are present during the ritual share their problems? I thus observed what occurred around the patients at four levels: individual, group, family and community.

In addition, I observed the treatment in the psychiatric system. The purpose of these observations was to find answers to the following questions: What is the psychiatrist-patient
relationship, and how do the parties communicate? How does the psychiatrist treat the Bedouin patients, male and female? Does the psychiatrist explain to the patient his or her situation? How does the patient respond during the treatment process? Is the patient active or passive during the treatment? How does the psychiatrist manage the treatment? Does the patient understand what the psychiatrist says to him or her? Does the psychiatrist explain to the patient his or her diagnosis and the prognosis? Does the psychiatrist involve the patient’s family during the treatment process? Who is more active verbally throughout the treatment, the patient or the psychiatrist? Does the psychiatrist ask questions about the religion or the belief systems of the patient? During the treatment process, what does the psychiatrist focus on, and what does the patient focus on? Are the psychiatrists aware of the cultural diversity of the Bedouin patients? The length of the observation was about one-half hour.

Throughout the study the researcher tried to stay close to the patients and to follow what they did. I played a minor part in most of the healing rituals that these patients practised; I joined in group prayers. I observed the encounter between the patients and psychiatrists and between patients and healers. Throughout the study period, I tried to develop close relationships with the three types of subjects; this led to trust between the researcher and the subjects. Such a situation helped the subjects to reveal themselves during the interviews. All the data suggest that the
participant observation was successful, that trust was established between the researcher and the subjects.

Other Sources of Data

I also read the psychiatrists' clinic files of each patient (patients' reports). The traditional healers' magical and religious books also were used.

Data Collection: May 1994 through August 1994

Throughout the data collection period, I travelled between both systems, following the patients. The initial contact was in the psychiatric system and later on I visited homes and communities to observe the traditional system and to interview subjects.

Sometimes I spent three days in the psychiatric system and three in the traditional, depending on the number of patients in the psychiatric system. Sometimes I spent more time in the traditional system, according to the locations of the rituals and the healers. The meetings were friendly in the healers' homes and when ritual healing took place. Coffee, tea, meat and rice were served during the interviews and the participant observation.

In the traditional healing system, I had to be flexible in terms of time. Sometimes the healer had patients who were waiting for treatment; therefore, I had to wait until he or she finished treating the earlier patients. After the interview with the
healer, I participated in and observed rituals that the healer recommended to the patient. Sometimes the ritual took place at the healer’s house, or an outside location such as a saint’s tomb, or the patient’s house. Length was approximately two to three hours; this included the interview with the healer and participant observation when the healing rituals took place.

Note-Taking during Interviews and Participant Observations

Notes were taken during the interviews and observations and written up afterwards. All the subjects were willing to allow the researcher to take notes during the interviews and the observations. The patients spoke slowly, and they tried to follow my speed of writing. The educated ones asked if I had finished writing what they had already said, before continuing. In general, all the patients showed patience and readiness to allow me to take notes during the interview with them; they were also ready to explain terminology used in expressions and proverbs.

During the observation of the encounter between the patients and the psychiatrists, I took notes and observed the patients' behaviours and how the psychiatrists managed the treatment encounter. Any questions which arose from the observations later on, I referred to the psychiatrists or to the patients for explanations. The psychiatrists were willing and allowed me to take notes during the interviews with them; they even asked me to emphasize some sentences that they used during the interviews.
The healers also allowed the researcher to take notes during the interviews and the observations of their encounters with the patients. The healers, however, showed particular readiness to explain any activities that took place during the interviews and the participant observation.

By the end of every day, I read the interviews and the observations and transcribed the data collected that day. Sometimes, when I read and transcribed the data, I found that some behaviours, activities or phenomena needed explanation from the patients, healers and the psychiatrists. I was often able to refer to the right person for explanation.

Data Analysis

After completing the task of transcribing the standardized interviews and the participant observations, I began coding their contents. I began by reading each interview and the participant observation to determine which of the statements were relevant to the research questions.

There were three sets of notes for each patient: from the patient, psychiatrist, and healer interviews. These were qualitatively analyzed by standard, ethnographic procedures (Berg, 1989). Themes were identified in the following areas: conception of illness, ideas of cause, effectiveness of treatment, the patient’s emotions and beliefs about the future; relationship of patient and practitioner; the patient’s perception and strategies
of managing the use of both systems. I searched for the differences between females and males in terms of perceiving, and managing their use of both systems; I looked for differences between patients based on the degree of acculturation, education and employment. I looked at the experiences of conflict during treatment according to both systems.

Themes were refined by studying and analyzing the data. I checked critical concepts and interpretations with the patients, psychiatrists and healers. There were consultations with other professionals, including Bedouin professionals, in developing interpretations. This helped to establish reliability. The approach is more than simply phenomenological, since the participants' own ideas -- as well as the ideas expressed by practitioners in both systems -- are fundamental aspects of data collection. One would generally expect that they would not object to the investigator's account of their ideas and feelings (Taylor & Bogdan, 1984).

Limitations

This was an ethnographic study carried out over a short period, with a small sample at one medical centre in the Negev, Israel. The aim was to explore usage issues through multiple data sources. The collected data do not permit generalization to other Arab populations, or even Arab minority situations. It must be
assumed that the specific, historical and social context in Israel shaped all the variables examined.

Other Arab health care contexts, even in Israel, require their own investigation. The author's choice of Soroka was a product of personal and professional history, not sampling considerations. My naturalistic, participant observations of the Bedouin patients and traditional healers were enhanced by my own background as an Arab and a Muslim. But my culture, of course, led to some communication difficulties with the Russian psychiatrists. I was not told of their personal issues, and I can only hypothesize about their adjustment difficulties. Further, while my background promoted good rapport with the healers, they were not a random sample, nor necessarily representative of all traditional Arab healers as a group, even those within Israel. They were approached through networking, which opened many doors, but may have kept me in certain cases from seeing deeply into the familiar.

It is argued that the data and interpretations, notwithstanding these limitations, suggest or indicate a range of critical issues within a largely unexplored field. If definite conclusions are far off, I believe the evidence has indicated an abundance of clues and some of the richness of patterns of mono- and bicultural interaction in the help seeking situations.
Summary

A research approach was selected that would be appropriate given the nature of the research questions and the type of data being sought and because of the traditional, patriarchal structure of the society that I was dealing with. Thus, to enter the Bedouin society for such a study was not an easy task; throughout the research period, I had to be very cautious and sensitive; every act was considered. On the one hand, I understood the women's perspective. On the other hand, I had to maintain good relationships with their families, otherwise the man could interrupt the interview and the female patient's treatment in the psychiatric system. In the traditional system, instead of addressing a female healer, I had to address her husband to ask for his permission and later on the healer herself. In addition I was aware of the sensitivity of the encounter between a strange man and females from other families or tribes. I had learned, through my experience with the Bedouin society as a social worker, and also having been born a Bedouin, how to establish and implement an effective strategy (Fahim, 1982): when the healer was a female, I was accompanied by my wife all the time.

The following chapter sets out the findings of the study.
THE ENCOUNTER OF THE BEDOUIN PATIENTS
WITH MODERN PSYCHIATRY

Introduction

The main findings for the initial sample are set out in two parts in the present chapter and the one following. All patients under study are "dual users" in the broadest sense. Some used both systems frequently, whether concurrently or non-concurrently; others switched or alternated between systems. In any case, the key criteria was the experience of both systems.

The following two chapters will thus elucidate two types of encounters with very different process characteristics, human experiences and outcomes. The first encounter is between a Bedouin patient and a psychiatric system, the psychiatrist having a modern, scientific worldview and (often) European medical training. The second type of encounter is between a Bedouin patient and a traditional healer, with a much stronger traditionally Bedouin frame of reference. The present chapter will analyze the encounter with psychiatrists; in so doing, reference is made to all 60 patients from the initial sample.

The ethnographic data illuminate many of the difficulties of the encounter by helping to characterize the contrasting perspectives of the Bedouins and their psychiatrists toward one
another. The problems of mutual perception or understanding are elaborated not as failings of individuals but as symptoms of less than optimal functioning of a mental health care centre in a difficult, bicultural context.

**How the Patients Understand their Disease**

The term *illness behaviour* has been used to indicate how various people recognize that they are ill and what they do about it (Mechanic, 1966). In Bedouin society, the concept of illness as well as the action taken by the patients and their families show that the patient is sick and needs help, whether from the healers or the doctors. The main symptoms that made the Bedouin patients perceive themselves as sick were related to pain. Pain was certainly the main factor that led the patients to seek medical attention. Bedouin patients perceived such somatization complaints as physical disease, and they sought medical treatment from the GPs and the psychiatrists.

Both males and females understood that they were sick; in their opinion, they had a physical illness. The GPs referred them to Soroka to an expert doctor for further examination and treatment. When they arrived at the psychiatric clinic, they wanted to tell the psychiatrists where the pain was located. All the patients, male and female, who were diagnosed as neurotic presented physical complaints and told how the disease affected them in several body areas.
Male patients tried to focus on where the pain was located in their bodies; often they pointed to their hands or legs. They talked of physical weakness; some presented loss of consciousness (Docah). The women presented physical complaints everywhere in their bodies; they also described how the pain travelled and moved from one part of the body to the other part. These patients expected medical examinations and physical treatment because of the physical pain.

All the patients regardless of gender, education and social strata understood their problems as physical, not mental. In the first meeting with the psychiatrists, they focused on their bodies; they did not distinguish between physical and mental issues. The neurotic patients did not connect their personal or family problems to their disease. One said to the psychiatrist, when the latter was trying to understand what happened to the patient prior to the disease, "What is the connection between your questions and my pain? ... I am telling you I am sick." In my interviews, I showed respect and acceptance of what the patients said; this led them to talk about non-physical symptoms, and dreams.

The psychotic patients presented physical complaints, and they focused on their head and brain. One patient said, "I feel that my brain is confused." The relatives who accompanied them reported major behavioral change; the patient became aggressive and violent. But they too talked about physical complaints. Therefore this group of patients presented both physical and behavioral disturbances. The psychotic male patients were violent and
hyperactive in the clinic, and their families tried to control them. In contrast, the psychotic females were quiet, and parents who accompanied them sat beside them and did not allow them to misbehave. The psychotic females often were accompanied by their own family members such as father, mother, brothers and sisters, not their husbands. In these cases, the woman generally goes back to her parents, and they take care of her. If a woman did something unacceptable, the Ar (shame) will be on her parents, not her husband (Mass & Al-Krenawi, 1994). Females represent the Ard (honor) of the family, so the family keeps her quiet as much as they can, so she will not put them to shame.

**Perceived Etiology of the Disease**

This section deals with the disease explanations from the patients' perspectives. They perceived the disease as having a supernatural etiology, such as punishment from God or God's will, spirits' actions, sorcery and the evil eye caused by spirits' activities or those of human beings.

Male patients presented several reasons why they suffered. For example, case number 1, table 1 confessed, "In the last Ramadan, I had a sexual relationship with a prostitute; a few months later, I felt that I committed a sin that caused God to be angry with me." Ramadan is considered by the Muslims to be a holy month; in this month, especially, Muslims should do good deeds, not sins. This patient believed that God was punishing him because of
what he had done. His retribution was punishment from God, Aqab Mn Allah. This patient said, "When I did that, nobody saw me. But what about God? He can see you anywhere." Patient number 3 believed that black magic was involved and caused the disease; he said, "I remember what exactly happened to me; I fell down on my face." He believed that the Jinnih loved him, since afterwards she appeared in his dreams and made love to him. Another patient said, "My female relative did Amaal (sorcery) on me to destroy my life." He kept saying, "Al-Nsoan Ma lehn Aman," meaning "You cannot trust women." The Bedouin believe that every human being has a companion Jinnih from the opposite sex. Sometimes the Jinnih falls in love with the human partner and tries to enter his or her body. As a result, mental illness occurs (Sebai, 1981).

All the male patients regardless of social class, education and/or diagnoses believed that supernatural power such as Jinn and sorcery was the cause of the disease. Even the educated patients commonly said that the disease was "Mn Allah," God’s will (Al-Krenawi et al., 1994; Caliph, 1989; El-Islam & Abu Dagga, 1992; Sanua, 1979; Sebai, 1981; West, 1987). Their families were involved in the treatment process and corroborated such explanations.

Females also believed that supernatural forces were involved in their disease, such as Amaal (sorcery) done by Sahr through the intervention of another woman. One of them said, "Soanh Ale Ma Becafan mn Allah," which means, "They did Amaal on me, those who are not afraid of God"; she meant that women did that against her.
Another patient said, "Tharti Askatah wa slat Qalbah, Wa clatah ma egdar Ishofna," meaning "My husband’s second wife gave him something to drink, and she gained his heart; he cannot see me and my children." Some of them believed that spirits caused the disease. Thus the common ascribed reasons for the female diseases were from Shr (black magic). Sorcery plays an important role in the lives of the Bedouin and Arab women (Al-Saati, 1984; Bar-Zvi, 1988; Dickson, 1949; Doughty, 1936; personal communication with amulet writer, 1994). Al-Issa (1989) stated that women in the Arab world tend to use traditional healers more than men. Similarly, Al-Sabaie (1989) and Al-Juhri (1991) reported that women in Saudi Arabia and Egypt use the traditional system much more frequently than men do. El Sayed et al. (1986) state that culturally, women in Saudi Arabia are encouraged to seek traditional healers more than men. Al-Dramdash (1991) found that one of the goals of sorcery is to cause family disputes; he inferred that sorcery is practised among all the Arab communities everywhere; it has become the weapon of the weak people to achieve their wishes (Al-Saati, 1984). Bali (1993) defined the Shr (sorcery): "It is strongly connected with the spirits’ actions; the healers promise to do bad deeds in order to satisfy the spirits, and the spirits promise to help the healer" (p. 17). According to Bali (1993), there is a collaboration between the Sahr and the spirits. Sorcery can be considered a symbolic system producing specific social and psychological effects, under the cover of ritual activity (Favret-Saada, 1989). However, it can be said that sorcery is perceived by
Bedouin and other Arab women as an instrument which helps them to cope with social and personal difficulties.

Al-Issa (1989), in his study of Algerian society, pointed out that male sexual dysfunction is often regarded as evidence of female persecution and/or sorcery. A jealous woman may want to destroy a marriage by "knotting", under the influence of an evil spirit; this is a form of magical control of the husband's genital activity which must be counteracted by a sorcerer (Al-Alooji, 1964; Bazzoui & Al-Issa, 1966).

In sum, among the female patients there were two kinds of explanations for their illness: one supernatural-centred and another environment-centred, according to whether the patients attribute problems to supernatural agents, e.g., Jinns, or to natural agents, e.g., humans or the physical environment (Al-Sabaie, 1989; El-Islam, 1978; El-Islam & Ahmed, 1971; Sanua, 1979; Sebai, 1981).

Reading and Saying Religious Words in Times of Pressure

Since the difficulties of life are attributed to the will of God, Arabs often use the expression Maktoub (it is written). Any happy event or windfall represents the manifestation of God's grand design, and likewise, failure to receive such good fortune is also God's will. Thus anything that happens to human beings is the will of God, according to Islam and as stated in the Koran (e.g., Surah Al-Toubah, v. 51). The supernatural power is always involved in
disease or disaster, so people in difficulty need to satisfy the supernatural powers, such as God, the Prophet Muhammad and the men of God (saints). By calling on these agents of supernatural power, patients feel relaxation and closeness to the power, for the Koran states, "God said, 'Call Me, I will repay.'" Further, God is described by the Koran as merciful and forgiving to those who appeal to him. Thus, when disease or disaster strikes the person, he or she often prays to God for help and forgiveness.

Muslims derive meaning from spiritual, physical, social and psychological experiences that accord with the letter and spirit of their religion. Life is seen as a transition, a bridge that a person crosses to go to eternal life. Committed Muslims therefore feel they have one foot in this world and the other in the hereafter. This orientation provides existential meaning for Muslims, especially during times of disease or stress, and enables them to find solace in the knowledge that although this life is a test, true comfort can be found in the hereafter.

Male patients often read Koranic verses in times of stress or tension. One of the male patients said, "When I had dreams about death which caused me to be afraid, I read the Koran to be close to God"; he kept saying, "God's words bring me relaxation, safety and closeness to Him." Another patient said, "When I feel pressure and pain, Klam Allah Brehni," meaning "The words of God bring me relief." The men mentioned God during the interviews and during their encounters with both systems, according to my observations. One of them said, "Anma Bdhikr Allah Tatman Al-Qlub," meaning "Just
by mentioning God's name, the hearts feel safe." Male patients regularly read Koranic verses and referred to Islamic tradition in case of fear from death, pain and stress. Salim (1986) described the power of God's words in the Koran for treating mental health problems. He quoted a study done by Abu-Islam (1986) in the United Arab Emirates which found that the Koran led patients to a state of relaxation and brought them relief in terms of the pain.

The women also regularly mentioned God and His Prophet. In addition, they mentioned dead saints and holy persons whom they believed had supernatural power; they called the saints "Rijal Allah Al-Salhin," meaning "The holy men of God." They routinely invoked God, the Prophet and saints in times of pain, hopelessness, and stress. During the interviews, when they felt difficulties in talking about their situations, they commonly said, "Ana Mr西亚 Hamli Ala Allah," meaning "I am leaving what I am carrying, to God." In other words, she will leave it to God to take care of her disease or problem.

Sometimes women expressed their difficulties by referring to God; they said, "Fe Rabb Beshof," meaning "There is a God who can see." The psychiatrist had to figure out what this phrase meant; women expected the psychiatrist to understand that they were suffering. Females used proverbs and phrases which are used in the Bedouin society in general. In contrast, males commonly mentioned Koranic verses and the tradition of the Prophet Muhammad; this indicates the differences between the genders in terms of literary. Males also were more exposed to the external world, such as Arabs
from the Gaza Strip, West Bank and north Israel. By contrast, the females lived in a limited space in the Negev, and the Bedouin society limited their relationships because of the family's honor.

Through mentioning God and His Prophet Muhammad and saints, the person attempts to be close to the power of God and to the supernatural power. As one of the female patients said, "Al-Hakmah Hakmat Allah, Wla Al-Abid Ish Bedh," meaning "The cure and treatment is the treatment of God, and His servants cannot do anything without God's wish." The patients believed that disease or disaster can be removed just by God's willing it; the doctor and the healers are agents, and the cure is due to the wish of God. One of the patients said, "I am afraid that I am going to die, I try to be close to God by mentioning Him all the time and asking forgiveness." This patient committed several sins during his life; when he felt that he was near death, he tried to supplement what he had done by good deeds. In his opinion, to satisfy God, one has to be close to Him and to ask His forgiveness (Messiri, 1984; Rizvi, 1989; Salim, 1986).

Religion has been found to promote either emotional health or emotional strain in time of crisis or disease (Banawi & Stockton, 1993; Eguchi, 1991; Reisner & Lawson, 1992; Umoren, 1990). Other studies show that people with strong religious background consider divine intervention a part of the healing process of mental illness (Lenderach & Lenderach, 1987; Shilon, 1981); as well, Umoren (1990) points out that illness explanations and treatments are related to a world view that can best be described as strongly religious.
Muslims believe in an afterlife and "Yom Al-Hisaab," the Judgment Day. They have to do good deeds, believe in God and practice the Islamic pillars. One patient said, "Ish wadk Itgol la Rabak Bokrah," meaning "What do you want to say to God tomorrow?" He meant after death. Islam teaches the Muslims that whenever they feel that they are going to die, they have to mention God and His prophet Muhammad; thus they will die as Muslims. They should say, the first Islamic principle, called Al-Shadah, the testimony. God said, "O you who believe, keep your duty to Allah, as it ought to be kept, and die unless you are Muslims" (Koran, Surah Al-Imran, v. 101). The Islamic tradition teaches that every Muslim must live a life of true submission to God, so that when death comes, it should find him or her a Muslim.

In sum, patients fear unexpected death or fatal disease overtaking them before they have the opportunity to repent and remedy their wrongdoing with goodness, piety and worship. Islam considers each individual accountable for his or her deeds. The Koran advises Muslims not to feel responsible for the deeds of others. In time of sickness, the first thing patients did was to mention God and try to be close to the Creator by doing good deeds, which led to an experience of relief and satisfaction with the supernatural power represented by God, the prophet and holy persons (friends of God). Death anxiety was a major issue in the treatment process, from the patients' perspective. Death anxiety motivated the patients to be close to the supernatural power. In this
regard, it is noted that death anxiety may be especially high among the Arab people (Abdel-Khalek & Omar, 1988; Templer, 1991).

In a similar vein, Bach-Y-Rita (1982) reported that, in the Mexican-American view, the will of God is frequently seen as the cause of illness and suffering as well as the source of cure in which the healer is only God's helper. This influence is evident in the prayers used in treatment and by the incidence of healers claiming to have powers through God or a saint (Rose, 1978).

The Pathways of Referral to the Mental Health Clinic

This section describes the pathways that the patients took to reach the psychiatric system in Soroka. Three main sources for all patients were the referrals from GPs, the emergency room at the Soroka Medical Centre, and private physicians. The data show that the patients were unfamiliar with the psychiatric system, and there were differences in degree of unfamiliarity between males and females.

None of the female patients knew what the psychiatric clinic really was. The majority did not know what the clinic name was; the female patients called it "Al-Hakmah," the hospital. They expected treatment and more examination from the clinic; as one of the patients said, "I am sick and my doctor could not help me, so he referred me to Al-Hakmah. In contrast, educated male patients knew the clinic name, but they did not know the way the clinic works. They believed that the psychiatric clinic treated by
medication -- partly true -- and some of them asked for medical examinations.

None of the patients had any idea about his or her psychiatric diagnosis. Indeed the "diagnosis" itself was strange for them; I explained to them what the term means. The general practitioners in primary health care did not give them any information about their diseases or about their situation. The GP used to say to them, "You are OK. All the examinations were good, so you have no disease." The patients expressed anger and disappointment with the GP. One of the patients said, "They send us Russian doctors to learn medicine on us"; he kept saying, "They do not know anything."

There are a large number of Russian physicians who work with the Bedouin population. The Russian doctors are under a stigma in Israel; many Israelis look down upon their skills (Shuval, 1985). These physicians have their own adjustment difficulties: they do not speak Hebrew well, they do not know Arabic and are not familiar with Bedouin culture.

Zola (1963) highlighted the difficulties of the communication between patients and physicians. He mentioned three non-medical factors which affect the communication between patient-physician, and may lead to misdiagnosis and mistreatment. These are as follows: 1) the patient's ethnic background, 2) the physician's medical specialty-orientation, and 3) the clinic's spatial design and organization. Zola concluded that the doctor should be more aware of their patients' needs beyond the somatization complaints. Doctors should be in a position more to intervene and to support
the patient's own efforts to cope with his or her disorder. However, as mentioned above, the physicians who treated the majority of these patients were unfamiliar with the patients' culture and language. In such encounters between the patient and physician, patients communicate through the pain and the symptoms presented. However, these physicians often appeared not to consider the human beings beyond the symptoms, which caused a distance between the parties.

Male patients consulted their own families; often they consulted their mothers, but not their wives. This suggests that the man is trying to show his wife that he is strong and nothing could hurt him. The mother is considered the dominant emotional figure in Bedouin society, so her offspring turn to her in case of disease. In contrast, females consulted their families, friends from the extended family or tribe, and even women from other tribes in the primary health care catchment. Females routinely consulted their own families, not their husbands or their husbands' families.

All the patients had consulted traditional healers from their communities before they approached the psychiatric system. Males consulted traditional healers often through the help of their families, whereas females consulted traditional healers often without their families' intervention.

None of the female patients knew what the psychiatrists do; they perceived them as specialists in physical disease. This perception was found among the illiterate male patients. Those who were educated perceived the psychiatric system as treating by
medication. Some of the male patients (educated) and those who were employed mentioned the term "Aqghdh Nafsanih" (psychological complex), but they did not know exactly what this term meant. Educated patients explained this term as a person having a problem in his or her (Nafs) soul, which resulted in symptoms. Even the educated patients refused to accept the idea that they had psychological problems. This may be because of the stigma and their perception of their situation. As one of them said, "I am sick, I have no problems, I can deal with my problems alone." He kept saying, "I need treatment." Some of the educated patients had high expectations from the psychiatric system, treatment by medication, injection, and X-ray. Some of the patients even asked for an operation or hospitalization if it seemed to be needed. None of the patients who were interviewed mentioned the term "psychotherapy."

Based on the data, most patients had bad experiences with the GPs; however, when the GP referred them, they came to the psychiatric clinic of the hospital (Soroka) with high expectations. They thought the GP could not help, and referred them to the hospital where a physical examination could be done. All of them believed that the doctors in the psychiatric clinic would help them with these physical problems. In most Arab countries the most common interventions are by psychiatrists who mostly rely on medications (Ibrahim & Ibrahim, 1993). Bazzoui and Al-Issa (1966) pointed out that medication treatment is very frequently used, and it is the most popular treatment among patients and psychiatrists.
alike. Psychotherapy, on the other hand, has little appeal to the patients. In general, psychotherapy per se is not represented in the Arab world (Ibrahim & Ibrahim, 1993). Gorkin, Masallaha and Yatziv (1985) point out that the Israeli Arab student expects to receive concrete advice and direction from the therapist; long-term treatment is seldom anticipated (Gorkin et al., 1985; Racy, 1985). This is partly due to the fact that psychotherapy usually takes a long time, unlike the quick magical effect expected from the traditional healing system. West (1987), in her study in Saudi Arabia, stated that the patients do not believe that talk therapy is worth paying for and believe that without medication the therapy will be ineffective. Banawi and Stockton (1993) found that psychotherapy in general, and group counselling in particular, are not yet culturally and religiously accepted means and sources of help among Muslims. Hornstra and Udell (1973) reported that all of the therapy with traditional people was relatively short-term, the majority of cases continuing for fewer than ten sessions. Kinzie and Tesng (1978) found that the low-income patients, defined as receiving public medical assistance, stayed in therapy significantly longer than those who were not receiving medical assistance.

Based on my experience and the data, I think such situations occur in the encounter between Bedouin or Arab patient and psychiatrists; often the therapist is faced with "resistance" since many of the patients do not assume responsibility for their pathological actions (Al-Krenawi et al., 1994). The notion that is
held in the West about responsibility and the "self-made" person
takes on a different meaning in Islamic society. The Islamic
influence on Arab psychology is revealed in the acceptance that
life as well as the future are in the hands of Allah. Many
patients believe that every member of the psychiatric clinic is
Hakeem, that is, a wise man and traditional healer, not a physician
in the Western sense but a professional working through the hands
of Allah. These patients place the responsibility on the therapist
(psychiatrist) to heal them. They often appear silent, expecting
the psychiatrist to guess their problem or disease and to know the
answers. I think that such patient perceptions are based on the
traditional healing system. When the patient meets the healer for
treatment, the healer is the one who identifies what the patient's
disease is and the treatment. In other words, the healer acts as
a person who has access to supernatural power and therefore the
ability to help. Although the patient may be asked to carry out a
ritual, his or her assistance or direct collaboration in healing is
not required. This factor may affect the Bedouin or Arab patients'
perceptions when they refer to doctors, psychiatrists and
psychotherapists. Based on my experience as a social worker to the
Bedouin, I have observed that patient's tend to tell the doctor or
the therapist his or her symptoms; the latter then has to take
responsibility for treating the disease or problem. Such a
situation raises questions about how to do psychotherapy with Arab
people and other traditional communities around the globe. I will
deal with this question below.
Because a patient was sometimes treated by more than one psychiatrist, he or she often received different diagnoses. The psychiatrists were not always sure about a patient's situation, and had to consult the patients' files in order to be certain of the diagnoses. Having had access to the files myself, however, I was certain that there was nothing written in the patient's file about the explanation of his or her disease. Not surprisingly, the psychiatrists appeared unsure about the causality; some of them referred to traumatic events, family difficulties, or social problems. They were in a situation where it was almost impossible to find out details of history and context. Others talked about "hysterical personality." In general, the psychiatrists appeared to perceive the patients' diseases in individual or, at best, family terms. I am leaving aside, for the moment, the problems of accident and trauma in the male patients.

Female patients were a major difficulty for the psychiatrists. Psychiatrists assumed -- not without justification -- that because of their complicated lives, every case was a family problem or an adjustment problem, but could not inquire into such issues because of presence of translators and lack of patient trust. With male patients, doctors often mentioned the term, "traumatic events." When I compared what the psychiatrists said with my data on the patients, I found that the psychiatrists had often not obtained
pertinent information. They, of course, had no information on those who left the psychiatric system due to misunderstanding.

The psychiatrists frequently perceived the patient's psychiatric problems in the context of social and family problems. However, when I asked the psychiatrists about the patients' prognoses, often they would say "we have nothing to do except give medication; we cannot solve their problems." Being distant from Bedouin society and culture, they felt -- and often were -- powerless to address major issues underlying patients' symptoms. All the prognoses of female patients were quite gloomy; as one of the psychiatrists said, "We have nothing to do; she will stay in this situation until the society changes." GPs often wrote letters to the psychiatrists for the male patients, after road accidents or other traumatic events. Such cases were immediately labelled by the psychiatrists as "post-traumatic stress disorder" (PTSD).

Regarding approaches to treatment, all the psychiatrists used medication with the Bedouin patients of both genders. They believed -- often correctly -- that the Bedouin patients were mainly seeking medication and further investigations. Patients indeed asked for injections. There were other reasons for the medication approach. Psychiatrists had problems of language and culture. The Romanian psychiatrist said, "I don't want to open anything behind the symptoms because I am afraid of causing damage instead of helping." Of course the patients themselves focused on the physical symptoms -- somatization. According to my observations of the encounter between psychiatrists and patients,
the patients actively led the psychiatrists to focus on their symptoms, rather than their emotional difficulties. Thus, there were both patient- and doctor-related issues which led to the almost exclusive focus on physical complaints and medication. This might have been the basis for a working relationship but the psychiatrists could not support the patients' views of etiology and more basically were in a situation in which it was impossible to establish rapport.

The relationships between the psychiatrists and patients had several difficulties: They were described by the psychiatrists as formal. The relationships with the female patients were indirect because there were translators or other family members involved in the treatment process. All the psychiatrists stated, however, that they had good relationships with the male patients, because the males spoke Hebrew. The Bedouin patients throughout treatment in the psychiatric system brought gifts to the psychiatrists. The psychiatrists thought that the patients respected them and brought them gifts as a symbol of honour.

From the patients' perceptions, the relationships appeared differently. Although they had some respect, they needed and even feared the doctors as authorities. Patients sought the doctors' favor. Because of the patients' actions, the psychiatrists generally overestimated the quality of their relationships with the patients.

All psychiatrists stated that they preferred the educated patients and their problems; they could communicate in Hebrew and
express themselves fully. Yet the psychiatrists were unaware of
cultural context. One of the psychiatrists said, "When I have an
educated patient, first I am alone with him. I treat him well."
Another said, "The educated patients know the roles, and if you do
not treat them well, they can complain about you."

One can conclude from the above that the patients who were
familiar with the modern system and its roles could get good
treatment; those who were not familiar -- females, and the
uneducated -- generally were not treated as well although this may
not have been intended by the psychiatrists.

Another important issue emerged in relation to the educated
patients: The stigma of psychiatry affected them, so they often
left the clinic or went to private treatment. One of the
psychiatrists said, "The stigma influences the educated Bedouin
patients, and they often ask if I have a private clinic." The
psychiatrists could do little to diminish the stigma and build
continuing relationships with the patients. The Romanian
psychiatrist said that the Bedouin learn "Israelization," meaning
that they ask for letters to the social welfare services. The
issue of letters to social welfare services was raised by all the
psychiatrists; their patients often talked about their economic
problems at the second session.

As well, there was a biophysiological orientation among the
psychiatrists, particularly those of Russian background. Not
believing religion was a primary factor in patients' difficulties,
they never investigated this area. They never asked such questions
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of the patients, nor about practices of traditional healing. They
did admit to me that cultural difference made it difficult for them
to understand the patients' problems. As one said, "I do not know
anything about the Bedouin, their belief systems, their life."

The Romanian psychiatrist thought that the treatment of the
traditional healers could help in cases of neurosis, but not in
psychosis. In contrast, the Russian psychiatrists believed that
the traditional treatment was likely ineffective and could
undermine the modern treatment. They said that folk treatment was
not scientific, and they thought that the healers would stop the
patients from taking medication. As one female psychiatrist said,
"If the Bedouin patient goes to traditional healers he or she will
stop taking the medication and trust unprofessional people." This
was not exactly what I found. A male patient of hers had consulted
a traditional healer concurrently and did believe that the healer
helped him more than she did, but he continued taking the
medication she had given to him.

In a case with another Russian psychiatrist, a male presented
physical symptoms; he also said that he believed that he was
married to a Jinnih (a female Jinn). The psychiatrist started to
laugh, and the patient left the session. She ran after the patient
and brought him back to the session; she then focused on his
physical symptoms and ignored what had been said before. In
fairness to the psychiatrist, part of her reaction, however
inappropriate, can be attributed to basic language and cultural
barriers. And to her credit, she did attempt to maintain a therapeutic alliance.

The psychiatrists complained that the Bedouin patients came early to the clinic when they had appointments at noon or in the afternoon; the psychiatrists did not pay attention to the informal groups that formed outside the clinic. One of the psychiatrists said to a female patient, "You should come after noon. What are you doing here?" However she did not understand what he said and ignored the comment.

Cultural difference has often been reported to affect psychiatrists' ability to diagnose and treat patients' problems effectively (e.g., Bravo & Grob, 1989; Chiu, 1994; Schwartz, 1985). The present psychiatrists had an idea that the Bedouin society is complicated and that the patients, male and female, could be treated just with medication, so there is usually no need for psychotherapy. Even when these psychiatrists sometimes suggested psychotherapy for the male patients, there would be, because of language and culture, almost irreparable difficulties. In psychotherapy, language itself is not enough; therapists need to be familiar with the patients' culture, belief systems, and when and how to intervene (Al-Krenawi et al., 1994; Bilu & Witztum, 1993, 1994a; Ibrahim, 1985; Lefley, 1986; Ruiz & Langrod, 1976a; Sanua, 1989).
I made many observations of the encounter between the psychiatrists and patients. I will call such an encounter the institutional treatment procedure. There were several communication problems observed. First, I will consider the male patients. When the patients arrived for treatment, they had in mind physical pain and somatic complaints. The psychiatrists looked at the patients while they presented the physical symptoms and focused on these symptoms, trying to reach a diagnosis. These patients sometimes expressed difficulties by proverbs or using Arabic words which the psychiatrists did not understand. The patients also had difficulty translating the proverbs into Hebrew; when they translated, it did not make any sense. Both the patients and the psychiatrists often looked toward me, asking my help. One male patient said to the psychiatrist, "Bhass Rasi Zai Al-Bedha Al-Haedah" (I feel my head is like a damaged egg). Since it was hard for him to translate this proverb into Hebrew, he looked at me and the psychiatrist to see if either of us could help. I did not intervene; I stayed in a neutral position, just observing what occurred between them. The psychiatrist ignored what the patient said and stayed with the physical complaint.

With the female patients, the situation was different. First, there was another person involved in the treatment. The patient's male relative or another person from the family was present. In other words, there were four members involved in the treatment
ritual: the psychiatrist, translator, female patient and the researcher. The communication was carried out through the translators. The patient sat beside the translator, trying to explain her complaints to him, and he translated what she said to the psychiatrist. The psychiatrist then directed questions through the translator. In this situation of indirect communication, the psychiatrists often did not pay attention to the patient’s body language or her clothing. For example, a female patient who was in the mourning process wore blue and green clothes symbolizing grief but this was not understood (Al-Krenawi, 1993). The translator also sometimes answered the psychiatrist’s questions without asking the patient’s response. When the translators were relatives of females, they were often very active during the treatment process, answering the questions from their own points of view. The psychiatrists nonetheless accepted what the interpreter said as facts without referring to the patient. This process occurred while the patient sat aside, ignored by the psychiatrists. There were some questions that the translators did not even ask the female patients because the translator felt too shy to pose questions related to sexual or family matters.

From my point of view as observer, the psychiatrists took the females less seriously than the males even though the females seemed to suffer more than the males, and to need serious attention apart from medication issues.

One may raise the following question about these meetings between psychiatrists, female patients, and translators. How can
a Bedouin female express her emotional or family problems in front of her relatives or her husband, or a strange man whom she does not know and is not ordinarily allowed to talk to?

There were many misunderstandings between the psychiatrists and the female patients. Take the example of a 16-year-old unmarried, pregnant female who presented a variety of other bodily complaints to the psychiatrist; her brother was the translator. This patient could not present her problem in front of her brother. What she did is unacceptable in any Muslim society and might have led to death. The psychiatrist faces an insurmountable obstacle in such a case unless there is a cultural intermediary, acceptable to the patient's family and trusted by her.

In a formal, institutionalized procedure there is little opportunity to establish a good relationship and gain patient trust. The psychiatrists did not usually give any explanations to the patients about their situations. After the psychiatrist reached the diagnosis, he or she commonly just explained to the patient or the interpreter the treatment instructions. For instance, one psychiatrist said to a patient with no explanation, "Take this medication and I will see you after one week." None of the psychiatrists told the patients the diagnoses. There was no cultural common ground on which the psychiatric diagnoses could be explained or discussed. When the patients sometimes insisted that they needed medical exams, the psychiatrists often answered, "Your doctor did all the investigation for you and you are OK. You have no disease in your body." The psychiatrists often pointed to the
GP's letter that indicated that all the medical exams showed negative findings. Such a situation usually increased the patients' frustration, and they responded with anger. One of the patients said to the psychiatrists, "The pain is in my body, and I feel it; not you, and not the GP." The patients usually asked about the treatment and the prognosis. For example, "What is the treatment and when will I feel better?" The psychiatrists typically answered such questions as follows: "First, you have to take the medication, and later on we will see how it works."

During the sessions, the male patients more actively presented physical symptoms focused on their bodies, and told how the diseases affected their function. With the female patients, the psychiatrists and the interpreters were more active, dealing with the woman's life while she observed and could not do anything except answer the psychiatrist's questions through the interpreter. Much information was missed in the process of the translation. After the psychiatrist reached the diagnosis, he or she managed the treatment by giving the medication and saying when to come back. The psychiatrists often used professional terminology, and the patients did not understand what it meant. Even had the psychiatrists put scientific concepts of disease processes and etiology into common speech, there would still have been a chasm between the worldview of the psychiatrist and that of the patient. Males routinely asked questions about what the psychiatrists said, speaking to me, asking for my explanation.
The psychiatrists involved the female patients' families, inquiring about their situation. Such intervention is not considered proper, and could harm the female instead of helping her. There was a case of a female patient who was accompanied by her husband and her mother; her husband was in a feud with her parents. This man was trying to punish his wife by making her crazy; he said to the psychiatrist that his wife behaved in a crazy manner, neglected her children, and sometimes ran away from home to another tribe. The psychiatrist was sure that the man's wife was psychotic. The mother looked very angry; she looked toward me, saying, "Tell me what is going on, I do not speak Hebrew." The female psychiatrist was very kind to the patient's husband; she heard everything he said. Even when the female psychiatrist asked the patient, her husband translated what he thought was right.

The psychiatrist gave the wife an anti-psychotic medication and made an appointment for the next week. The patient's mother was very angry. She tried to say something, but nobody paid attention to her. This patient later told me about the problems between her parents and her husband; her husband treated her badly, even beat her. As might be expected, this case never came back to the psychiatric system; the parties turned to the traditional system. Again, a non-Arab psychiatrist, unaided, could not possibly deal with such a problem.

In the case of female patients, psychiatrists believed it was desirable for a family member to translate; the families generally agreed, but it was tricky to involve the family in treatment. The
psychiatrists did not ask the male's family to be involved in the treatment ritual. In the psychiatrist's opinion, male patients speak Hebrew, so individual interviews were feasible. The psychiatrists were in an entirely unworkable position: they could not interview females alone, but they could not involve families without families imposing perspectives and filtering the facts reaching the doctors.

It should be emphasized that the patients generally succeeded in leading the psychiatrists to focus on the somatic symptoms. Sometimes patients expressed their emotional difficulties in proverbs, and the psychiatrists could not understand what these proverbs meant. In general, none of the psychiatrists who treated the Bedouin patients were familiar with the patients' culture. None asked questions about the patient's religion or belief system. Psychiatrists often showed what can only be described as cultural insensitivity; for instance, on several occasions they asked a female patient, in front of a strange man or her brother, about her sexual life. The psychiatrists, because of cultural disparities and Bedouin gender-conduct norms, faced difficult or sometimes impossible situations.

The Psychiatrist-Patient Relationship From Both Perspectives

The psychiatrists generally did not introduce themselves to the patients. Usually the general office in the clinic referred
the new patients to the chief psychiatrist. The Bedouin patients especially the females and the illiterate patients were unfamiliar with the Russian psychiatrists' names. It was difficult even for the educated to pronounce the psychiatrists' names. None of the female patients knew the psychiatrists' names. They commonly described them in terms of appearance: such as "the tall one," "the short, [or] older, younger, male and female [etc.]." Few of the male patients knew the psychiatrists' names. The rest of them described the doctors according to how they looked. Male patients recognized the Russian doctors; they routinely said, "Al-doctor Al-Rossi" (the Russian doctor).

The unfamiliarity of the psychiatrists with the Bedouin culture and the patients' language caused several problems in communication between the patients and psychiatrists. Such a situation led some of the patients to be angry with the psychiatrists and with the whole medical system, including the primary health care centre and the psychiatric system. The following data illustrate the type of relationships between patients and psychiatrists from the patients' perspectives; psychiatrists' relationships were formal with male patients and indirect with the female patients because of third party presence in the treatment process (the translator).

All the female patients reported that the psychiatrists did not understand their difficulties. The psychiatrists communicated with the female patient through the translator. However, the females felt that the psychiatrists did not understand them because
they could not speak of their pain directly to the doctor. One of
them said, "La hoa fahim Ale Wla Ana Fahmih Aleh," meaning "I do
not understand him and he does not understand me." Some patients
were disappointed because they expected X-rays and blood tests, and
this did not happen. Some of the female patients, however, still
hoped that the doctors would do a medical examination to find the
reason for their pain.

Male patients often had difficulties expressing themselves in
Hebrew. Such patients said, "sometimes I need to say something
which really reflects my situation, and I cannot do it in Hebrew;
when I say it, it does not make any sense." This group of patients
who spoke Hebrew adequately complained that the psychiatrists could
not understand them, because they did not speak Hebrew well. A few
of the male patients described their relationships with the
psychiatrists as "OK" although the patients had experienced less
than full understanding from the doctors. In contrast, all of the
females reported that the doctors did not understand them well.
The psychiatrists had, in fact, asked the female patients to come
with proper translators, but these patients often did not pay any
attention to this suggestion. They often said, "Ma Had Fadi
Lahad," meaning "Nobody has time for me."

It is noted, in the final sample, that several of the patients
were treated by more than three different psychiatrists. This
upset the patients. As one said, "Col mrrah Lazam Nbtidy mn
jedid," meaning "every visit, I have to start from the beginning."
Because several doctors were involved, I sometimes found the same
patient had two or more diagnoses. In general, there were misunderstandings between the psychiatrists and the patients, which affected their relationships. In other words, the psychiatrists' understanding and treatment of the patients raised questions about the former's awareness of the latter's background (Casimir & Morrison, 1993; Kagawa-Singer & Chung, 1994).

**Symptoms: How the Patients Described their Symptoms to the Psychiatrists**

Male patients focused on physical complaints, and how they affected their ability to work and to function in the society. In other words, the diseases, from their perspective, influenced them physically, economically, and socially (Pliskin, 1987; Zola, 1973).

The female patients commonly described their symptoms by

1) bodily complaints (somatization);
2) words or proverbs;
3) dreams;
4) objective analogy.

**Somatization.** Bodily symptoms have been described as among the most common presenting symptoms of psychiatric disorders affecting Arabs (in Tunisia, Pamela-Ann, 1987; in Iraq, Bazzou, 1970; in Egypt, El-Islam & Ahmed, 1971; in Saudi Arabia, Racy, 1980; Al-Sabaie, 1989; in Kuwait, Kline, 1963; in the Emirate of
Dubai, Ghubash, Hamdi, & Bebbington, 1994; in Algeria, Al-Issa, 1990 and in Israel, Gorkin et al., 1985). Patients often attribute their somatic symptoms to body dysfunction without insight into their possible psychogenesis. El-Islam (1969) stated that the illiterate patients in the Arab society are often unable to give abstract verbal description of their emotions such as anxiety or depression and can only report the associated somatic symptoms. Gorkin et al. (1985) noted that Israeli Arab students expect to receive advice and direction from the therapist. The common symptoms and pathology were somatization of conflict. However, these studies did not take into account the powerful and expressive proverbs that the Arab patients commonly say in time of tension or stress (Al-Atiel, 1978; Al-Hassan, 1988; Al-Rassi, 1987; Al-Shahi, 1972; Messiri, 1984). An expressive analysis of proverbs is given in the next section.

Bedouin patients generally focused on the somatic symptoms, but as the therapeutic sessions progress, they routinely express their negative feeling by proverbs or by pointing on an objective item reflecting their subjective feeling. These actions indicate some level of emotional understanding, even abstraction.

Male patients presented physical complaints such as head pain, breathlessness, loss of appetite, poor sleep. They pointed out how the pain affected their ability to work and to function in the society. One of the patients said, "I am not able to walk sometimes." They presented physical weakness, or lack of energy, complaints which are categorized by them as severe. They also
focused on how the disease affected them socially; they could not participate in the family or tribal events such as weddings, funerals, and other social gatherings. Culturally, men in Bedouin society have commitments to their extended families and the tribes; they have to participate and share with their relatives any event, good or bad. One of the patients said, "I feel so bad because I cannot share anything with my family; my relatives are going to marry next week, and I cannot help because of the pain in my chest." Another patient said, "I don’t want to participate in the wedding in my tribe because I am afraid of losing consciousness in front of the people; then I would be ashamed."

Nonetheless, as the interviews continued, they presented other symptoms, such as dreams, feelings of anxiety which are caused by supernatural power according to them, bad moods.

In presenting bodily complaints (which the psychiatrists called "somatization") females commonly pointed to where the pain was located in the body. It is interesting to mention that they routinely complained about their hearts, while they pointed to their stomachs. They experienced the pain as travelling in their bodies. One of the patients said, "Al-Waga Abetnagle Fe Jissmi mn mtrah la matrah," meaning "The pain moved in my body from place to place." The majority of the females presented sleep disturbances; one of the patients described herself like fish in the sea, "Aza Kan Alsamak Fe Al-Bhar Bnam Ana Bnam" (As the fish in the sea sleep, I sleep), meaning that she did not sleep, just as the fish in the sea did not. Another main problem with the females was that
they lost consciousness (Docah); patients who had complaints about such a situation were afraid that they had severe disease. One said, "Bteeh Wa ma Badri in Halih," meaning "Often I lose control, fall down, and lose consciousness." This patient was worried about her situation; she asked for an X-ray and blood tests. She said, "Wdi Fahas Lkol Jsmih"; "I need a general medical exam." Another common symptom was breathlessness or tightness in the chest called by them, "Deq Nafas" and "Deq Fe Alsadar." It is literally described as a feeling that the chest can no longer accommodate the patient’s breath; as though it had become too small or too tight to contain a deep inspiration. This is a common somatic expression of tension; this symptom was presented by both males and females, but it was emphasized more by females. El-Islam and Abu-Dagga (1992) pointed out that the breathlessness symptom is one of the common- most presenting symptoms among Arabic-speaking patients.

Females expressed their difficulties non-verbally; their faces expressed sadness and pain; they used their hands when they answered the psychiatrist’s questions. They showed when they were disappointed. For instance, when they asked for a medical exam and the psychiatrist said to them, "you do not need a medical exam, you are OK. What you need is only to take the medication." In such cases, they often said, "Allah Ale Behoat Wallah Ale Berfah," meaning "God is the one who can inflict disease and only He can remove it." This suggests that the patient felt that no person could help her.
Male patients blamed physical diseases and their destiny for what happened to them. In addition to the bodily complaints, they often said, "Al-Shakoah Lger Allah Madalh"; "Complaints to anyone except God are shameful." This cultural message represents what the Bedouin society expects from a man. The cultural message is, a man should be strong, not weak. So a man is likely to state a mental problem in physical terms. It may be that, in Bedouin society as well as in other Arab countries, the reluctance of patients to express depressive moods is related to the cultural teaching to children that public expression of feelings is shameful (Al-Issa, 1990). A man is perceived by the Arab society as the protector/provider of the household, and that he should be strong, powerful and dominant (Swagman, 1989). Therefore, men may elect to cast their illness experiences in alternative cultural idioms that do not imply any basic fear or weakness in character, that might be seen by others. The Bedouin society also encourages males not to talk too much. As one saying goes, "Ida Al-Haki mn Fedah Fa Al-Sekoot mn Dahab"; "if talk is bronze, silence is gold."

Old men used very powerful proverbs. These they conclude with the phrase "the rest of the story is on your side," which means you have to figure out what is meant by the proverb. The young male patients also often used proverbs during their encounters with the psychiatrists. Therefore, from the cultural point of view, there may be several reasons for using proverbs: the proverb is more powerful, and instead of telling the psychiatrists or the
researcher a detailed story, the proverbs compress the patients' difficulties and his or her story.

The female patients felt free to talk about their difficulties and weakness behind the physical complaints. The females looked for someone who was ready to listen to them; that happened after they felt safety and trust with the researcher. In contrast, males hesitated and were reluctant to talk about their weaknesses and difficulties. This is because of the cultural message as mentioned earlier. After the interview continued, and the trust between the researcher and the patients was obtained, they became more open.

In summary, somatization is the conscious or unconscious expression of social, personal, psychological, or emotional problems in physical symptomatology. The body thus becomes a metaphor for personal distress. Coding distress in physical symptomatology enables the person to distance himself or herself from personal problems and not assume responsibility for them, since the problems often are either not cognized or not considered to be related to the bodily symptoms. Somatization as a category of illness must be viewed as an individual and cultural expression linked with a system of meanings with which it is perceived, sensed, sustained and treated (Good, 1977). The body is a vehicle for the expression of the emotional and psychic pain. Somatization is the use of the body to express and to cope with social and personal distress (Kliger, 1994; Marsella, 1993). Kleinman has pointed out that somatization must be interpreted as a "particular cognitive-behavioral type whose adaptive or maladaptive
consequences involve assessment of social, cultural and personal variables" (1986, p. 60). Mary Douglas stated that "natural expression is culturally determined ... There can be no way of considering the body that does not involve at the same time a social dimension..." (1966, p. 65). Anthropological research shows that the use of the body to manifest distress is, in many cases, directly related to, and expressive of, specific forms of cultural tension -- in particular, unequal power relations (Low, 1989; Martin, 1987; Racy, 1980).

**Proverbs**

Proverbs and emotional disclosure. It is important to mention that all the patients, male and female, were more open and clear with the researcher and revealed themselves to him more than to the psychiatrists. The patients perceived me as one of them. One said, "you are one of us, so you can understand us more than they do." Trusting me, both males and females used proverbs to express their difficulties, such as "Ale Malh Bacat La Itab Wla Yashqa," meaning "the person who has no fortune does not need to work hard, because his or her future is already determined." This proverb conveys the hopelessness and sadness the person endured. When a female patient was asked about her problems, she said, "Ya Hasrah, ... Kalihi Fe Al-Qalb Tghah Wla Tatlaa Taftah"; "What a sorrow ... Leave it in the heart to keep making pain and injury, rather
than saying it, and this will create a trouble." She meant that she has many undisclosed problems and much trouble in her life.

Another one of the female patients had a brother who was the Sheikh of a tribe; he had been murdered by another tribe in a dispute between the two tribes. She was depressed and wore blue and green clothes which symbolize the mourning process. When she was asked about her situation, she expressed her sadness and her grief very powerfully; she said, "Johi Yaa Ean Wla Tabhali Ala Ahiah," meaning "Weep my eyes, and do not be shy for my brother." She kept describing her brother as "Jamal Al-Asherah," the camel of the tribe; from her point of view, her brother was the one who took care of everything concerning the tribe. The camel in Bedouin society is a symbol of power and patience. Finally this patient said, "Ma Baraoq Gher Ysfaha Galilih," meaning "I will feel better when we will take revenge for my brother."

Another female described her situation by saying "Abnemshi Al-Hiatt Al-Hiatt Wa Bengoal Ya rab Al-Sotrah, Wamosh Mastorein"; (I walk beside the wall and look for safety, but I am not safe). Another female said about her husband "Ale Ma Bedri Bequal yaa rath Fe Dearna," meaning that one who does not know him would say, "I wish I had such a person as a member of my family." What she meant by this proverb is that to an outsider, her husband looks like a good person, but from her point of view, he is a bad person.

A male patient was in love with a female from another tribe. Her parents and her tribe refused to allow him to marry her. This patient was upset and angry with the family of his beloved, and he
felt hopeless. He had suicidal thoughts and told me that nobody in his family understood him. During the interview, he said he believed that one of his loved one’s relatives did sorcery (Amaal) on him to separate him and his loved one. This patient was diagnosed as depressed and treated by medication, but he was not satisfied with the treatment. He spoke freely to me during an interview, and expressed his frustration: “Lwin winin Al-Hoiar Yoma Albaal Qutarat Anah” (I will cry like the small camel when the other camels left). This patient mentioned the romantic love story between a boy and a girl (Kais and Lailah) who met at the pasture, this story is known to every Arab child. At the end of the story, Lailah’s family rejected Kais, just as this patient was rejected by his loved one’s family.

Another proverb often said by the female patients: “Al-Darah Morah Lo Kanat Edan Jarah” (the second wife is very sour even if it is a handle of the pot). The term Darah in Arabic means the second wife. The female patients described how their husbands’ remarriage affected them deeply: “Elain Baserah Walead Kaserah” (my eye is blind and my hand is short); this meant that she felt unable to do anything. Many patients said, “Yarab Tsbrana Methal sabar Aeob” (My Lord give me the patience of Job). Job’s story is mentioned in the Koran and the Bible. Patients connected their suffering to that of Job who was being tested by God. Another proverb related to patience is “Mn Baad Al-Sabar Ila Al-Qabar,” meaning after a long patience and frustration, this will lead to the grave (to death). One of the male patients who was depressed and
disappointed with his life, cited the poem of a famous writer. He said, "Ana Hadii Ka Daqign Bein Shooken Bthrouh Wa Qalo Lhofaten Yeom Rehin Agmaoh"; (My fortune is like a flower and they threw it on a windy day among thorns, and asked people without shoes to collect it again). This poem means that the damage is already done and there is no way to bring it back. This poem expresses frustration and hopelessness; the patient did not see any way to escape from his difficult situation.

The patients commonly expressed their difficulties during the interview with me, and during participant observation, using proverbs. The reason for that might be because both the researcher and the patients shared the same culture. Patients expected the researcher to understand them and their needs and to help them in the psychiatric system; for example, to talk to the psychiatrists about their situation.

From my point of view, when patients said proverbs, this was an invitation to their internal and secret world, revealing both personal and family-related problems. But, in my opinion, they also wanted, even expected, the psychiatrist or the doctor to understand their suffering. The issue of the psychiatrists' understanding of the proverbs is addressed in the following section.

Proverbs as psychological manifestation. Proverbs are often effective in therapeutic communication because they cloak anxiety-laden, raw conflicts in more abstract, and therefore more
acceptable, symbolic form. That is often the case if both the therapist and the patient share the same culture. In a recent study of Chinese psychiatric practice, Kleinman (1988) cited the case of a middle-aged Chinese woman who suffered from neurasthenia. She resented her husband’s taking sides with his mother, who lives in their household. The Chinese psychiatrist tells her:

It is your responsibility to care for an old mother-in-law. Perhaps it is your neurasthenia that makes you irritable and stubborn. It interferes with your duties as a wife and daughter-in-law. ... "Be deaf and dumb!... strive not to argue." Once the disease is better, your relationship with your mother-in-law will improve. (p. 97)

The Chinese psychiatrist used a proverb to advise the woman that she should adhere to traditional family values of caring for older parents, and that she should try to repress her resentment for the sake of family harmony. The proverb reinforces the notion that it is sometimes more congenial in this society to treat familial conflict through the more impersonal and less controversial somatic medium (Nguyen et al., 1991).

Using proverbs, however, arguably requires abstract and higher-level cognitive abilities. According to Haneck and Kibler (1984), to use proverbs requires four cognitive transformational steps of considerable complexity and sensitivity. The first step involves recognizing that the literal meaning of the proverb does not fit the situation under discussion. Next the subject realizes that the proverb must apply to the situation in some way. The subject searches for a "figurative," or abstract categorical meaning which can then be applied to all future analogous
situations. Haneck and Kibler described the final stage of proverb realization, what they termed "instantiation," but perhaps it is better called "abstract generalization." They argued that proverbs are more abstract than many other types of communication in that they can be applied widely and have an immediate, here-and-now pragmatic point to make. Proverbs often seem to make conflictual situations simpler, are explanatory, and like good psychotherapeutic interpretations, are usually non-confrontational (Nguyen et al., 1991; Whaley, 1993).

The present Bedouin patients routinely expressed their hidden personal and family problems or conflicts by proverbs. But how did the Russian or other psychiatrists who worked in the system understand what these proverbs expressed? First of all, the Bedouin patients realized the differences between themselves and the psychiatrists: for instance, it was difficult for the patients who were speaking Hebrew to translate the proverb into Hebrew from Arabic. In such a translation, the proverb loses its significance. The differences between the psychiatrists and the patients were such that the psychiatrists, according to my observation, apparently did not understand the Bedouin proverbs and generally ignored them.

Bedouin patients in the psychiatric system often appear unwilling or unable to talk and think in a "psychologically minded" way during attempts at intercultural counselling or psychotherapy. It is frequently assumed that these patients are more concrete and pragmatic, less abstract and introspective, in their cognitive
styles. Such a perspective leads to a psychotherapy of offering "supportive" advice regarding the practical problems of everyday life. Oriental religion, philosophy, and proverb construction, however, strongly indicate the possibility of more profound dimensions of cognitive style, which are most likely considered properly kept within the family sphere and within the self. As Searles (1972) has pointed out, all humans have inherent requirements for psychological help from one another using language.

Messiri (1984), in her study of the Egyptian personality through folklore, pointed out that there are several types of proverbs divided according to events. Proverbs contain a powerful message and help the person to express his or her difficulties indirectly and concisely. She stated that the Egyptian people adopted ways of dealing with each other using proverbs which became part of the culture and a way of communication. Al-Shahi (1972) discussed the power of proverbs in Sudan; he stated that they contain the social values of the person's culture. He concluded that through proverbs, we can learn about the person's culture. Thus our task as mental health workers is to understand what the patients are trying to say in proverbs. Through proverbs we can learn about the patients' culture and the patients' problems specifically about his or her emotional problems (Al-Rassi, 1987; Abu-Lughod, 1986; Briggs, 1985; Fischer, 1988).
Non-physical symptoms. This section deals with the non-physical symptoms that the patients presented during the interviews and in their encounters with the psychiatrist and the traditional healers, according to my observations. These symptoms included dreams, delusions and hallucinations. There were differences between the male and female patients' dreams. The males expressed feelings of fear in their dreams which they are not allowed to talk about during daily life. If a man in Bedouin society mentions these feelings, it would mean he was weak and laughable. In contrast, females expressed feelings of being threatened; frequently they told of seeing snakes. Women's dreams often reflected the restrictions and anxieties of their social roles; men's dreams often reflected basic uncertainties and fears which their culture discourages them from expressing (Levine, 1991).

Male patients presented dreams about death, which caused them to feel afraid and threatened. Case number 1 table 1 said, "Bhas Ani Mtarad," which means that he felt threatened, and someone was running after him. The same patient said, "I hear someone say to me, 'Do not stop praying to God.'" He kept saying, "I am hearing this message all the time day and night." Men complained about fear from death; one of them said, "Bshof Zai Zalamh Wdh Yoktal Neh," meaning "in my dreams, I see a man following me who wants to kill me." One patient who in his dreams was afraid of death tried to justify his position; he stated that he never felt fear and did not know what fear is -- he was afraid only of God. This sentence reflected the Bedouin culture; that a man can have a strong fear,
but not of other men. In dreams, male patients frequently saw animals such as dogs and camels; these animals threatened them. One patient said, "In my dream, a huge animal appeared to me; I do not know which type of animal wants to attack me."

Patients also talked about their thoughts of death during the day. One of the patients said, "all day, I am thinking about dead people from my family, and that I am going to die soon." Another man reported, "in my dreams all night I saw just dead people; my life became like hell; I feel that I am living among dead people." Bad dreams, from the males' point of view, are a sign from the spirits. As one of them said, "Ahalam Shytaniah," meaning Satan's dreams. Or, another patient said, "these bad dreams are like a red light from God; meaning 'You forgot your Creator.' God reminds us, by these dreams, that there is no God except Him, and we should return to the right way."

Female patients presented several types of dreams, for instance, of snakes. This type of dream was common to all the female patients; as one of them said, "Ahalam Hamm Wa Khamm," meaning "Dreams of trouble and worry." They often said, "Halmak Ilmak," which means "what you dream, you will see." In Bedouin society, the snake is called "Haam"; when women see a snake in their dreams, it indicates for them a bad day and future problems. As one of them said, "Alhaam Hamm," meaning "the snake indicates trouble and a bad future."

This example will illustrate here how women felt and what happened to one of the patients who described her dream about the
snake. She said, "in my dream a big snake appeared to me and sometimes it appeared to me like a man; it wants me [she meant that the snake wants to make love with her]; all night I fought with him until the morning; when I woke up, I was very tired and afraid. This snake often appears in my dreams; when it does, all of my day is terrible." This account shows how the snake indicates a bad future for Bedouin females. They also reported fear of death and of what was going to happen to their children after they die.

Another type of symptom was described by female patients who were diagnosed as neurotic. This symptom was a sort of delusion; one of the patients said, "Bashof Wahad Abegri Warai Wadh Etbahni," meaning "I see a person run after me and he wants to kill me"; she was saying it is not a dream, it is reality. Another patient said, "I was lying in my bed, and suddenly there appeared to me a man with knife who wanted to stab me; I cried and I ran out of the tent." In her opinion, this was a Jinn's attempt to attack her. Another patient tried to convince me that what she saw was reality, and she swore by the name of God that it was fact; she said, "I kept seeing a figure of a man, but he did not look human." She thought it was a Jinn who was trying to attack her. He tried to jump into the window of her hut. When she told me this story, she was scared; her fear was expressed verbally and nonverbally; she was shaken and nervous.

In sum, female patients presented their life difficulties in their dreams. The snake appeared to indicate anger, trouble and hopelessness. The snake, of course, is a phallic symbol. And as we
can also see, when the snake sometimes took the shape of a man, it might have indicated marital or family problems. In several respects, then this type of dream reflected the women's difficulties in daily life. The relations between delusions and culture have been described by several investigators who emphasized the influence of religion, magic and myth as culturally supported institutions (Al-Issa, 1977; El-Islam, 1985; Lenz, 1974).

Dream sharing is also important in the teaching of cultural folk wisdom, as evidenced by its mythic and visionary content and the public forum in which it takes place (Dombeck, 1994; Tedlock, 1992). Murphy (1967) coined the term "delusory cultural belief" to designate a belief that "receives general acceptance within a cultural unit, but which appears to be improbable, to lack objective verification or even to be objectively disprovable" (p. 684). The present argument is consistent with that of several authorities, delusions and hallucinations, typical pathological symptoms of psychosis, can only be assessed in the context of the patient's cultural milieu (Al-Issa, 1977, 1970; Chung & Lin, 1994; Leff, 1981; Naka, Togchi, Takashi, Ishizu, & Sasaki, 1985; Schwartz, 1985). The Westerner must be cautioned that hallucinations and delusions may not necessarily reflect psychopathological mental states but instead may be in keeping with particular religious practices and beliefs.

It also should be noted that female patients had a final, distinct way of conveying problems. They often pointed to an objective item which, in their opinion, reflected their subjective
feelings: "my heart looks like my clothes -- black" or "zai Alsakaan" which means, "my feeling has the color of ash." One woman said to me during the interview in the psychiatric system, "Shaef Korsiak Qalbeh Lonh," meaning "you see your chair; my heart looks like your chair, black."

The Patients' Perception of Psychiatric Treatment

The patients' perceptions of any mental health professional is of a doctor who gives medications; the term psychotherapy is unfamiliar to these patients and for almost all Arab patients who need mental health treatment. This was the case with females, illiterates, old males and females; in contrast, the educated patients sought concrete advice and direction in addition to physical examinations. Further, in the patients' opinion, any mental health practitioner is responsible for figuring out what the patient's disease or problem is, and deciding on an appropriate treatment. From the patients' perspective, the treatment is the worker's task and responsibility.

All patients reported that they were treated by medication. None of them, regardless of gender, education and social strata mentioned the term "psychotherapy."

The following is one observation of an encounter between the psychiatrist and the patient. The psychiatrist suggested psychotherapy to a female patient, and the interpreter asked the psychiatrist what that meant. After the interpreter explained
things to the patient, the latter questioned the idea. "I came for
treatment not for talking. I can talk at home."

Another patient said, "Wesh Halhekmah Ale Bdawi Belhaki,"
meaning "Which type of clinic is this that treats people by
talking?" She obviously wondered what the psychiatrist was
suggesting. In another typical instance, one of my Bedouin women
clients who had never before received psychiatric treatment, was
identified as a possible social work client and sent to a mental
health clinic. At the intake assessment she presented as
suspicious of any intervention, asking repeatedly "Which type of
doctor are you?", and when she would be prescribed medication.
Refusing to engage with the social worker, she grew more and more
adamant that this was to be her first and last encounter with
psychiatric therapy. The session abruptly ended with her
terminating the treatment, refusing to contract for further
appointments, and disdaining the social worker and what he was
attempting to do, dismissing the entire process as "nothing more
than talking."

The Bedouin patients wanted instrumental, objective treatment;
something that they could feel and touch; similar desires regarding
treatment modality have been reported for Jewish Moroccans and
Iranians in Israel (Al-Krenawi et al., 1995; Minucin-Itzigshon et
al., 1984; Pliskin, 1987). But more than this, there is a second
culturally-specific factor which bears upon many Bedouins'
encounter with Western forms of helping. It must be emphasized
that psychiatric treatment is new and in many ways foreign to this
traditional population, having been initiated only in the last thirty years, in predominantly pharmacological treatment by psychiatrists, all of whom are Jewish and thus of a different cultural background (Al-Krenawi et al., 1995). "Talking therapy," which is even newer, was first introduced in 1981 by a Bedouin psychiatric social worker, the author of this dissertation.

The present data indicate that the Bedouin patients, male and female, prefer treatment by medication rather than "talking therapy." Some of the male patients had deep conversations with the psychiatrists, but they still expected medication at the end of the session. From my point of view, in addition to the medication there was a place for some form of talking or psychotherapy with these patients. This judgment is based on what the patients expressed through proverbs they mentioned and in the non-behavioral messages detected during the interviews and the observations.

Therefore the question is raised: on what basis could psychotherapy be offered to these patients? To answer this question, one must first ask some questions about the psychiatrists who were treating Bedouin patients: 1) did the psychiatrists speak Arabic; and 2) were the psychiatrists familiar with the Bedouin culture? The answers to these questions are negative; so there seems to be little prospect of effective psychotherapy. There can be no psychotherapy without understanding, and I have shown evidence above that powerful messages contained in proverbs were apparently not understood and clearly not acted upon by the psychiatrists.
Some of the patients reported that psychiatric treatment helped them a little bit, for instance in reducing pain in the body. But such treatment did not always help; some patients thought that the medication caused them to suffer more. One of the patients said, "the medication made me suffer from paralysis, I could not move my body." This patient was angry and nervous about what happened to him with medication. It is a clear case of misunderstanding between the psychiatrist and the Bedouin patient. One of the new referral patients visited the psychiatric clinic twice after he was referred by his family doctor. He presented physical complaints, especially weakness and loss of appetite. He told the psychiatrist that he had changed and could not sleep well. While the session took place, he said that his life had become like "Jahim" (hell), and he hated his wife and his children. He also complained about paranoid thoughts, such as "I think my wife caused all of this situation." He suspected that she had a romantic relationship with a man from his family. As a consequence of this situation, he lost his job and he suffers. In the psychiatric system, he was diagnosed as having a paranoid state and treated by antipsychotic medication.

A few days after his first meeting with the psychiatrist, I met him, and he told me the whole story. He thought that his wife had a sexual relationship with one of his relatives. His parents had seen a man passing beside his house at midnight. A day after, they told him the story and were upset. It was a shock for him. He felt that his honor was violated. He started to beat his wife,
but at the same time he loved her, and she swore that she had no relationship with anybody. He tended to believe her, but as he said, "it is difficult for me, I cannot forget this event." He said, "this problem eats with me and drinks with me"; it accompanied him all the time.

A healer suggested to him to take his wife to a healer who lived in Sinai-Egypt, for Bsaha, meaning "to lick the fire"; this ritual is practised by the Negev and Sinai Bedouin in cases of any suspicion (Apstien, 1973). Thereafter, he went with his wife to the healer in the Sinai and told the healer his story. The next morning, the healer called him and his wife for a ritual. The healer put a tool on the fire until it became red. Then he called upon the suspected person to lick it. If the person is telling the truth, nothing happens to his or her tongue; if not, the tongue is burned (Al-Aref, 1934). In this case, the wife licked the tool, and a few minutes later the healer addressed the husband and said, "Ardak Abeath" meaning "Your honor is white [she is not guilty]." The husband brought a tape recorder and had recorded the entire ritual process. When I met this patient after he came back from Egypt, he was very happy, and his life was totally changed for the better. He started to work and there were no more fights at his house.

Another case of misunderstanding will illustrate the difficulties when the psychiatrist is not familiar with the patient's culture. A 16-year-old unmarried female had been referred to the psychiatric system by the GP. The GP wrote in his
letter to the psychiatric system that the patient suffered from a conversion reaction. She complained about headaches, and loss of consciousness for a few hours at a time. She came to the psychiatric system accompanied by her older brother; her brother served as the translator. He described what happened to his sister. The young girl looked afraid, and she did not answer any of the psychiatrist's questions. The patient's brother was very active, and he responded for his sister. The psychiatrist concluded from the meeting that the patient had an adjustment disorder and gave her medication. The patient was not satisfied with what happened; she had not expressed her main difficulty.

Three days later, I met her in the healer's house. When she saw me, she said, "I have to talk to you now, because my life is in danger." We made an appointment for the day after. I met her in the primary health care centre in her community, and she told me her story. She had been involved in a sexual relationship with a man who was not from her tribe, and she was pregnant. She said that nobody knew about this except me; while she was telling me her story, she appeared to be worried and afraid, confused and hopeless. She started crying and asking me what to do; she said, "they will kill me, please do something." Her story put me in a hard situation; do I intervene or should I stay in a neutral position as a researcher? I decided to intervene in the case and help solve the problem with the help of her family doctor, with whom I used to work. This patient was very happy after she had the
abortion; she said to me, "Angathat Heati," meaning "you saved my life," and she never came back to the psychiatric system.

One more case that I interviewed in the psychiatric system will also demonstrate misunderstanding arising from the patients' situation with which the psychiatrist was not familiar. The patient was 25 years old, married and had four children; he lived outside the Bedouin villages and had six years of school. He was referred to the psychiatric system by a private, general practitioner. In his first session with the psychiatrist, he presented physical complaints, especially headaches, sleep disturbances and frequent bad dreams that somebody was running after him; he had become nervous, and every small event triggered tension, even shouting.

Later on, he told the psychiatrist his story: He was a "Meshamas"; at that point, he addressed me, asking how to say that in Hebrew. I did not say anything. He tried to explain this term to the psychiatrist. "Meshamas," which literally translated means "exposed to the sun," refers to the formal expulsion of Tashmis (outcasting). The patient's nuclear family and the tribe had declared in five Sheiks' houses that he was Meshamas, and that he does not belong to his family and the tribe anymore. They said they were not responsible for anything he would do thereafter (Al-Aref, 1934; Ginat, 1987). He described himself as having had problems during the last two years; he had not worked and had been in bad company. He had caused several problems between his tribe
and other tribes. This led his tribe to be angry with him, and to expel him.

The psychiatrist appeared confused when he heard what the patient said, raising the question what to do. However, when the session was nearly finished, the psychiatrist said, "No problem; I will send a letter to your father and your brothers, and we'll discuss that with them." He then recommended medication to the patient, saying, "take this medication and we'll see you next week." The patient looked at the psychiatrist, wondering, "what are you talking about? How come you want to talk with my parents?" The psychiatrist said, "I am a doctor, and I can talk to them and everything will be OK." The patient took the medication and left without saying anything. I had another conversation with this patient, and he was asking about the situation; he said, "this doctor has no idea what is he talking about." During my meeting with him, I felt how much he suffered and hated himself; he lived without hope, confused and worried.

According to Bedouin customs, once such a decision is made and after you declare in five Sheiks' houses that a person is Meshamas, there is no way to accept him back to his tribe. This patient was confused; he made another appointment with the psychiatrist, but he did not come back. These cases illustrate the importance of being familiar with the patient's culture. To understand such patients, one needs to speak the language and to know when and how to intervene. The present data are consistent with findings in several studies about the difficulties that commonly occur when the

In sum, the Bedouin patients faced difficulties in terms of communicating their emotional needs. The cultural differences between the patients and the psychiatrists caused misunderstanding and led to disappointment with the psychiatric treatment and even to leaving it. In the encounter between the psychiatrists and the Bedouin patients two different cultures met; different belief systems and different perceptions. To be effective in such situations, mental health workers need to become familiar with the culture of those they serve.

The Psychiatric System Provided Informal Help for the Bedouin Patients

Social contacts. The psychiatric system provides several informal services for female patients. The primary health care centre and the hospital are considered necessary services in the Bedouin society; in case of disease, a female can visit such services without her husband's or her family's interference and without breaching the cultural norms.

For female patients in particular, it is a good opportunity to get out of the house and to visit the city of Beer-Sheva. They
meet friends from different tribes and share several matters related to their difficulties; they exchange thoughts about their diseases. They support each other and build a wide social network. Moreso than the men, they reveal themselves to each other, and informally discuss in detail their diseases and problems. One can observe group dynamics occurring when they meet each other; they commonly sit in groups and share their difficulties regardless of their social strata. All of these social behaviours were observed among the females of the present sample.

Social stratification was not an issue among the female patients. One of the patients said, "I have friends from other tribes and from other areas, and we meet in the clinic because this is the only place we can meet." Women often came early in the morning and sat outside the clinic and opened friendly conversations among themselves. They exchanged ideas about traditional medicine; one of the patients brought her herpes medicine, and she gave it to the other female patients. They visited friends from their tribes who were hospitalized in Soroka. The men who accompanied the females often left them at the psychiatric service and came back later to take them home. Patients who were diagnosed as neurotic after the first session in the clinic regularly came accompanied by mother, an older sister or their sons.

Male patients routinely discussed social issues, but they had difficulties discussing their personal lives in public. The issue of social strata played an important role among the male patients.
Patients who belonged to the True-Bedouin class stayed away from the other patients. They sat in pairs, not larger groups. This reflected the cultural norm that a man should be strong, and he cannot reveal his weakness to strangers. Male patients discussed their rights to the social services in public, but they did not discuss their personal difficulties within a group setting. Such things happened in subgroups, when two patients, usually from the same area, became friends. They supported each other, and they came together and waited for each other. In sum, the male patients did not share their personal problems as did the female patients; however, they exchanged ideas and helped each other concerning their rights, such as social services and how to apply for assistance. They also discussed the traditional system and pointed out which healers are good. In addition, there were subgroups formed among the male patients, based on social strata, relatives and neighbourhood.

Bedouin and Jewish Patients in the Psychiatric System

It should be noted that there were considerable encounters, of a therapeutic nature, amongst various patients. The Bedouin patients under study male and female, met Jewish patients who had come from Muslim countries and who had a similar background, such as Moroccans or Yemenites; they spoke the Arabic language, had similar perceptions related to mental illness, and believed in
supernatural power as the cause of disease or problems. Therefore, these patients found a common issue with the Bedouin patients. Female patients discussed the traditional healing system in the Bedouin society. Bedouin females gave the Jewish females addresses and locations of traditional healers in the Bedouin society. Moreover, they made appointments and visited healers together.

During my research, I saw Jewish patients of both sexes who were referred to traditional healers by Bedouin patients in the psychiatric system. Conversely, the Jewish patients explained to the Bedouin patients their rights to social services and how to apply for these services. In other words, male and female Bedouin patients found themselves involved in relationships with other communities that shared the same beliefs; both groups of patients believed in supernatural powers. These data are consistent with several published reports (Bilu, 1980, 1978; Hes, 1964; Minuchin-Itzigsohn et al., 1984; Palgi, 1981; Shuval, 1970).

Arab Psychiatrists Provide Different Perspectives

Two Arab psychiatrists from outside the clinic were interviewed, one from the Gaza Strip and the other from East Jerusalem; they had treated several of the initial sixty patients under examination in the present study. The two psychiatrists had the advantage of familiarity with the patients' religion and used religious words during their encounter with the Arab patients. Moreover, they understood the Arab psychology and culture; they
were able to gain trust and elicit relevant information about the larger picture associated with the symptoms.

The Bedouin patients often mentioned them as good doctors, and often went to them. I contacted these psychiatrists, and met them individually. I said that I wanted to discuss how they treated Bedouin patients. From the interviews with them, several issues emerged. In the first stage of the treatment, they often met the patient individually, and let him or her present physical complaints without intervention. They tended to believe that the patient suffers physically. In the second stage, they asked the family about the patient's situation; the third stage was the treatment. It is important to mention that these psychiatrists were Muslims and often mentioned God and religious words during the treatment. One of them said to the patient: "take this medication, and by the will of God, you will be OK." Another said to his Arab patient, "we do what we can do, and leave the rest to God." It can be seen that while the foreign psychiatrists could reach the first stage, cultural disparities prevented their reaching the second.

Treatments included medication and injections where the pain was located; sometimes the psychiatrists asked for further medical examinations. They used electroshock and chemotherapy because the patients requested treatment. The psychiatrists treated the Bedouin and the other Arabs using the same methods. They believed that Arabs tend to complain about physical symptoms. What they did was to take the patients' physical complaints as real, and treat
the physical symptoms. In addition, they knew that Arabs and the Bedouin, in particular, simultaneously consulted traditional healers. These psychiatrists did not discourage such consultations; on the contrary, they encouraged patients to do so, but not to stop medication. The psychiatrist from Gaza said that some of the healers in the Gaza Strip often referred patients to him who suffered from severe mental illness, such as manic-depressive psychosis, organic psychosis or epilepsy. The patients who were treated by these psychiatrists reported to me that the psychiatric treatment was effective.

One may raise the question, why didn’t all the Bedouin patients go to these psychiatrists? There are a number of reasons: 1) this treatment costs money; 2) travel is involved; 3) Israeli health insurance does not cover the medication given by these psychiatrists; and 4) the social welfare system in Israel does not accept the Arabs’ (from the Gaza and West Bank) medical reports. So in spite of the approachability and perceived effectiveness of these Arab psychiatrists, the majority of the Bedouin patients could not go to them. Prospective female patients, in particular, are not allowed to travel such a distance without a man from her family.

Summary: The Encounter with the Psychiatric System

Several issues emerged throughout the observation of the psychiatric treatment rituals. One of the most fundamental,
overriding questions is: why should the Bedouin patients continue
to utilize a psychiatric system that in many ways is problematic?
The patients' reasons for continuing treatment in the psychiatric
system can be summarized as follows:

1. Patients had an excuse to get out of the house (the
   tribe) to the city of Beer-Sheva.

2. Female patients got social support from each other. They
   met friends and exchanged ideas on social and family
   matters.

3. The family doctors encouraged patients to keep in touch
   with the psychiatric system (Soroka). (One of the
   patients said, "The doctor said to me, 'If you stop going
   to the psychiatric clinic (Al-Hakmah), do not come to me,
   because I have to treat you according to the doctor's
   recommendation.'")

4. Patients received instrumental support; all the social
   services require medical reports.

5. Male patients sometimes had to provide medical reports to
   the employment office about their situation; otherwise
   they would lose their monthly payment.

6. Information about health insurance and social security
   could be exchanged between the old and the new referral
   patients in the psychiatric system. (In Israel, every
   person has to pay for health insurance. If the person is
   sick and cannot work, then social security will pay on
   behalf of the person.)
7. Patients wanted to be under medical control, as some of the men mentioned. They perceived that the modern system included psychiatric as medical treatment. In addition, some of the patients reported that the medication reduced the frequency of the pain, and helped them sleep well. The patients got the psychiatrists’ messages that the medication needed time to work. One of the female patients said "Lazam Wqat Hata Aldowa Ectalat Ma Al-Dam," meaning "It takes time until the medication is mixed with the blood."

8. Patients benefitted from the sick roles. Female patients often got their husband’s and family’s attention when they were sick (West, 1987).

Summary

The psychiatrists treated the male patients differently from females; they considered the males as patients who are familiar with the modern system, and could ask for their rights. Such a situation led the psychiatrists to address this group of patients more seriously than the illiterate and the female patients. One can conclude that the psychiatric system seems to support what is acceptable in the Bedouin society; females are largely ignored by society, and by modern psychiatry.

Female patients could not express their difficulties to the psychiatrists. Interpreters were needed. Yet the interpreter’s
presence interfered with the female's expressing herself directly to the doctor. The patient had to do that through a third person's perspective; her message lost a great deal of information in the translation process. The same occurred with the psychiatrist's messages to the female patients. Because of cultural restrictions and the backgrounds of the (male) psychiatrists, the female patients, like their doctors, faced insurmountable obstacles.

The psychiatrists were not familiar with the Bedouin culture at all and generally did not show sensitivity to it. This has manifested itself in a wide range of cultural issues that continue to plague patient-psychiatrist interaction. In addition to the basic issues of differential expectancies (Higginbotham, 1977), these include: basic communication difficulties and bias in interviewing; linguistic barriers in evaluating psychopathology; failure to interpret symptoms within the religious and cultural matrix; and failure to differentiate between adaptive and maladaptive behaviour in the cultural context (Budman et al., 1992; Lefely, 1986; Marsella, 1993; Ruiz & Langrod, 1976a). Therapy must be in the language in which the patient is fully capable of expressing emotion even during periods of stress, regression, or disturbed thought process (Bach-Y-Rita, 1982). What appeared to be important for the psychiatrists was to reach the diagnosis; first to label the patients under a category of diagnosis, and then to deal with the treatment. They focused on the patient's symptoms to determine if he or she was neurotic or psychotic. The
psychiatrists put more effort into the psychotic patients than the neurotic ones.

The issue of symptoms was a major problem from my point of view. Females often presented types of delusions, and some of them even presented hallucinations which were part of the Bedouin cultural belief systems, such as spirits. Thus, the psychiatrists did not take into account the patients' culture. Their training had been based on medical and physiological models, rather than social systems and cultural models. They acted and treated patients as they would any Western patient presenting such symptoms. So it is not surprising that 50% of the patients left the modern system, and the others utilized the traditional system in parallel with the modern.

The lack of cultural knowledge caused several problems in terms of the diagnosis, which of course was one of the reasons that led the patients to abandon this system and to turn to outside healers, Arab psychiatrists or general practitioners in the Gaza Strip and the West Bank. There are reports in the literature of cultural differences preventing establishment of rapport and leading to discontinuation or underutilization. Inappropriate underutilization of mental health services by an ethnic minority group was reported by Sue and Mckinney (1975). For Asian Americans, they found a 52% dropout rate after the first session; even for those who remained, there was an average of only 2.35 therapy sessions. Acosta, Yamamoto, and Evans (1982) ultimately developed patient and clinician orientation programs to clarify
therapeutic roles. The research indicates an apparent need to close a substantial cultural gap between clinicians and patients of specific backgrounds. The use of intermediaries, particularly bicultural persons, knowledgeable in medicine, is clearly one possible approach to these problems.

In contrast, the Arab psychiatrists had several advantages: they were familiar with the culture of the patients and even encouraged dual use of the traditional system. Because they were of the same religion, they used well-understood religious words during their treatment of the patients. Their treatment was considered effective by the patients, but as mentioned earlier, was, in general, accessible only to a subset of male patients. In an ideal situation, Arab psychiatrists would be employed in Israeli medical centres which deal with substantial numbers of Arab patients.

Finally, it should be stressed that the somatization was a vehicle through which patients could communicate with their respective health care providers. In this sense, proverbs have been shown to be particularly effective communication tools. And rituals, as will be demonstrated in the following chapter, are in like manner highly effective means of patient-practitioner communication, and patient treatment.
Chapter Seven

THE ENCOUNTER OF THE BEDOUIN PATIENTS
WITH TRADITIONAL HEALING

Introduction

Now that some of the difficulties for the Bedouin within the psychiatric system have been elaborated, it is appropriate to examine the quite different experiences and outcomes arising from the encounter of the Bedouin patients with the traditional healing system. Again the naturalistic data help explain the character and congruence of this encounter by bringing to light the deep similarity of perspectives of the two groups of subjects. The two main sections deal respectively with patients and healers. The patients under analysis are principally the final sample of 20; it also should be noted that some of the remaining 40, from the initial sample, also were encountered as participants of traditional healing treatments.

The Patients' Familiarity with the Traditional System

Because of the structure of the Bedouin society, every member has many opportunities during his or her life to participate in traditional treatments/rituals. The healers are part of the society and they live among the people and share with them every
event; so it is easy for any member to become familiar, in one way or another, with the indigenous system. The Bedouin social system relies on religion and the power of God, and the healers are often religious people. Stories about the men of God and their abilities to perform miracles are often told by older people and by religious leaders. In addition the patients get the advice of their families in case they need help in understanding religious explanations and rituals.

All the patients, male and female, regardless of their education or social strata were referred to the traditional system before they were referred to the psychiatric system. The healers were Bedouin and Arabs from the Gaza Strip and the West Bank. Females were referred to traditional healers from the Bedouin community. Males also were referred to Arab healers who lived in the Gaza Strip and the West Bank. All the healers were familiar with the Bedouin culture. Religion reflects culture and is considered part of the culture (Geertz, 1968; Tibi, 1990).

When the female patients mentioned the healer’s name, they asked God to give them the healers’ blessing. They also talked about the healers’ abilities, such as saying, "he or she has Baraka"; or, "she or he has Sahab Jedd," meaning the healer’s grandfather was a well-known healer. The psychiatric system was a transit for exchange information about the traditional system in the Bedouin society, such as which healer is more powerful and has more reputation and success. For male patients, often this information about the competencies of the healers in the community
was collected by their mothers or sisters, who accompanied them to the community clinic centre.

The Healer-Patient Relationships from both Perspectives

The healers developed close relationships with their patients; this type of relationship was perceived by the patients as familial. The treatment process and the waiting process in the healers' house appeared informal, which led the patients to feel free and to trust their healers. The patients were satisfied with the healers' ways of dealing with them, which of course has its impact on the effectiveness of the treatment. The patients perceived their healers as parent figures -- father or mother -- and the healers took care of them as parents or as members of their own families.

All the patients reported that they had good relationships with the healers. Most of the healers were Bedouin, spoke the Arabic language and the Bedouin dialect, and shared the same culture and religion as their patients. The treatment atmosphere was informal; the patients and the healers routinely ate and drank coffee and tea together. Moreover, the patients felt free to help themselves; they prepared coffee and tea for the other patients and those who accompanied them to the healer's house. The healer and the patient discussed issues related to the patient's disease in public, in front of the other patients. From the observer's point of view, the factor of stigma did not exist in the traditional
systems. All the patients, regardless of their gender, education, and social strata became friends and shared their diseases or problems together, male as well as female.

The male healers used to call their male patients "Yaa Waldi" (my son), and their female patients "Yaa Benti" (my daughter). The female healers call their female patients "Yaa Benti" (my daughter) and their male patients "Yaa Khoi" (my brother); if the healer was older, she called the male patient "Yaa Waldi" (my son). The healers created close relationship with their patients. This close relationship led the patients to trust and respect the healers and never to speak of them badly; on the contrary, they mentioned the healers' abilities and their supernatural powers. In the patients' opinions, the healers were supportive and showed care for them throughout the treatment process.

This situation of close relationships made it possible for male healers to visit their male patients at the patients' houses. Also they often sent their regards to their patients through other patients who were their relatives or neighbours. Female healers do not do that because of the cultural canon. The healers would say to the patient, "Allah Yrda Alic," giving God's blessing to the patient and asking that God be satisfied with him or her.

The healers in the Bedouin society appear to function as therapists, friends, fathers and mothers concurrently. The patients often consult the healers about their own personal and family plans such as marriage, family dispute and divorce; the healers often intervene in such cases to help the patient. One of
the patients said, "Bahasha Zai Aboi" (I feel that the healer is like my father). The patients reported that they felt secure in the healers' homes; as one of them said, "Btriah fe Betaha" (I feel safe in the healer's house). Thus, the healers fulfilled a need of these patients for father- or mother-figures. Such relationships also reinforced the patients' trust in the healers abilities.

Female patients believed that the healers could understand them. They often said, "everybody does that [goes to a healer]"; in fact it is a custom that when a disease affects a female physically or mentally, she commonly consults the traditional healers in the Bedouin community. One of the female patients commented, "I referred to the healer because the doctor does not help me..."; in contrast to psychiatric treatment, the healer's treatment helped her. Another patient said, "The doctors do not understand such diseases [of the spirit]; they treat fever and blood diseases." The majority of the female patients were referred to the traditional healers through their own choice; a few of them went at their families' and relatives' suggestion. The females also reported that their female friends from the tribes or the primary health care centre, or in the psychiatric clinic (Soroka) recommended that they be referred to healers. Females in the family who gave such recommendations gave examples of people who were treated by the healers and cured.

Male patients usually consulted the traditional healers because of their family's choice. One of them said, "My mother suggested to me to go with her to a healer." This patient believed
that his mother was more familiar with the system than he, so he tended to agree with her suggestion. Other patients said that their close friends suggested such visits for them, and even went together to the healer. One patient said, "Codh min Abdallah Wa Toakl Ala Allah" (take from the servant of God and trust God). This means the healers and the doctors are the servants of God, and they are doing what they can; but the cure is only by the will of God. One of the patients who was a teacher said, "Al-Arqan Abetmask Fe Ahpal Al-hoa" (when a person suffers or is in trouble, he or she tries to catch the rope of air). Some of the male patients were disillusioned with the family doctor and, later on, with the psychiatric system; from their point of view, these two systems did not help them, so they turned to the traditional system. The same was reported by female patients.

The healers perceived their patients like members of their families. The old healers stated that they felt that the patients were like sons and daughters. One of the healers said, "I treat my patients as my family."

In such trusting, family-like relationships the patients shared the matters behind the disease. The healers understood that the patients suffered, and they needed somebody who could understand them and show them "Hanan Wa Musaadh" (love, understanding and help). The healers seemed to be aware of the issues of understanding and support required by a person who is suffering or under stress. One of the healers, a Khatib said, "when you establish good relationships with the patients and
understand their difficulties, they will trust you and believe in the healer's capacity." All the healers reported that "trust" is a key word in their work, and closeness to patients has been reported often to lead to more openness with healers (e.g., Kiev, 1968; Vontress, 1991). In addition, there is physical contact. During the treatment process, the healers touch the head or shoulders of the patient, giving support and encouragement.

The healers spent more energy in treating educated people; they perceived that the educated people did not believe in what they were doing. The healers explained to these patients what their diseases were and what the treatment was. They tried to convince them that this is the appropriate treatment for the situation. The healers presented cases to them that they had treated and cured. After the first session, when patients felt a little better, they started to believe that the healer's treatment was effective. A healer told me a story about one educated patient who came to the healer for treatment accompanied by his family. This patient was disappointed with the modern system. The healer treated him and explained to him what he suffered from. A month later, he was cured and came to thank the healer; moreover, this patient started to refer people who had the same disease as he had.

The healers who treat according to the Koran often present to the patients what they are doing, and impress on the patients that they are educated. If the patients do not agree to the treatment, the healers often asked them, "so why did you come to us?" There were two elements which led the educated patients to trust the
healers' treatment: the power of the healers and the beliefs of the patient's family. I often observed that when young, educated males were referred to the traditional system, they were surprised by the power of the healers. They would ask for example, "how do they know the patients' symptoms without asking?"

All the healers stated that the female patients trusted and believed in their curative abilities more than the young male patients did; female patients were more familiar with this system. The healers stated that females collaborated with them without any questions and usually did what the healers recommended. Females did not need any help in terms of explanation. The males presented a contrasting picture. One of the healers said, "Male patients need more explanation about the treatment's construction, and without their family's help, they cannot do that; females usually know exactly what to do."

**Diagnosis**

Related to the question of the patients' diagnoses, when the healers were asked this question, they looked at the patient, or asked the patient's name and said what the diagnosis was. Often it was the same diagnosis that the patients told me before the meeting with the healer.

It also should be noted that every patient whom the researcher interviewed knew his or her traditional diagnosis. The healers
routinely informed the patient of the diagnosis and etiology. Female patients often knew and understood what the diagnosis meant without their family's help. In contrast, some of the male patients asked the healers or their own families what the diagnosis meant. All the patients, however, were interested in knowing their diagnoses and their causality. The healer's terminology regarding the patient's diagnosis was taken from the patient's culture, which made it easy for the patients to understand what the diagnosis meant.

Male and female patients showed respect for, and honor to the healers when they mentioned their names or addressed them. The patients believed that the healers had supernatural powers and could cause damage to a person who laughs at them or talks about them badly. One of the male patients said, "I do not need trouble; all the men of God are respected people." This patient asked God to give him the "Allah Yatina Rida Rijal Allah Al-Salhin," the blessing of the men of God.

A Comparison of Psychiatric and Traditional Diagnoses

The psychiatric diagnoses of the male patients are given in Table 15; traditional diagnoses are included for comparative purposes.
Table 15.
The diagnoses in the psychiatric and the traditional healing systems; male patients.

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>Traditional diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Neurotic depression</td>
<td>Hafat Bladd (shaken from the earth)</td>
</tr>
<tr>
<td>2. Anxiety state</td>
<td>Hariah (anxiety)</td>
</tr>
<tr>
<td>3. Conversion disorder</td>
<td>Jinnih (married with a devil female)</td>
</tr>
<tr>
<td>4. Somatization disorder</td>
<td>Hariah (anxiety)</td>
</tr>
<tr>
<td>5. P.T.S.D.</td>
<td>Amaal (sorcery)</td>
</tr>
<tr>
<td>6. Depression</td>
<td>Saat Shytian (caused by Satan)</td>
</tr>
<tr>
<td>7. P.T.S.D.</td>
<td>Hariah (anxiety)</td>
</tr>
<tr>
<td>8. Anxiety state</td>
<td>Hariah (anxiety)</td>
</tr>
<tr>
<td>9. Conversion reaction</td>
<td>Malbos + Amaal (Jinn controlled him, caused by sorcerer)</td>
</tr>
<tr>
<td>10. Hysteria</td>
<td>Nufs Mn Al-Jinn (air from the spirits)</td>
</tr>
</tbody>
</table>

The table shows that there are similarities between the two systems in terms of the severity of the diagnoses. None of the patients were diagnosed as a psychotic by the psychiatric system. The diagnoses ranged from neurotic depression to hysteria. Thus, they fell under the category of minor mental disorders. Similarly, 8 of the patients were diagnosed by traditional healers as suffering from less severe disturbances, namely the actions of the spirits, not possession.

Case number 3 believed that he had married a Jinnih; the Jinnih appeared in his dreams, and he made love to her. The healer confirmed that the person was married to a Jinnih. In case number
9, the patient was diagnosed as Malbos, which means he was controlled by Jinn, and the Jinn was connected with a Sahr. According to the healer, this Jinn periodically entered and left the patient's body; it did not stay there all the time. Also in case number 3, the Jinnih showed up in the patient's dreams, but not in his daily life, making the problem less severe. Both patients were very religious. They were treated by Sheikhs-Din; the latter concluded that the patients did not suffer from severe mental illnesses.

The psychiatric diagnoses of the female patients are given in Table 16. Traditional diagnoses are included for comparative purposes.
Table 16.

The diagnoses in the psychiatric and the traditional healing systems; female patients.

<table>
<thead>
<tr>
<th>Psychiatric diagnoses</th>
<th>Traditional diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Panic disorder</td>
<td>Amaal (sorcery)</td>
</tr>
<tr>
<td>2. Conversion reaction</td>
<td>Amaal (sorcery)</td>
</tr>
<tr>
<td>3. Anxiety</td>
<td>Malmosh Mn Al-Jinn (the spirit touched her and caused fear)</td>
</tr>
<tr>
<td>4. Depression</td>
<td>Hafat Blaad (shaken from the earth)</td>
</tr>
<tr>
<td>5. Adjustment disorder</td>
<td>Amaal (sorcery)</td>
</tr>
<tr>
<td>6. Depression</td>
<td>Hafat Blaad (shaken from the earth)</td>
</tr>
<tr>
<td>7. Depression</td>
<td>Amaal (sorcery)</td>
</tr>
<tr>
<td>8. P.S.T.D.</td>
<td>Nafs Mn Al-Jinn (air from the spirit)</td>
</tr>
<tr>
<td>9. Somatization disorder or Anxiety</td>
<td>Mahasodh (the evil eye)</td>
</tr>
<tr>
<td>10. Depression</td>
<td>Amaal (sorcery)</td>
</tr>
</tbody>
</table>

The healers considered the common problems presented by the females as connected with sorcery, which generally means that because of their life conditions, they were being attacked by other females. The Bedouin women see themselves as closer to black magic and more vulnerable to it than men. Remarriage, as mentioned, leads to psychological problems in the wives (Al-Krenawi, 1993, 1987; Lewando-Hundet, 1976). Because of the social structure of this society, women fight each other by sorcery; sometimes it appears that this is the only weapon that the Bedouin females can use against their husbands, or their husbands' wives (Al-Issa, 1989, 1990).
There are similarities between the diagnoses in both systems. The diagnoses in the modern system ranged from panic disorder to depression. In contrast, the diagnoses in the traditional system fell under the categories of easier disturbances or problems; all of the diagnoses involved problems caused by the spirits' activities directly or indirectly, by the Sahr (sorcerer) who used the devil in his works and the evil eye.

The psychiatric system is something new for the Bedouin population, although they are familiar with the primary health care centre in their communities related to physical illness. However, the new era has introduced them to the modern system, i.e., the psychiatric clinic. Psychiatric diagnoses based on Western concepts were not easy for female or male patients to understand; moreover the psychiatrists spoke Hebrew, so even if they used the terminology, it was in Hebrew.

I think these are some of the reasons that even the educated employees in public services and the wealthy male patients were not interested in knowing their diagnoses; for the female and the illiterate male patients, the difficulties of such concepts are almost insurmountable. Another possibility is that the patients wished to ignore their mental illness diagnoses.

None of the patients, male or female, were told of his or her diagnosis in the psychiatric system. They did not even ask or show any interest in the diagnoses. One of the male patients said, "even if I knew what the diagnosis is, I would not understand what it means." All of the patients wondered when I raised this
question. One of the female patients said, "This is the doctor's business." In contrast, patients were interested to find out about the treatment and the prognosis. They asked about the treatment; they even asked for injections. In addition, they asked questions about the disease; "How long will it last and what is going to happen after we take the medication?

Traditional explanations of diseases and problems. The interviewees, both patients and healers, employed three main etiological categories in order to explain the diseases: the spirits (this included Iblis and his assistants); sorcery (Shr); and the evil eye (El-Ain, or Mahassod). However, according to the healers all diseases and problems are caused by the spirits' (Jinn) intervention, directly or indirectly. The fortune tellers believed that the human eye can cause disease or damage to a person's health, property or children; so the evil eye is connected to human beings, not just to the spirits. In contrast, the Dervishes, amulet writers and the Sheikhs believed all diseases and problems are caused by the spirits.

Spirits cause suffering or disease in the following ways. They sometimes attack a person directly; an example is when the patients fell without mentioning God's name. In the Bedouin culture, when a person falls down, he or she should say: "in the name of Allah, the beneficent, the merciful." By saying this, the person receives God's protection from any attack. Sometimes spirits cause a disease as a punishment from God for the person's
bad deeds. Spirits attack indirectly when a sorcerer was involved in the process; for instance, making an amulet to cause a particular person to become sick or to die. All of the explanations of the diseases in terms of spirits came from outside the patients' abilities.

The degree of severity of the diseases. All healers placed the patients into two categories. The first category was diseases caused by spirits' actions, meaning the spirits did not enter (and remain in) the patient's body. This could be a direct or indirect attack from the spirits. They believed that the Jinns sometimes enter the body and leave it. The healers considered this category of disease to be less severe, and they believed that they could overcome such illnesses quite readily.

The second category of disease included severe, and very severe subtypes. In the first subtype, the healers believed that the Jinn entered the patient's body and stayed inside the patient: "Yaskon Fe Jism Al-Marred" (the Jinn lives in the patient's body). The patients who were labelled under this severe category in the traditional system, such as Darbaat Blaad (an attack from evil spirits inhabiting the earth), Murkob (the Jinn rides on the patient) were diagnosed in the psychiatric system as psychotic.

The following diagnostic categories are of the very severe subtype: One example is "Somah" (when the patient frequently loses consciousness and falls down). The healers believed that such situations happen because the patient is possessed by two spirits
simultaneously, one male and the other female. The two spirits fight each other, which causes the patient to lose consciousness and to suffer. One such patient who was interviewed was diagnosed in the modern system as suffering from epilepsy. Another diagnosis is called "Darbah Fe Al-Rass" (struck on the head). The etiology is that the Jinn strikes the patient on the head which causes "Carbath Fe Al-Moch" (brain damage) (Al-Krenawi et al., 1995). Another diagnosis is called "Jinn Ahmar" (red Jinn); the person is attacked before being born, causing defects; the modern category is called mental retardation. The Jinns' colors place them at extremes; for example, red is associated with blood. A similar process was described by Boddy (1989) in Northern Sudan. Contrary to the Bedouin healers, however, the Sudanese healers perceived the red Jinn as extreme, but not causing severe illness. The Bedouin healers did, of course, treat patients with such diagnoses, knowing that there was no chance for full cure. But they often referred such patients to the modern system for treatment in addition to their treatment.

The patient who was labelled under any category got the message from the healer that he or she will be well by the will of God. The healers from the four groups often supported and encouraged the patients and their families; by the power of God and the saints these healers will help overcome the spirits and expel them from the patient's body. There were several factors that increased the patients' trust and faith in the abilities of the healers. The healer often told the patient and family about
patients that he or she had treated and who had been cured. The healers even mentioned names of patients who were treated by them, and asked the patients to talk to them about their experience. The patients who were present during the treatment process supported and encouraged the patient to follow the healer's treatment and to feel better. The other patients also gave the new patients examples of similar patients who had suffered from the same disease and been cured by that healer.

The Sheikhs commonly tape-recorded the treatment process to show other patients how they dealt with the spirits. In the case of new patients, the healers allowed them to listen to the cases that they recorded to prove their abilities to manage and to control the Jinn by the Koran. These healers gave the new referrals a message, "do not worry, we will control the spirits." One healer said to the patient, "the Koran grates the Jinn, and makes it into ash." Such messages increased the patients' trust in the abilities of the healers and increased their faith in the Koran and God.

For all healers, in general, there was a differentiation in terms of symptoms. Males complained more about weakness and females more about "Aojah Fe Al-jism" (pain in the body) -- so-called somatization. From the healers' points of view, females were connected with "Shr" (sorcery) more than men. According to them, the females were familiar with this craft, and they used it against themselves and against their husbands and other women. An amulet writer told me that there are numerous females referred to
him for matters of sorcery. In addition, an old female fortune
teller said, "women are dangerous; if they decide to kill or attack
anybody, they can do that." She kept saying that females have
special stones and beads in addition to the Shr. One of the
important beads is called "Al-Qoblah" (literally, it means to
accept someone). The purpose of using such beads is to influence
the husband to accept his wife and not to think of remarrying a
second wife. However, such beads are considered dangerous
according to the Khatibs and the Al-Fatahs. The ability of
witchcraft in traditional cultures either to heal illness or to
cause death has been medically substantiated (Cannon, 1957; Ruiz &

The healers believed that females are also more vulnerable to
the spirits' deeds than males because of "weaknesses" in their
character. They believed that the spirits can convince a female,
more than a male, to do things that are morally unacceptable in the
society and to cause suffering to others.

None of the healers thought that the psychiatrists' treatment
could affect their treatment. The Dervishes, amulet writers and
fortune tellers believed that the psychiatrists (doctors) were just
doing their jobs by treating the patients' body. These healers
treat the Jinn, sorcery and the evil eye that actually cause the
disease. They also knew that the doctors did not believe in what
they are doing. Likewise, the Sheikhs believed that their
treatments are better than the psychiatrists' treatments, and they
did not think that the psychiatrists' treatment affected their
treatment. These healers did not say to the patients to stop going to the modern system; even when they knew that the patients took medication, they did not intervene -- they left it for the patients' decision.

One of the healers said that sometimes when he faces a difficult case, he refers the patient to doctors. In fact, one of the healers said, "Allah Khalaq Altibb Wa Aldowa" (God created the medicine and the medication); thus human beings rightly look for cure through all means. In the healers' view, the modern system gives medication and injections, which they could not do. But the modern system could not deal with the Jinn and the sorcery that were the primary cause of the patients' problems.

In sum, the healers and their former patients gave the new referrals messages that their situation would improve and they would be cured by the intervention of the healers, God willing. The patients came to believe that they would be cured regardless of their diagnoses.

Treatment Approaches in the Traditional System

The four types of healers with different ways of dealing with the so-called "mental illnesses."

The approaches of the Dervishes. Among the Dervishes there exist four Turug, (schools of thought) each with different practice
principles. The group of Dervishes researched in this study belong to two of these schools of thought: Al-Anemaat and Al-Jreraat.

Several techniques were used by the Dervishes when they dealt with their patients. The most frequent technique was Tazeem (dialogue with the spirits) in which the communication is done in the spirits' own languages.

**Tazeem (Dialogue).** Adherents of Al-Jreraat attempt to expel spirits by overpowering them with superior power and authority. Dervishes of the Al-Anemaat, on the other hand, communicate with the spirits to convince them to leave the patient, using their authority gradually. In the Tazeem technique, the Dervishes read verses from the Koran, and they also refer to the power of their supervisors and to other saints, and ask their help to overcome the spirits.

**Dg Altaar (the drum).** Dervishes of the Al-Anemaat school used music when dealing with the spirits. When the spirits refused to communicate with the Dervishes, they used Dg Altaar (the drum) to convince the spirits to do so. The Dervishes said that the spirits like the music and usually react to it, beginning to communicate with the Dervishes through the patient's body. Al-Anemaat Dervishes used this strategy to invite the spirits for dialogue, while Al-Jreraat, believing that spirits must be overpowered, would command the spirits once they had been contacted.

Dervishes of both schools used the drum every Thursday evening, inviting their patients and those of other Dervishes. In
this ceremony, the patients and the Dervishes sing and dance together to the accompaniment of the drum.

The ritual process can be understood as a social drama (Waugh, 1989). In this ceremony all the participants shake their heads from side to side while moving their bodies, leading to a state of ecstasy. Al-Jreraat calls this ceremony Dhikr (remembering) because the participants remember God and invoke His name. The participants repeat words and phrases such as Allah Hai (God is alive). Al-Anemaat calls this ceremony Hadrh (to invite blessing from God).

This kind of ceremony is like that of the Zar throughout northern and western Sudan, in Ethiopia, in tribes of West Africa and Somalia, Egypt and Arabia, and throughout the Sahara (Grotberg, 1990); the intent is to cure mental illness by making contact with the spirits who have overwhelmed the person and caused the illness (Boddy, 1988; Kahana, 1985; Kennedy, 1967; Lewis, Al-Safi, & Hurreiz, 1991; Messiri, 1975). Rituals like these have also been found to be effective in various cultural contexts in curing psychosocially related illness (Grotberg, 1990; Peter, 1978; Ward, 1984). The rituals have powerful effects because they represent the sacred values of the culture and the core relationships of the society (Dulaney & Fiske, 1994).

There is a technique for treating the victim of the evil eye called Tahweetha (seeking the shield of God's protection). The Dervishes took a thread and made it into a circle; while they were doing that, they read Koranic verses. The thread, then, was
thought to help protect the victim from the evil eye if the patient
carried the Tahweetha on his or her body. According to Islamic
scholars, this method of intervention was recommended by the
Prophet Muhammad (Al-Juzuyyah, 1993).

*Beating the spirits.* In instance of Darbaat Blaad, if the
spirits refuse to leave the patient's body, the Dervishes of both
schools are willing to resort to beating it out of the patient, a
practice common to traditional healers in many cultures (Al-Issa,
1990; Al-Juhri, 1991; Al-Sabaie, 1989). Among the Dervishes, this
is done with a stick, beating the soles of the patient's bare feet,
the area of the body where the spirits are thought to normally
leave. Beating ceases once the Dervish has been able to
precipitate communication with the spirit, the purpose of the
beating being to gain the spirits' attention and to threaten the
spirits with the forces of good; once the beating has ceased, the
process of Tazeem can be re-initiated.

After this point, the spirits bargain with the Dervish
regarding which part of the body they shall exit. The Dervishes
only allow the spirits to exit through the patient's toes, since
exit through the head, the lungs, the heart, or through other vital
organs would cause somatic damage. If, after this stage, the
spirits still refuse to communicate with the Dervish or to leave
the patient's body, the Dervish, with the agreement of the
patient's family, typically asks the patient to stay in the
Dervish's home for a certain period of time -- a sort of
hospitalization -- such that more intense and sustained forms of treatment can be given. It should be noted that the Dervishes themselves are said to be protected from possession of spirits exiting others' bodies, by virtue of possessing the Baraka and of therefore being holy people. As well, since the process of exorcism takes place in the presence of incense, prayers, and other forms of religious expression -- which the spirits detest -- the spirits are thought to speedily vacate the area where spirits are being exorcised.

In another technique, the Dervishes encourage the patients' families to support them and to respect them. The Bedouin patients visit the Dervishes accompanied by their families and relatives from the extended family or the tribe. This type of support helps the patients to cope with their problems.

Aftercare. Once initial treatment has been completed, a kind of supportive therapy is instituted. In individual sessions, the Dervish supports and understands the patient's situation, encouraging him or her. All the Dervishes encourage their patients to practice Islamic principles and to believe that the Koran is the best treatment in the world; that when the spirits hear the words of the Koran, they run away. The Prophet Muhammad said, "The Koran is the best cure" (quoted in Al-Juzuyyah, 1957, p. 138).

Both schools of Dervishes recommend that patients visit a saint's tomb as an ongoing part of therapy, since in popular Islamic culture, the term Wali (saints) refers both to God and
God's friends (Eliade, 1987). With the passage of time, many legends have been woven around each tomb and the buried holy man, wonderful tales of the willingness of the saint to help the downtrodden, to cure illness. The Bedouin swear by Wali (saints) and also swear on them, believing that whoever takes a false oath on one of these holy tombs will die or suffer from a great tragedy within a short time. This ritual establishes deep psychological/therapeutic dependence of the Bedouin on the healers (including the Dervishes) and other holy men (Rijal Allah Al-Salhin) (Al-Krenawi, 1992; Askenazi, 1974).

The Khatib or Hajjab (amulet writer). These healers work according to the books that they have. The famous books that they use are called "Shamas al-Muarrif al-Kubra, Mandal as-Sulayman (Solomon's magic), and Isthdar Miluk Al-Jinn" (to bring the spirits' kings), the latter edited by Al-Marzoqi (1941). These books contain verses from the Koran and several types of figures. The most frequently used technique is the amulet--Hijjab. The amulet contains quotations from the Koran with or without ritualistic figures prescribed by religious men and is meant to serve as an appeal to divine powers through Koranic verses (Al-Issa, 1990; Baasher, 1967; El-Islam, 1982; Sanua, 1979; Sheber, 1990). It is a secret; nobody can understand what is written in the amulet except the Khatib. According to the healers, the purpose of the amulet is to expel the spirits and keep them away from the patients. As one of the healers said, "The amulet often
contains special verses from the Koran. Its purpose is to protect the person from attack or action of the spirits." One of the healers said, "Al-Hijjab Yahmi Al-Ensan men Al-Ins we Al-Jinn," meaning "The amulet protects the person from human beings and the spirits."

**Hijjab (The amulet).** After the amulet is written, it is then folded into a triangle, wrapped in cloth or leather and hung on the body. If the bearer is possessed by Jinn (earth devils, Darbaat Blaad) the amulet is placed under the pillow in the patient’s bed. For another spirits’ actions, the patient was told by the healer to hang the amulet on his or her neck or to carry it all the time (Abu-Rabia, 1983; Al-Krenawi, 1992; Sheber, 1990). These healers believe that no one else must open the amulet and read it; whoever does this will be punished by the devils. They also believe that the effectiveness of the amulet lapses when it is opened or gets wet (personal communication with amulet writer, 1994).

Another technique used by these healers is the Tazeem, reading verses from the Koran over the patient’s head. They also invited the spirits to dialogue with them through the books that they had. These healers believed that they had good relationships with the spirits, and the spirits helped them to cope with the patients’ diseases. One of the healers was open with me, and he told me a secret: that this group of healers also works as sorcerers (Sahrian), in addition to their main jobs. However, the Sahr (sorcerer) works in cooperation with a devil. The Sahrian
(sorcerers) are persons believed to have the capacity to communicate with spirits through sacrifices and prayers in the interest of the supplicant (Al-Ataar, 1989; Bali, 1993).

Hashar Al-Jinn (to put the spirits in a hard position). When the patient is attacked by a spirit and the spirit enters the person's body, the healers commonly opened a dialogue with the spirit while they read from the book; the dialogue contains verses from the Koran, especially from Surah Al-Jinn (the Jinn chapter), and they also mention words and phrases not in Arabic. As one of the healers said, "it is the spirits' language." If the spirit refused to communicate with the healers, they used to beat him until he or she responded and communicated with the healer.

The Khatib sometimes recommended the patients to visit a saint's tomb or a saint's Magaam (a holy place). Some of these healers adopted a modern technique in dealing with their patients. This technique is "talking therapy"; after the initial meeting is finished, they would open a friendly conversation dealing with the patient's difficulties. This conversation included support, encouragement and a process of venting and catharsis. We can thus arguably observe the impact of modern medicine on the healers. In fact, one of these healers said, "Nafsanian Al-Haki Beriah Al-Wgaan," meaning "psychologically, the talk helps the patient." This Khatib learned through his career to talk with his patients and to allow them to express their negative feelings; he regularly did so after the treatment took place.
Al-Fataha (the fortune tellers). This group of healers use cultural techniques as their way of dealing with their patients. The fortune tellers, however, treat just the easier problems such as Hariah (anxiety), Khof (fear), Mahsood (evil eye). These problems would be considered by psychiatrists as minor mental disorders; in the traditional system, they are considered easier-to-treat disturbances, the results of actions originating with spirits (Aamal Shytaniah) or with human beings.

The fortune tellers' methods of dealing with disease or problems are as follows:

Al-Dagajh Al-Samra Ao Al-Beda (the black or the white chicken). They use this method in case of Hariah (anxiety). If the anxiety happened at night, a black chicken is needed; if it was during the day, then a white chicken is used. The patient has to cook the chicken without spices and eat as much as she or he can; the rest of it should be buried at the junction of roads early in the morning. The healers believe that the spirits gather in the mornings at the junctions of roads. The patient shares this food with the spirits, a process of interaction between the patient and the spirits.

Tasat Al-Tarbah (a pot that is never exposed to the sun). This ritual is yet another method of dealing with the anxiety state. The patients would borrow this pot from the healer. The procedure is that the patient or a family member has to put water
or milk in the pot and to leave it on a high uncovered place at night time. This process is called "Tanjim," meaning "to leave the pot under the stars." Then, the patient must wake up early before the sun rises, and drink the milk or the water. The healers believe that this process will expel the Hariah. One of the healers said, "Hariah Abtordr Hariah," meaning "One anxiety expels another." When the patient drinks the water or the milk, he or she experiences fright, and when the patient feels this way, it means recovery will occur.

_Tamreeq_ (Massage). This group of healers sometimes treat their patients by a massage. Another ritual is a Tahreeg, meaning to expel the evil eye that attacked the patient. After the patient is diagnosed by the healer as Mahssod or Ein (attacked by the evil eye), he or she comes close to the healer, and the healer reads two small chapters from the Koran over the patient's head. The healer takes salt in her hands while she reads these chapters; when she finishes reading them, she throws the salt, and says, "Agoab Yaa Share"; she asks the pain and the evil eye to leave the patient's body. The purpose of these chapters is to expel and to remove the evil eye from a person. These chapters are as follows:

_Say_: I seek refuge in the Lord of the dawn, from the evil of that which He has created. And from the evil of intense darkness, when it comes. And from the evil of those who cast (evil suggestions) in firm resolutions (Koran, Surah Al-Falaq).

_Say_: I seek refuge in the Lord of men. The king of men. The God of men. From the evil of the whisperings of the slinking (devil), who whispers into the hearts of men. From among the Jinn and the men (Koran, Surah Al-Nas).
The following is another method for dealing with the evil eye:

*Shabah* (alum) The healer takes three pieces of alum, places them in the coals of the tent fire and leaves them for some moments; then she removes the three pieces of "Shabah" and examines their shapes carefully. The shape of one of them will determine whether the source of the evil eye is man, woman or devil. In the next step, she takes the three pieces of "Shabah," crushes them in her hand and swings her hand around the head of the patient several times, appealing to Allah and the holy men (Awlaya) asking them to heal the patient.

Sometimes in addition to, or instead of the above healing procedure, if the person who is suspected as the source of the evil eye has been identified, the healer will try to take a small piece of cloth called *Alaq*, even a thread, from his or her clothing without his or her knowledge. The healer places this in the fire, so that the smoke enters the nostrils and the eyes of the patient. This process is known as "Ktoor."

**Other methods.** In addition to these methods, fortune tellers often recommend to their patients to use *Bakhor Salhin* (incense of holy peoples). All the patients who were treated by this group of healers used the *Bkhor*. The way incense is used is to put it in the fire and to smell it twice a day. The healers believe that the *Bakhor* promotes health and removes pain from the body; it is special incense bought from Al-Atareen (healers who sell special herbs, plant species) (Al-Krenawi, 1992). Also, they recommend
certain plants for physical pain. Some of the medicinal plants are as follows: Jadeah (teucrium polium) is used for stomach ache, diarrhoea; Hasa Alban (rosemary); Sadrah (lotus tree); Babonaj (chamomile) (Abu-Rabia, 1983); Habat Al-Baraka (black cumin seed) is so valuable in Islamic medicine that the Prophet Muhammad said: "the black cumin will cure all illness" (Al-Juziyah, 1957, p. 229). These healers recommend these seeds if the patient complains about breathlessness/tightness. Another common plant remedy used is the Arbain (forty), which consists of a mixture of forty different types of plants and is considered to be a cure for all pains (Alush, 1976; Bailey & Danin, 1981; Roihia, 1974; Tal, 1981). These healers in their work combine medicinal plants according to their experiences and based on consultation with the herbalists.

The same chapters of the Koran that were mentioned above are often read by these healers in case of Kabsa: Kabsa is the unwitting and unexpected entrance of a symbolically polluted individual into the room occupied by a vulnerable female, often after giving birth to a child (Inhorn, 1994). These healers believe that for the Nafasah (a woman who gives birth), especially to a baby boy, her body is open for forty days, and her life is in danger because she is Njsh (impure). The treatment for such a situation is reading Koranic verses, and visiting a saint's tomb and sacrificing a lamb; after the slaughter of the lamb the woman's body is bathed with water and the blood of the lamb.
Sheikh-Din or Moalaj Belkoran. The main method that this group of healers use is Al-Raqi BelKoran (reading Koranic verses over the patient) (Al-Ataar, 1989; Al-Jzari, 1987; Badawi, 1992). After the patient has been diagnosed by the healer, the next stage is the treatment. The healer asks the patient to lie down on the bed; then he puts headphones on the patient’s ears. There are special chapters and verses from the Koran recorded for this task (Cf. Surah Al-Jinn v. 1-9; Surah Al-Baqara v. 1-5, 163-164, 255-257). In addition, the healer puts his hand on the patient’s head and reads other verses. The atmosphere is religious and helps the people who are present during the treatment process. This situation continues until the spirit responds through the patient’s body; then the healer removes the headphones.

When the spirit appears, the healer communicates with it and wants to know information about the spirit’s background, such as which kind of spirit, religion, sex, the reason why the spirit entered the patient’s body. Also, the healer asks him if there are other spirits inside the patient, and their location in the patient’s body. The healer wants to know if the spirit works alone or with a magical healer, Sahr. When the healer recognizes a spirit, he tries to convince him or her to become a Muslim (Al-Jzari, 1987; Bali, 1993).

The dialogue between the healer and the spirits sometimes can take more than one hour, depending on which type of spirit is in the patient’s body. If the spirit has entered the patient’s body, stayed there and refused to leave, the healers call this "Halat
Sarah, a confused state. According to the healers, the type of spirits who cause such situations are especially dangerous, and it is not easy to deal with them. In the Sarah case the patient was totally controlled by the Jinn (Daawod, 1992). If the spirit refuses to leave the patient’s body, the healer makes threats by continuing to read the Koran in the patient’s ear. In addition, the healers keep beating the patient during the treatment process in order to expel or to remove the spirits’ influence from the patient.

**Cumin.** Another technique is Habat Al-Baraka (black cumin seed) or as the healers call it, “the blessing seed.” The healers recommend that the patients eat it with honey. Honey is also considered by the Muslims a good cure for the body and soul; in the Koran, black cumin seed and honey were recommended by the Prophet Muhammad as effective treatment (Abdul-Aziz, 1991; Ashoor, 1987). The healers also recommend the oil of the black cumin seed be applied as a lotion on the body before going to sleep. Another technique of treatment is a purification ritual (Al-Taharh); its purpose is to clean the body and the spirit from sins. That ritual involved drinking or washing in water that has been run over Koranic verses on a plate (Al-Sabaie, 1989; Sanua, 1979). This ritual is highly recommended by the healers and Muslim scholars who treated according to the Koran (Al-Ataar, 1989; Al-Dramdash, 1991; Badawi, 1992; Bali, 1993).
All the healers regardless of their gender, craft and methods of dealing with the disease or the problems, recommend to the patients to practice Islamic tenets and to remember God and His Prophet Muhammad all the time. They also ask patients to follow the treatment instructions and to keep in touch with them. All except the healers who treat according to the Koran recommend to their patients to visit saints’ tombs. In contrast, the healers who treat by the Koran do not recommend that because they believe only God can help; however, they recommend other rituals such as *Aqīqa* (a vow to God) and invite people to eat food with them. Another ritual is *Mulad* (the birthday of the Prophet Muhammad). They also recommend praying in groups and going to the mosque for *Salat Al-Jumah* (the prayer of Friday); Friday is the holy day for the Muslims. In a similar vein, Bach-Y-Rita (1982) has pointed out that there is no need to go outside common cultural practices to treat religious Hispanics.

**Traditional Healing Rituals in Bedouin Society**

There are three other traditional rituals that patients indicated to be beneficial. The first of these is the *Zuarah* (saint’s tomb visiting); the second, which is closely relating, is to visit *Maqaam Al-Nebi-Musa* (the site where the Prophet Moses is buried). The third is the *Rahamah* (memorial ritual for the dead).

In Islamic society, saints are seen as "a particular kind of friend of God, one whose special closeness to divinity [is]
mediated between the ordinary faithful and [an] all-powerful and distant deity" (Eliade, 1987, p. 2). Saints' tombs are holy places, associated with stories of relieving personal anxiety, healing physical and mental ailments, and mediating requests to God (Bazzoui & Al-Issa, 1966; El-Islam, 1982, 1967; Kline, 1963). They are visited regularly, by individuals but by families in particular, during periods of disease, economic hardship, or minor and major mental health issues identified by the traditional Bedouin healers as induced by evil spirits. Similar visits are made to "Magaam Al-Nebi-Musa", a site where Muslims believe that the prophet Moses is buried (Asali, 1990).

At either Nebi-Musa, or a saint's tomb, Koranic verses are read, candles and incense are lit beside the grave, and white cloth is hung on the tomb itself. Vows are intended to appease the saint's soul, and special requests are then made to prevent tragedy or illness from striking the supplicants, their children, or their property. Supplications are said corporately and individually; additional supplications not dealing with the initial reason for the visit often arise. After all requests have been made, a lamb is led around the grave and is slaughtered as a symbol of a fulfilled vow, cooked and eaten. This is followed by readings from the first chapter of the Koran, and by a final supplication where all address God, through the saint's soul, and ask that their prayers be granted. When the supplicant and his or her family return home they are met by other members of the tribe and by friends, who say Mbrock Alzuarah (congratulations), a symbolic
recognition of their wish that God has accepted the visit and has provided assistance to the supplicant.

Memorial ritual for the dead (Rahamah). When an individual's deceased relative or friend appears in a dream, the result is often a memorial ritual for the dead. In one such example, a husband appeared in a Bedouin widow's dream and indicated that he wanted to take her to where he is; she became fearful, interpreting the dream as a sign that her dead husband wanted her to enter the afterlife (Al-Krenawi, 1993).

The Bedouin term for this memorial is Rahamah, which in direct translation, means "to obtain food for the dead person's soul and to invite people to eat the food" (Al-Krenawi, 1993). This ritual is always held on a Thursday, the day before the Muslim Sabbath, and begins with the dreamer's daytime visit to the grave, accompanied by relatives, while other family members and friends obtain and prepare food at the dreamer's home. That evening, a dinner is held to which extended family and friends are invited. The meal starts with the reading of the Koran, which is intended to prevent the soul of the dead from re-appearing.

In all rituals, the patients put themselves under supernatural power; in some instances, this is facilitated by the presence of a dead saint, Moses' grave; in other cases by specific rituals (the Dhikr, the Rahamah). Intense feelings and often outwardly emotive forms of prayer and crying are often accompanied by catharsis, venting, satisfaction and psychological release (Atkinson, 1987).
Religion is central to these processes, providing individuals and groups a sense of the meaning of life, which may in turn promote support and consultation in the context of psychosocial problems; the relationship of religion to the transcendental realm also provides a sense of security and self-worth, particularly in instances of mourning (O'Dea, 1966). For the Dhikr in particular, the transition from the subjective reality of personal experience to the irrational world of the Divine helps the patient to cultivate a new basis of coping.

Such rituals invariably have strong group therapeutic components in several respects. Group members give emotional support, universalization, as well as a network of support outside of the ritual.

On another level, in the immediate context of participating in a ritual, there is created a ready-made, natural, helping group which provides the opportunity for the expression of negative feelings, sharing of information about the problem, discussion of coping strategies, and the universalizing recognition of common problems (Al-Krenawi & Graham, in press). The ritual process itself provides a further sense of union with other members participating in that ritual, reinforcing greater group cohesion (D’Aquili, 1985; Van der Hart et al., 1988).

Finally, it should be noted that there are many Islamic rituals, which are inextricable parts of daily life and which have considerable potential regarding therapeutic value. Often daily prayers are performed in congregation, especially the prayer of
Friday, and Muslims celebrate two religious feasts (Ramadan, *Id Al-Fitr* and the sacrifice, *Al-Adha*) in a group setting. To further illustrate Muslim group consciousness, the experience of group is reflected in the fact that a consensus of a body of Islamic religious scholars (*Al-Ejma*) is viewed as sacred law. Thus, with this view of the inherent group orientation of Islam, group therapy can seen as an optimal setting and a way for Muslims to experience personal growth. But this group emphasis is not without limits. The individual in Islam is an independent member of the group who makes decisions to satisfy his or her needs and interests without hurting the group (*Al-Radi & Al-Mahdy, 1989*). So the interests of the individual and the group do not necessarily contradict one another; rather, they are supposed to reinforce each other. The individual's voice is not silenced, and group members are always expected to express personal views.

Muslims, of course, rely greatly on each other for support. This can come in the form of advice or actual help. Thus, in groups where rituals take place, Muslims may feel comfortable exchanging feedback or extending help. The participants in such group activities have the opportunities to express their emotional needs to God from a holy place, to Muslims, the house of God, the Mosque. In sum, in Islamic prayer we can observe therapeutic components at different levels. At the personal level, the individual satisfies his Lord and himself or herself, which leads to relaxation and relief (*Rizvi, 1989*). At the group level, there is emotional support and exchange of ideas or difficulties with
other prayers or with the Imam of the Mosque. Group cohesion is reinforced by Islamic theology: "hold fast together by the rope of Allah and not by being divisive among yourselves... Believers are like a building, strengthening and supporting each other... God helps he who helps his brother" (Koran, cited in Al-Rady & Al-Mahdy, 1989, p. 274). Also every Friday, they have more opportunities to engage with more people in the Mosque or during the feast prayer, which can be understood as a community therapy and wider social support and social network.

In summary, throughout history and across cultures, emotional arousal has been utilized as an important aspect of change and healing techniques. Traditional group rituals often produce healing associated with emotional catharsis (Grotberg, 1990; Wallace, 1975) as do esoteric shamanistic healing techniques (Eliade, 1964; Ness & Wintrob, 1980). The less religious forms of thought control and brainwashing make use of emotional arousal often associated with pain and fear (Frank, 1973).

The Experience and Effects of the Rituals from the Patients' Perspectives

Since their childhoods, the typical Bedouin has had the chance to participate in the cultural and religious rituals in their families, extended family and the tribe. They often tell stories about the supernatural powers of saints, healers and holy places; therefore the Bedouin child grows up in an atmosphere where he or
she learns about holy people and their abilities to perform cures and miracles. Small wonder, then, that an adult Bedouin would discern such power in holy people or in the practice of traditional rituals. Clearly for many Bedouin they have greater community sanction than Western forms of helping (Al-Krenawi, 1992; Al-Krenawi & Graham, in press). Not surprisingly, all the patients who were interviewed in the study had an idea of what a ritual was and its purpose.

Male patients reported that before the rituals took place, they felt fear and pain, especially in the chest; as they called it "Deaq Fe Al-Sadar" (pressure in the chest). In addition, they described a situation of confusion; how to face the reality of standing beside the saint’s tomb or the Dhikr or other rituals. During the ritual performance, however, they experienced closeness to the supernatural power. After the ritual took place, they felt improvement in their situations.

In the patients' opinions, the rituals reduced the pain in the chest, lessened bad dreams and fear. One of the male patients described his feeling when he participated in the Dhikr rituals: "It is a strange feeling; I felt that I was somewhere far from human beings." This patient said that the power of mentioning God’s name and just focusing on Him, led the person to be satisfied and close to his Lord. Another patient said, "Aloqof Amam Allah Wa Been Ydeah Hada Yshfi Al-Maread" (to stand in front of God and between His hands, this will cure the sick person). One patient described his feeling as "Sharth Be Rahit Baal" (I felt relaxation
and psychological release). However, before the rituals took place, patients felt fear and confusion about them. Afterwards, they reported feeling relief and safety; as one of them said, "Sharth Ano Sadri Wa Qalbi Mshroah" (I felt that my chest and my heart were open). This symbolizes a state of spiritual elevation, from the Islamic perspective. Spiritual elevation, in Islam, comes through submission to God. Thus God-consciousness and self-awareness are interdependent. Integration of material and spiritual life brings about an internal harmony that is the source of mental and emotional stability (Qutib, 1967). This consciousness leads to the remembrance of God, which is central to the Koranic concept of satisfaction and well-being: "Those who believe and whose hearts have rest in the remembrance of Allah. Verily in the remembrance of Allah do hearts find rest" (Koran, Surah 13, v. 28).

Female patients believed that the most powerful ritual is visiting the saint’s tomb, but they also practised other cultural rituals. All of them were very happy when they initiated the visiting ritual, because they believed that the visit to the Wali (saint) would give them protection from disease and from the spirits’ action. One female said, "The Zuarah (visiting the saint’s tomb) will protect me from Banat Al-Hraam [the bad women]." None of them were worried or afraid before the ritual took place; on the contrary, they were waiting to fulfil what they promised: "Allah Sahid," meaning God is the witness to whom I promised the Zuarah. After the ritual was done, they reported relief and
satisfaction because they fulfilled what they promised. One of them said, "Halheen Ana Maraiah," meaning "Now after I fulfill the Zuarah, I am protected by the Wali (saint)." Female patients even took sand from the saint’s grave because they believed that the sand of the Wali was blessed by God. Females reported that they felt improvement in their situation during and after the ritual took place, and they even promised to do it every year.

The Impact of Modern Medicine on the Healers

The Bedouin of the Negev live in a modern country; there are modern clinics and psychiatric services for them. Beside these practitioners, there are also healers with different specialities in the society. In addition, the Bedouin are exposed to influences from several societies, including Arab and Jewish, in the Gaza Strip, the West Bank, and north Israel. The Bedouin find themselves involved in several processes in transition from traditional lifestyles to modern, and they become engaged with modern systems, such as education, health services, welfare services. For these processes, there is a process of acculturation; the youngest among the Bedouin work in the Jewish cities and are in contact with the surrounding modern world. Still, in most areas, the traditional healing system does exert an influence. The main question related to the issue of modernization is how to survive and keep functioning under such influences?
The Bedouin healers have established strategies to function under such circumstances; yet the healers who deal with physical problems find themselves unable to deal with such problems because of the access and degree of utilization of the primary medical care (Srinivasan, 1995). In contrast, those who deal with so-called "mental illness" function more easily in the modern society. These healers emphasize religion in their treatment; they also refer patients to the modern system when they feel that they cannot help them. Another pattern occurs when the modern system fails to help the patients; then the patients refer to the traditional system.

When the physicians who work with the Bedouin community do not find any pathological indications, they commonly refer the patients to the psychiatric system, as was found in the present investigation. The patients were not familiar with the psychiatric treatment. These Bedouin patients, regardless of gender or education, turned to the traditional healing system before they turned to the psychiatric system. So after they were disappointed with the GP's treatment, they turned to the traditional system. Later on, after they encountered the psychiatrists, some of them left the psychiatric system and turned back to the traditional system, and others utilized both systems simultaneously. Such a situation indicates that there is a need in the Bedouin society for healers who treat non-physical problems. These healers still exist everywhere in the Arab countries (Abdul-Rahman, 1991; Al-Gamdi, 1990; Al-Issa, 1990; Al-Juhri, 1991; Al-Sabaie, 1989; El-Islam, 1982; Sanua, 1979). Furthermore, there is a recent movement
calling for treatment according to the Koran. This movement endorses what the Westerners call "psychological therapy"; they call it "Ilaj Rohani" (spiritual healing). This movement is increasing and gets legitimacy, from the Islamic scholars, to practise and to treat people (Al-Dramdash, 1991; Al-Jzari, 1987; Al-Sharqawi, 1992; Bali, 1993; Salim, 1986).

As a result of the emergence of this movement, there is a religious influence on the other types of healers who operate in the Bedouin society and in the Arab society in general. All the healers have started to emphasize Islam and its effects on the patient. The healers in the present study stated that the practice of Islamic tenets brings relief to the person. Even the fortune tellers who were illiterate told stories about the power of religion in curing human beings. I think that this Islamic revival movement has influenced the other types of healers.

The encounters with the modern system have some specific influences on some of the healers in their work. The healers talked about medical examinations, such as blood tests or X-rays. A fortune teller suggested that one of the patients go to the doctor for a blood test. Another spoke of a general medical investigation. We can thus see that the healers use modern concepts and have adopted Western concepts related to the physical diseases (Landy, 1974). They also referred patients who were diagnosed as suffering from severe mental disorders to the modern system. These diagnoses were epilepsy, brain damage and mental retardation.
During the interviews and participant observation in the traditional system, the healers asked me questions related to diagnoses. For example, one of the healers said, "what do you call this diagnosis in the modern system?" This healer was even ready to know more about the psychiatric system. Another asked about the treatment techniques; when I told him about medication and psychotherapy, he became interested to know what the term "psychotherapy" means. I told him. This healer said, "if this is what you call treatment, I do it all the time with the patient."

One of the healers, a 40-year-old Khatib said, "the key thing is trust; if the patients trust me, that means psychologically it will help them." Another healer said, "in the modern system, you used the term, 'Aqdadh Nafsanih' meaning psychological complex." This healer said that he understood what this term meant and even read books to know more about the modern system.

The Sheikhs who treat according to the Koran were familiar with many modern concepts in the psychiatric system, such as depression, anxiety, traumatic events. One of these healers said, "I took courses in psychology, but I do not believe in it; I believe in the words of God." This healer kept saying that all of psychology is in the Koran. These healers believed that talk helps human beings to release tension, and they used it in their treatment. The Sheikhs and the amulet writers used professional books related to their crafts; the Sheikhs often mentioned authors of books and what they said about diseases. Such situations indicate the influence of the modern medical system on these
healers, and the similarities between modern and traditional systems.

Both the Sheikhs and the psychiatrists are educated, and their professions are based on studies, theory and experience. There are similarities between the professions in terms of questioning the patients about their symptoms. I think that Sheikhs are familiar with modern psychiatry and related professions, and they built their craft based on modern medicine (psychotherapy). There are several books edited by Sheikhs talking about their experiences as therapists according to the Koran. Such books became useful for other Sheikhs, and they use these books as reference for their work. In this way, the Sheikhs exchange ideas and share their treatment with other healers.

In essence, all the healers tried to become familiar with the modern system by learning its concepts. They also tried to make it fit with the culture. In addition all the healers seemed to be familiar with concepts related to the body, even names of diseases such as heart attack, diarrhoea, fever (Abdul-Menaim, 1991). Male healers were especially interested in knowing about the psychiatric system; they raised questions about the modern system and tried to learn more. Sometimes the healers asked the patients what the doctor had told them; or the patients told the healers that the doctor said that nothing is wrong -- all you have is "Aoham," meaning "You think that you are sick, but in fact you are not."

It seems that there is a one-way interaction between the two systems, in those who treat the same patient concurrently.
Information is funnelled by the patients to the traditional system. The healers asked the patients about what the doctor said and what was suggested. In contrast, the psychiatrists and the physicians who treated these patients never asked them about the traditional system.

We can conclude that the traditional healers surrounded by the modern system, learn modern concepts as do the patients. When they learn such things they adapt them into the cultural context. Eventually the healers and the patients may find that the traditional system is essential even with the modern trends of this society; both the healers and patients think that there is a place for the medical types of healers who treat so-called "mental illness" -- in the healers' and the patients' language, spirits' actions, sorcery and the evil eye.

Summary: The Encounter with the Traditional Healing System

The main benefits which the patients perceived as coming from traditional healing included the following:

1. The males perceived it as a system for spiritual treatment.

2. Female patients perceived it as a system to treat sorcery, the evil eye, and spirits' deeds.

3. It removed the nonphysical symptoms such as bad dreams, nightmares, visions of animals, and fear of death. For females this system expelled hallucinations and
delusions. In their opinion, the latter figures were spirits.

4. There was trust between the healers and the patients which led to good relationships.

5. The treatment took place in an informal setting.

6. Female patients had opportunities to meet with healers individually without interference from husband or family.

7. There were social networks for females as well as for males.

8. Both the healer and the patient shared the same belief systems and the same culture.

9. Patients had faith in the capacity of the healer and the saints involved in the treatment process. The healers and the saints represented the supernatural power from the patients' perspectives.

10. The patients' families were involved and active in the traditional treatment. Also, their families took care of all the healer's recommendations such as the performance of rituals and the treatment instructions.

11. Females believed that they were protected and safe from sorcery and spirits' attack and actions because of the healer or the saints that they visited.

12. Males believed that they were safe because of the words of God (Koran) and because of their relationships with the healers who treated them.
One should emphasize, in particular, the last two points. Female patients used the word "Maraiah", meaning they were protected and safe on the above issues, because of their connection with the healers and the saints. In case a female felt under stress, she would call the healer’s or the saint’s names, such as "Yaa Abu-Hrirah Ana Fe Ardac," meaning "O Abu-Hrirah protect me, and I am in your protection." My female informants told me whenever they felt pressure and suffered they routinely called out their healers’ names or those of the saints whom they visited.

Male patients mentioned God and His Prophet Muhammad, and read the Koran in case of stress or heavy pain. They believed that the Koran would help the tension and the worry. Males are exposed to religious influence from the outside society more than females. This is a reason why there are differences in their perceptions related to protection.

Summary

It should be stressed that the patients in this study persist in using the traditional system alongside the modern system. For a variety of cultural, familial/tribal, and personal reasons, patients were familiar with the traditional system. Healer-patient relationships are forged in this context, and provide prospects for useful mental health healing. As the chapter has demonstrated, there is a complex system of traditional healer diagnosis and treatment. Much of this centres on the use of traditional modes of
rituals. But the impact of modern modes of psychiatric practice upon traditional healers is considerable. The question is, how can patterns of dual use be used to better understand the patient experience of both mental health systems?
Chapter Eight

THE EXPERIENCE OF DUAL USE

As the following chapter shall demonstrate, there are perceptible differences in why -- and how -- the Bedouin utilized traditional and modern systems. But beyond this, there are differences in utilization between male and female and between Bedouin of various educational or social strata. The traditional and modern treatment processes themselves vary markedly -- providing, as will be illustrated, a nuanced basis upon which utilization decisions are made and sustained. In the final analysis, much can be learned about integration, complementarity, and competitive, from understanding the encounters themselves -- between patient and traditional healer, and between patient and modern psychiatrist.

The Help Seeking Process

This section focuses upon dual users of both mental health systems. Studies show that in circumstances where both systems are available, traditional peoples tend to use both (Waldram, 1990). They develop a "hierarchy of resort" (Rommunucci-Schwartz, 1969) for the alternative treatments available, in a pattern described by some as "dual use," (Press, 1969), others as "concurrent use" (Woods, 1977), "complementary use" (Nyamwaya, 1987), and
"simultaneous use" (Garrison, 1977; Welsch, 1983). Even in modern countries where there is access to modern medical systems, people from traditional backgrounds utilize both systems concurrently. To some extent this argument applies to the Bedouin of the Negev; they live in a modern state, and modern health facilities are relatively accessible, but they still have a strong connection to the traditional healing system. Even among Native peoples of Canada, urban dwellers still show a strong attachment to their traditional health system, despite their utilization of the modern medical system (Waldram, 1990). Thus, Romanucci-Ross (1983, p. 13) has argued consumers of both systems are not concerned about the "explanatory principles" of various treatment modalities, but rather with symptoms and cures.

This process of seeking treatment from several systems simultaneously is common to Bedouin culture and should not be perceived as peculiar to the psychiatric patients under examination. The patient subjectively defines the presence of a disease, as well as its nature, etiology, and possible solutions. Such an interpretation, as argued in this study, is embedded in the patient's cultural beliefs and values, and reflects the available network of resources at his or her disposal. Many researchers have emphasized that the way one perceives a problem or disease strongly bears upon the person's degree of suffering and his or her efforts to seek help (e.g., Chirsman, 1977; Klienman, 1982). As well, it is important to emphasize the clinician's role in contributing to how a problem is defined and solved.
Bedouin psychiatric patients tend to follow the following modern health-care utilization patterns. To begin with, the patient will visit a general practitioner and will insist that interventions be restricted to the physical realm. Many physicians, in turn, pursue numerous, and sometimes unnecessary laboratory, radiological and "up-to-date" investigations in order to reassure and strike a therapeutic alliance with their patient. Conspicuously absent from most treatments is any introduction of the possibility of a psychiatric, as distinct from a physical, problem. When psychiatric referrals are made, they are invariably to the Soroka centre, a general hospital which is perceived to be less stigmatizing than a psychiatric hospital, and a place where somatic treatments prevail. As a result, the patient, assuming the problem is strictly physiological, tends to focus on physical complaints over the course of the psychiatric encounter. As one patient described Soroka, "This is a hospital, and we came for physical examinations and treatment."

The overall process of being referred from the GP to a psychiatrist also tends to increase patient anxiety, in raising the suspicion that he or she suffers from a disease that is either unknown or unduly complicated. Many patients, as well, experience high expectations of successful and quick treatment, and consequent disappointment when these are not realized (West, 1987). Some of the patients in this study, for example, were prescribed medications and returned the following day, complaining of side effects and of the medication's ineffectiveness against the
underlying condition. These disappointments early in the course of modern treatment, are in marked contrast to patient satisfaction within the early stages of traditional modes of treatment.

In summary, then, the following schema are helpful in conceptualizing major concepts of Bedouin health care utilization:

Family --> GP --> healer --> psychiatrist --> healer and GP --> Arab psychiatrists from Gaza or West Bank --> Bedouin and Arab healers from outside the Negev Bedouin society such as the Gaza Strip and Sinai-Egypt: This scheme of pathways was followed by male patients who were referred to the psychiatric clinic in Soroka Medical Centre.

The female scheme of utilizing systems for treatment was family --> GP --> healer --> psychiatrist --> healer --> GP --> healer. After a round of seeking cure and information about their difficulties, they used the three systems concurrently: primary health care clinic (GP) --> psychiatric (psychiatrist) --> the traditional system (healer). They sought answers to their problems or, in some cases, a frame of social support.

The research population utilized several services concurrently: GP --> healers --> psychiatrists --> healers --> GP --> social welfare services --> employment office --> National social security. These services provided information to the patients about their diseases or problems and about their rights.

The diagram on the following page shows the help-seeking behaviour and the patterns that affect the patient's perception in
utilizing both systems concurrently. (The diagram is related to the final sample.)
The help-seeking process (final sample)
Gender and Health Care Utilization

There were gender differences in terms of seeking cures: Males were generally referred to Arab psychiatrists from the Gaza Strip and West Bank, and they sought Arab or Bedouin healers from even outside Israel, such as in Sinai, Egypt. In contrast, the female patients sought treatment from the modern services that existed in the communities: the primary health care clinics and the psychiatric clinic in Soroka. The difference is that Bedouin males have more opportunities to travel outside their communities seeking treatment, and the Bedouin society legitimizes such travel activities. Females knew that their families would not allow them to travel freely. Thus, they used what was acceptable in the society, in addition to the modern systems. They attempted to avoid anything that would put them in jeopardy with their families and the society.

Patients who utilized both health systems learned how to use the following other social systems: social welfare services, the employment office, and the national social security. These services provide instrumental and emotional support and social networks. These services, in Israel, established an agency to exchange information about different issues. These systems were legitimized by Bedouin society, because they provide instrumental support and are located in the communities. For the Bedouin female, they provide good opportunities to get out of the house and
to meet friends; to build a social network, and exchange ideas with other Bedouin females about their difficulties.

One should stress that there are significant social support benefits derived from the modern system. In many instances, informal networks of help were cultivated. Among women, such networks tended to be wider than those of their male counterparts. Their social networks extended to females from different tribes and to Jewish patients who had similar linguistic or racial backgrounds. These social benefits encouraged women to use or at least attend the Soroka clinic.

Males, in contrast, tended to build networks among members of their own family, tribe, neighbourhood, or wider ethno-community. Bedouin encounters with Jewish patients tended to allow for the giving of information regarding traditional forms of Bedouin healing, and the receiving of information and advice regarding access to social services. In general, it also should be noted that those men with less education, as well as the majority of women, were more likely to have perceived psychiatry as part of the continuum of modern health care; subsequent use of either somatic or psychiatric treatment, therefore, was mutually reinforced.

In the males' perception, the modern system treats physical problems, yet some of them stated that they were frustrated with the modern system in dealing with these problems. One of the patients said, "the doctor said, 'You have nothing,' but I am suffering." Such a statement from the doctor increases the patient's disappointment with the modern system. In general, they
felt that the modern system did not believe them; one of them said, "Bhass An Al-doctor Ma Besdaq Nih." (I feel that the doctor does not believe what I am telling him).

Some of the male patients reported that the modern system helped in terms of reducing pains in the body. One of them said, "the modern system helped me; there are no more pains in my chest and in my head." Regarding the traditional system, one of them said, "the traditional system made me relax and removed the fear and the bad dreams." It seemed that patients distinguished between the two systems: the modern was for physical pain and physical treatment; the traditional system, in contrast, was to treat non-physical complaints via Ilag Rohani (spiritual treatment). Nevertheless, the majority of the patients reported that the traditional system was more effective than the modern. That is because they felt improvement in their non-physical symptoms, while they still complained about physical pain; in their opinion, the modern system did not help them enough, except for reducing the pain temporarily. One of them said, "Tasket Wajah"; he meant that the modern treatment just quiets the pain.

Female patients also reported that the traditional system helped them more than the modern. "The modern system treats Wajah [pain in the body]; this system does not understand us as the traditional does," said one of the patients. Female patients stated that the traditional system is more effective than the modern because they felt that there were some improvements in their situation as a result of the traditional intervention. When they
felt any improvement in their non-physical symptoms, such as dreams and hallucinations or delusions, they believed that was because of the traditional intervention, not the medication. The female patients perceived the traditional system as familiar with their belief systems, values, and that both the patients and the healers shared the same background. As one of the female patients said "Al-Dervish Mna Wa Alina" meaning the healer is one of us and he or she is familiar with our lives. Another patient said "Abnafham Ala Baad" we understand each other.

The male patients were seeking cures from all the available systems, modern or traditional. As one of them said, "in the beginning, I was very angry and tired; I was ready to do everything just to feel better." Another said, "the doctor controlled the body and the healer controlled the spirit." One of the patients who was religious and was familiar with the Koran described the traditional system as an expert system for treating the spirit; the modern was just for the body. This patient said, "there are two aspects of human nature, namely, 'al-Nafs al-Ammarah' [the impelling or carnal self] and 'al-Nafs al-lawwamah' [the reproaching or moral self], and there is a conflict between them." From the patient's point of view, such a situation leads to spiritual disease. This can be treated only by the traditional system, not the modern.

However, patients still sought physical treatment from the modern system. As one patient said, "I want to stay under medical follow-up, that is because I have pain, and I am afraid to neglect
in addition to the medical follow-up, there is the pattern of instrumental support (financial). The majority of the male patients left their jobs because of their diseases/problems. So they learned how to use their rights as sick people who cannot work and provide for their families; i.e., their rights to social assistance.

Female patients utilized both systems because the modern treated physical complaints and conducted medical investigations. Some of them understood that the modern treated physical problems such as fever, pain. They continued to think that the modern system would do physical exams for them in the future. In addition to the physical treatment, they expected instrumental support, since the majority of them presented economic problems.

For women, it was important that the traditional system treated sorcery, the evil eye and spirits' actions that the modern system did not address. One female said, "a female did Amaal (sorcery) on me, and the purpose of the Amaal is to destroy me and my family." In her opinion, such a thing cannot be treated by the doctor. In other words, the modern system is not familiar with the patients' belief systems. Another patient said, "Rabna Chalq Altib Wa Aldowa" (God created the medicine and the treatment). In her view, the person who is ill needs to look for the cure everywhere. A patient said, "the doctor and the healer do their jobs and the rest is upon Allah."

Male patients needed their families' help in the traditional system, whereas they had the ability to carry out the modern
treatment. In contrast, female patients needed their families' help in the modern system. In general the females were more familiar with the traditional system than the men. Both females and males got help in both systems from their families but in different levels. But in general, given the strong familial interdependence in Bedouin society, "individual" mental health problems are in fact invariably the concern of the whole family system (Al-Krenawi et al., 1994; Kim, 1995).

Some of the male patients were confused about which system to follow and which treatment is preferable. They described states of confusion. Some of them were hesitant to refer to the traditional system. However, there were several factors that furthered the utilization of both systems: the patient's family participated in the treatment in the traditional system. The patient's family took care of him; they went to the healer together, and one of the family members took responsibility for fulfilling the healer's instructions. Another arranged the ritual that was recommended by the healer. Patients got support from relatives and friends of the extended family and the tribe. These factors helped the patients to manage the treatment in both systems. Often when the healer recommended a ritual such as visiting a saint's tomb, the patient's family and other relatives accompanied him to fulfil this task. During the ritual performance, the patient's family and his relatives took care of the ritual while he sat beside the saint's tomb. The male Bedouin patient, however, was solely responsible for his treatment in the psychiatric system, and he did not
receive active support from his nuclear and the extended family in this regard. In fact, the patient's family and the extended family furthered integration between both systems; they generally approved of the patient's ideas of utilizing both systems concurrently.

Female patients tended to be confused about the modern system, until they got support from other female patients in the primary health care centre and the psychiatric clinic. The females required help in dealing with the modern system; their families, in accord with cultural norms, had to accompany them to the psychiatric system and to be translators during the treatment process. The translation included the patients' symptoms and the pain, and later on, the treatment instructions. The female patients were familiar with the traditional system more than males; they commonly followed the healer's instruction alone, because they knew exactly what to do.

Although the young females got help from their mothers, who accompanied them to the traditional system, the female patients generally got their family's support and help during the performance of the rituals. During the ritual performance, the patients, male and female were seated and the family took care of the proceedings.

**Patients in the Modern Mental Health System**

In many ways the Bedouin hold modern health practice in high regard, and tend not to find contact with modern practitioners
stigmatizing. Modern psychiatric practitioners, however, are perceived differently, and need to be utilized in ways that to a Bedouin, are less stigmatizing. Somatic symptoms, especially pain, are the major precipitating reasons why a Bedouin would seek medical attention. Somatic symptoms are readily comprehensible, but the Bedouin often have a hard time appreciating any psychiatric diagnosis.

Bedouins tended to be dissatisfied with the modern psychiatric system, to some extent at least because they were not familiar with its basic tenets and objectives. The term "psychiatry" was strange to many of the examined patients, especially the women. When asked, only a few of the men attempted to define it, and most of these tended to confuse it with the treatment of physical maladies; several of the subjects who were educated defined psychiatry in terms of a "psychological complex", but were unable to explain the term beyond this.

A number of the patients were diagnosed with paranoid or psychotic symptoms which were, in their specifics strongly reflective of Bedouin culture (Bazzouï, 1970; El-Islam, 1980; Leff, 1981; Namboze, 1983). Yet none of the informants were able to state the name of their diagnosis, let alone the meaning of such a label. In part, this was because of a tendency to defer to the psychiatrist's (doctor's) authority, and to assume that the patient therefore did not need to be concerned with these aspects of treatment. Diagnoses, as well, were made either in English or in Hebrew, neither of which are the patient's primary language. This
is not to suggest that patients did not ask questions. Most were very interested in learning about the nature of the treatment (for example injections versus oral medication), as well as the degree of severity and the prognosis of the disease. But the conceptual world of psychiatry was foreign to the patients. Thus, even if patients had been told the diagnosis, its meaning might have remained ambiguous at best, and entirely vague and anxiety-creating, at worst.

To this end, "modern" mental health practitioners are unable to fully comprehend the patient's symptoms without exploring their personal, and sometimes idiosyncratic, meanings. Somatization disorders thereby risk being misinterpreted as somatic complaints, rather than as true indications of irritability and anger. Like many Arabs, the present Bedouin patients expressed their disturbances by describing the head (which according to Arab culture, governs and integrates all body activity) and the heart (the centre of all feelings); for example, they would complain of giddiness when they felt incapable of proper social functioning, of an ache in the heart when they had pent-up feelings of emotional distress (El-Islam & Abu-Dagga, 1992).

Both sexes also experienced much of their problems via dreams -- and psychiatrists were not sufficiently culturally aware, or otherwise proficient, to help the patients to make sense of them. But dream interpretation, it must be stressed, is a fundamental aspect of the Bedouin cultural canon and is considered by Muslims to have a divinatory and prophetic function (El-Islam, 1982). The
women under examination tended to have nightmares about snakes, which often took the shape of a human being which then tried to attack the dreamer; these were generally interpreted to convey family or other forms of relational problems. Male dreams, in contrast, usually conveyed sentiments of fear and guilt, providing an outlet for emotions that are otherwise precluded by social conventions, from being displayed openly and publicly. In both instances, then, Bedouin cultural symbols such as snakes, as well as social constructions of gender and cultural customs and values, strongly bore upon dream content (Kilborne, 1976; Lee, 1958; Levine, 1991; Lincoln, 1935; O'Neil, 1977); these are the social prisms through which an individual's wishes and fears are expressed (Kilborne, 1976).

The two sexes presented somatic complaints at different levels. Males complained of fatigue and physical pain and weakness, and emphasized how these affected them economically and socially. Females also expressed somatic complaints, but focused, in contrast, on how pain travelled in their bodies. Many of the male patients blamed their disease on fate, rather than on an etiology to which a psychiatrist would subscribe. Many also used proverbs to convey their suffering and coping strategies, which were culturally-specific and thus often not fully comprehensible to the psychiatrist (Makinde, 1987). Moreover, Bedouin culture strongly proscribes males from venting their concerns and feelings. According to the cultural canon, men should appear strong under any circumstance. Complaining is unmanly -- it is considered female
behaviour. One common insult to a man, for instance, is "Abtishki Zai Al-Hormah," meaning "You complain like a woman." Some of the examined male patients reported that the modern system helped to reduce physical pain, but in general, were frustrated and disappointed with the modern forms of treatment. This was due, in part, to high expectations of successful outcome of any modern modality; and to the consequent expectation that psychiatric intervention, as a form of modern treatment, ought to have treated the symptoms and to have successfully expelled the distress from the body. In one patient's words, "I still suffer." It may be added that in the present sample, regardless of social status, education or economic background, most patients tended to distrust the psychiatrists, and many psychiatrists and patients remained in states of mutual misunderstanding. Patient resistance and denial also were wide-spread.

The issue of stigma can hardly be overemphasized in explaining patients' avoidance of the modern psychiatric system. Even the educated and the wealthy patients often felt considerable shame once they realized that they had been referred to a psychiatric service. This attitude towards utilization, it must be stressed, is inconsistent with the conclusions of many studies on access to modern health services (Chan & Chang, 1976; Chang & Lin, 1994; Fosu, 1995; Tijhuis, Peters, & Foests, 1990). Among the Bedouin who require psychiatric help, a generally inverse relationship has been found between the degree of education/socio-economic standing and the readiness to engage in modern treatments. But in the
present case, in all instances, irrespective of gender or marital status, acculturation was less influential than the predominant Bedouin cultural strictures. The fear of being stigmatized by a label of mental illness, and the consequent shame that this would bring to a family name, were far more salient influences than any perceived benefits of the modern treatment system.

Of all of the examined patients, only one family allowed their unmarried daughter to become a psychiatric hospital in-patient, after the diagnosis of a psychotic state. This was on the condition that the parents stay with the daughter while she was in hospital, and that the duration not exceed one week. The oldest son took care of the rest of the family, in his parent's absence, and was strictly instructed to inform the community that the parents and daughter had visited a healer in the Gaza Strip. In another instance, an unmarried daughter who had been diagnosed as a psychotic, was treated through intermediaries; all psychiatric contact, save for the initial assessment, was with the parents, not with the identified patient herself, who remained at home. The psychiatrist learned of the patient's progress by the parents' reports, and adjusted medications accordingly.

In both these cases, the unmarried daughters who consented to treatment belonged, respectively, to the Flahin Bedouin and Abid Bedouin, these ethnic subgroups having traditionally been conceived of as lower caste. In contrast, none of the True-Bedouin agreed to having their unmarried daughters treated either as in- or out-patients. Regardless of social status, the prospect of treating an
unmarried daughter was daunting; but, as in the case of male utilization, there tended to be an inverse relationship between the degree of socio-economic standing and the readiness to utilize modern treatments. In all cases, family decision-making was based on the culturally-based, negative attitudes towards psychiatric interventions; of anticipated problems in the daughter’s marriage prospects if she were labelled mentally ill; of consequent fear of the shame that could be brought to the family name, in the event of such labelling; and of a pervasive suspicion of outside intervention, which ultimately is held to threaten the family’s honor.

Among all unmarried female patients, it should be emphasized, the family, as distinct from the patient herself, was responsible for the major utilization decisions. (This was clearly different from male utilization patterns that allowed more decision making by the individual patient.) Among married women, family decision-making also was important, but utilization patterns showed less reliance on the male family members as chaperons. There were notable differences, in broad terms, between the group of married women whose husbands had only married once, as compared with the group whose husbands had more than one wife. Most of the latter group continued with the modern psychiatric system. It is probable that they were less inclined to terminate, since their husbands had already more than one wife; thus, the threat of a second marriage had previously been carried out. Most of the former group, in contrast, terminated the modern system by the first or second
psychiatric session. In my opinion, most women left the impression that marital therapy would have been indicated; none, however, pursued this option. In all instances, women were concerned that the label of psychiatric illness could be used, by their husbands or his family, as leverage for him to marry again.

Differences in Practice Approaches Between the Modern and Traditional Mental Health Systems

The patients who utilized both systems simultaneously faced two different realities. The first was the psychiatric system, represented by psychiatrists who had a different culture and followed a scientific system.

It should be noted that the Russian psychiatrists have only recently emigrated from a society where psychiatrists had a comparatively lower social status than in Israel or the West. In the Soviet system, moreover, psychiatrists frequently were representatives of the state -- and thus psychiatric practice was not always trusted. The health care system in the former Soviet Union lacked available drugs and diagnostic equipment. Many, moreover, felt that this situation actually deteriorated during the period of perestroika (Bernstein & Shuval, 1994).

Many might have felt that their current positions were somewhat tenuous. They had recently arrived to a country that had no shortage of physicians; theirs might have been a relatively sub-
standard education and experiential background from some of their colleagues; they were new to the country, unfamiliar with its health care system; many had few professional contacts; some lacked other forms of social support; many encountered language, cultural, and other forms of barriers. The researcher inferred, among the Russian psychiatrists, a sense of considerable gratitude for their current positions, and an overwhelming need to avoid making suggestions that would change or improve the mental health institutions in which they worked. They were often assigned patient loads that might have been considered by other colleagues as less than desirable (Shuval, 1985). On balance, then, the Russian psychiatrists, in their low status, and in their relative lack of empowerment, were not well placed to improve the standards of health care which the Bedouin patients received.

And to be sure, there were problems with the services rendered to the Bedouin patients. To begin with, the Russian psychiatrists did not speak Hebrew well, nor did they speak Arabic; the other two psychiatrists also did not speak Arabic. In a general sense, the psychiatrists were not familiar with the Bedouin culture at all. Such a situation led to misunderstanding, misinterpretation and in some cases misdiagnosis and mistreatment. This, of course, disappointed the patients and even increased their anger with the modern system (Bach-Y-Rita, 1982; Gomaz, 1982; Heck, Gomaz, & Adams, 1973; Lefley, 1986; Marsella, 1993).

The encounter between the Bedouin patients and the psychiatrists was characterized by two opposite perceptions. The
patients believed that supernatural power caused the diseases and they also suffered physically; they expected that the role of the psychiatrists was to treat the physical pain in their bodies. In contrast, the psychiatrists believed in science and not religion or spirits; though not uninterested in physical symptoms, they wished to diagnose mental disorders and to consider psychosocial etiology (Ruiz & Langrod, 1976a). As mentioned earlier, when a male patient said to a Russian female psychiatrist that he is married with Jinnih, she started to laugh at him, saying that there is no such thing. Such situations led the patients not to reveal to the psychiatrists their belief systems and their perceptions of their situation. They knew that the psychiatrists and the GPs did not believe in the traditional system and even laughed at it (Abdul-Menaim, 1991).

The psychiatrists often focused on the physical symptoms that the patients presented and did not try to understand what was behind the somatic symptoms. Like psychiatrists working with other traditional populations, they also tended to treat the patients as bodies, rather than as persons (Clark, 1993). In this sense, their "quick fix" practice was similar to what Beiser has described in young psychiatrists practising in India, who often dismissed indigenous explanations, in their enthusiasm for "rigid" and "authoritative" medical principles (1985). The frequent need for a translator, as well, tended to interfere with the process of direct communication. In many instances family members acted as translators, additionally inhibiting the patient's discussion of
familial functioning as it related to the disease. This was exacerbated by patients not expecting psychiatrists to undertake any form of talking therapy, other than what related to prescribing medications or giving physical examinations. Patients were therefore reluctant to divulge information which they felt was personal, unrelated to the treatment, and inappropriate to convey to someone outside of their culture. As one patient indignantly remarked to her psychiatrist, just before terminating the treatment, "What is the connection of your questions to my disease?" For these reasons, it is not surprising that misunderstandings, misinterpretations, and premature termination of the treatment by the patient (Lipton & Simon, 1985), were all common.

Not surprisingly, the psychiatrists frequently had difficulties in understanding the patients' symptoms; they almost never paid attention to the patients' dreams. They misinterpreted the patients' delusions and the sort of hallucination presented by some of the men and female patients, which were based on the culture and the patients' belief systems (Al-Issa, 1977; El-Islam, 1985; Murphy, 1982). The psychiatrists interpreted the patients' symptoms as if they were dealing with Western patients, without taking into account the cultural diversity of the patients (Chiu, 1994; Good & Good, 1986). The psychiatrists' treatment became just symptomatological treatment, while the basic conflict or problem remained; thus the patients sought help from the traditional
system. Such a situation raises the question of the effectiveness of the psychiatric system in treating Bedouin patients.

The healers, in contrast, were culturally familiar. The Arab healers from the Gaza Strip were Muslims, spoke the same language, and shared the same belief systems as the Bedouin patients about supernatural powers and the etiology of the diseases (Kiev, 1972; Prince, 1976; Ruiz & Langrod, 1976a; Torrey, 1972a, 1972b). The healers focused on the etiology of the disease and tried to explain to the patients what had happened to them and why they suffered. The healers emphasized that something from outside caused the disease. Often the healers message was "Hada men Amaal Al-Khabeith" (This is from the spirits' actions), or "Shr" (sorcery). In addition, the fortune tellers said, "Banaat Alharaam," meaning "there are a lot of bad females [who do such things]." The healer's message to the patient was "You are OK, but you cannot stand up to supernatural power to prevent the disease." The healers and the patients believed that the spirits were stronger than human beings; thus, if the patient was attacked by the spirits directly or indirectly by the sorcery or by another females' actions, it is not the patient's fault. In addition, the healers believed that illnesses are basically caused by God's punishment for sins committed. Or sometimes they explained the disease as God's will, "Aradat Allah" or "Hakmat Allah" (God's judgment). The belief in God's will as a fatalistic determinant of events is quite common among Muslim Arabs (Al-Krenawi, 1993; Caliph, 1989; El-Islam, 1978; Haj-Yhiah, 1984). In such cases, the cause of the

The psychiatrists, on the other hand, did not explain to the patients anything about the etiology; they focused on the obvious symptoms to reach the diagnosis, and did not inform the patients of it. When the patients asked for a physical exam, the psychiatrists often answered, "You have nothing wrong in your body, and according to the GP's letter you have no problems; all you have is problems or difficulties in your life." In other words, the psychiatrists' message is "internal locus of control." Further, psychiatrists used professional terminology during their encounter with the patients, whereas healers used cultural terminology with which the patients were familiar. In the initial stages of the treatment, the healers often gave some explanation as to their understanding of the presenting diseases. Torrey (1972a) and Bergman (1981) made the point that "naming" what is wrong with the patient in itself has a therapeutic effect. Such diagnoses enable individuals to understand their conflicts and symptoms in culturally standardized ways.

The psychiatrist-patient relationships were formal and inflexible. The first session often took about half an hour; after that, the psychiatrists reached the diagnosis; from the second session on, the encounters often lasted about 10-15 minutes. The psychiatrists wanted to know how the patients felt; they asked if the patients took the medication as prescribed. They treated the
educated male patients respectfully and differently from females and uneducated male patients. Psychiatrists did not pay attention to the females who were waiting for them in front of their offices. They often went for breaks or talked with other colleagues while a female patient waited her turn. When a patient asked the secretary about the psychiatrists, often he or she got the message, "Wait. Anyway, you have nothing to do." I felt that the female and the uneducated patients were treated without respect. One of the psychiatrists spoke to the female patients who were waiting for treatment and talking together, "Do not talk here; go out of the clinic"; she appeared to be angry with them. The psychiatrists, however, did not allow themselves to behave like this with the educated, and those who were familiar with the modern system. So psychiatrists' relationships with patients were quite formal; with females, there were indirect relationships.

In addition, mistranslation of idiomatic expressions, traditional beliefs, the presentation of organic complaints for which the physicians, with laboratory tests, find nothing wrong, and the repeated visits of Bedouin to different doctors in search of an illness label exemplify miscommunication and differences in explanatory models (cf. Klieman, 1980). Throughout the encounter between the Bedouin patients and the psychiatrists, there were mistranslation; translators for the patients translated literally what was said. This was often very different from what the patients meant.
In contrast, the healers treated the patients as part of their families. In these familial relationships with their patients, they visited them and asked about them, which of course increased trust and faith in the abilities of the healers. The patients felt free in the healers’ houses; they drank coffee and tea during the treatment process. The former patients helped the new referrals by giving them something to drink and taking care of them in terms of seating. At lunch or supper time, patients would eat together; they often brought Frahah (food) or sweet things and shared them with new referrals. There was no identification of money interfering with the therapeutic process. Healers do not ask directly for money from the patients, nor do they turn patients away if they are unable to pay. Since their mission is seen to be religiously-derived all patients must be initially received. There is, however, a social expectation of at least a small payment.

As well, much of the healers’ treatments focused on dreams, feelings of fear, anxiety symptoms such as breathlessness, lack of energy, or headaches; dream analysis was particularly relied upon over the course of treatment. Patients often described their personal difficulties via proverbs, which resonated with the traditional healer but often seemed foreign to the modern clinician. Female patients, in particular, frequently used similes and metaphors common to Arab culture, to indirectly convey highly subjective feelings. True, as several researchers have argued, “talking therapy” or psychotherapy is not popular among Arab patients (Banawi & Stockton 1993; Gorkin et al., 1985; Ibrahim &
Ibrahim, 1993). But, one should also emphasize, contrary to many researchers' conclusions (El-Islam, 1969; West, 1987), illiterate Arab patients are quite capable of thinking abstractly and of conveying these thoughts to others (Racy, 1985). It also should be noted that all types of traditional healers -- save for Koranic healers -- frequently guessed at patient's symptoms; this was done with remarkable discernment. As one male patient later commented, "I was surprised how the healer knew my symptoms exactly." Such a process invariably increased the patient's trust in the traditional healing system.

An important factor in increasing faith and expectations and the likelihood of a successful outcome of treatment is the induction of the patient into the process of being cured. Salzman (1984) wrote that the utilization of the patient's positive powers, in particular the will to cooperate and participate, enhances the therapeutic process. Bergman (1981) discussed the rituals of indoctrination as important in creating for the patient an atmosphere of expectancy to be cured. Whether it is a healer's connection with God or the psychiatrist's connection to scientific theory, faith is an important factor (Calestro, 1972; Frank, 1973; Kearney, 1974; Kiev, 1964; Torrey, 1972b). The therapeutic effects of treatment in the healer's home with its aspects of Islamic religion and traditional healing methods (reading verses from the Koran, burning incense, communicating with the spirits) undoubtedly increase the patient's willingness to cooperate and expectation of relief (El-Azayem & Hedayat, 1994; Kiev, 1968; Torrey, 1972a).
Both systems provided social networks for the Bedouin patients. In the modern system, the female used the opportunity to be in the hospital and to meet other females from different tribes and areas; they visited relatives and friends who were hospitalized in Soroka. The females became friends and shared ideas about their diseases and their difficulties. They exchanged information related to the traditional system and helped each other. In addition, they met Jewish patients who shared the same background as the Bedouin, such as Moroccans and the Yemenite. They helped each other in terms of the traditional system, and the Jewish patients helped them in terms of their rights to social services. Male patients were organized according to national or neighbourhood ties in subgroups. In the traditional system, the patients spent more time together. In this situation, they created social networks, females as well as males. Male patients felt free to share their difficulties, while in the modern system they were hesitant. I think the issue of stigma bothered the males in the modern system, whereas there were no stigma attached in the traditional system.

The traditional system provided more opportunities for social support and social networks, because in this system there were people who were present who were not patients, and they participated in the rituals. As well, throughout the ritual performances, the patients had opportunities to meet patients from different areas that they did not know before. This system provided psychological and social support, at the individual,
group, family and community levels. There was support by the healers and the patients who were present in the healers' houses as a spontaneous group, and by the family and other relatives who were involved in the treatment process or rituals (Al-Krenawi, 1992; Prince, 1976). This contributed essentially to the efficacy of treatment (Haines & Hurlbert, 1992; Turner & Marino, 1994). The psychiatrists, in contrast, did not pay attention to the natural methods being used by the patients (Al-Krenawi & Graham, in press; Escobar & Randolph, 1982; Specht, 1986; Timms, 1983; Waltman, 1986).

In the modern system the patients were isolated from their natural environment. The psychiatrists involved the patient's family in case the patient was female; her relatives became the interpreters. The male patients generally spoke Hebrew. The psychiatrists showed little cultural sensitivity. In contrast, in the traditional system, the patients were familiar with everything, and if some of them (male patients) were not familiar with something, they got help and explanation from their families and the healers. The healers often treated the patients in public in front of all the patients. As was acceptable in the Bedouin society, there was a separation between males and females; females sat in the female side, and males sat in the place where the males usually sat. It was acceptable also to talk to the healer individually. The Sheikhs treated the male patients individually, and females had to be accompanied by their male relatives. The healers were able to form an alliance with one of the most powerful
members of the patient's family, often the mother, father, or eldest son. The psychiatrists, on the other hand, were apparently not aware of this important issue; in any case they did not -- or could not -- address it.

As several researchers have observed, the patient's family occupies a central position in the diagnostic and therapeutic process in the traditional system (Hajal, 1987; Skultans, 1988; Vontress, 1991). According to the healers such acts were very important for the patients and the visitors. One of the Sheikhs said, "as Muslims we have to follow what the prophet said in this matter." The Prophet Muhammad asked us to visit the sick, feed the hungry, and procure the freedom of captives (Aomr, 1989). The healers encouraged the patient's community to get involved in order to support him or her during the course of the disease. In other words, this is so-called "community therapy" (Spiegel, 1983). The healers often understood their patients' difficulties better than psychiatrists do because the healers live in the same neighbourhood and know it well. The healers generally treated all the patients equally regardless of gender, education and social strata. However, the amulet writers spent more time with educated patients in order to convince them that their treatment was effective. The Sheikhs and the Dervishes stated that all human beings are equal before God. The healers commonly mentioned the Prophet Muhammad, who treated people equally. They often mentioned an Islamic saying: "there is no difference between human beings; the only difference is the degree of belief in God." Another healer gave
this aphorism based on tradition (Hadith), "human beings are as equal as the comb's teeth."

From my point of view, the patients were treated with instrumental approaches in both systems: the psychiatrists treated them by medication, and the healers treated them by amulets, instrumental advice such as rituals and other concrete methods. In addition to receiving instrumental advice, the patients were treated psychologically (spiritually) in the traditional system, at different levels. From the data, we can see a process of catharsis, abreaction and "venting" at the individual level; we find elements of group therapy in the social processes at the healers' houses and throughout the ritual performances. In addition, the patients gained their families' and the extended families' support through the course of disease (Al-Krenawi & Graham, in press; Kahana, 1985; Messing, 1959; Prince, 1976; Schindler, 1993).

Kiev (1968) described elements of the "universal therapeutic"; these include the faith of native healers in their system; emotional aspects of psychotherapy; the role of group forces; influences of therapist; and psychological catharsis. The literature has highlighted other fundamental features such as a shared worldview of healer and help seeker; a warm personal relationship between them; high prestige of the healer; hope of people seeking help; and the power of suggestion (Calestro, 1972; Meyer, Blum, & Cull, 1981; Prince, 1976).
As mental health workers, we expect such elements to be present in treatment in the modern psychiatric system. Nonetheless, we have seen that the healers understood the patients' psychology, used instrumental and spiritual treatment, and components of traditional psychotherapy (Baasher, 1967). The healers were found to have integrated instrumental, emotional or so-called "psychological therapy." The Bedouin patients, like other traditional communities, often expected concrete treatment or instrumental advice (Minuchin-Itzigsohn et al., 1984; Pliskin, 1987). Therefore, as reported by the patients, the healers' treatment was more effective than the psychiatrists'. One can conclude that it is time to rethink and to learn the healers' strategies for dealing with patients from traditional societies (Bulus, 1989; Forssen, 1978; Green & Makhulu, 1979; Rappaport & Rappaport, 1981; Ruiz & Langrod, 1976a; Seguin, 1974; Torrey, 1972b).

Other investigators have voiced similar ideas: psychiatrists and general practitioners can learn from the healers and collaborate with them (Bilu & Witztum, 1993; Chi, 1994; Donald & Hlongwane, 1989; Edwards, 1986; Ezeji & Sarvela, 1992; Harding, 1978; Heilman & Witztum, 1994; Ikema & Hitoshi, 1979; Katz, 1982; Lambo, 1978, 1974, 1966; Meketon, 1982; New, 1977; Rappaport & Rappaport, 1981; Razali, 1995; Schwartz, 1985; Wessels, 1985; Yoder, 1982). The World Health Organization (1975) has initiated a collaborative effort to develop strategies for extending mental health care in rural areas in a number of developing countries.
Ruiz and Langrod (1976a), Delgado (1979), and many others have described involvement of folk healers in mental health programs as a means of providing culturally appropriate care for their patients. The use of bicultural translators and intermediaries by modern practitioners with culturally diverse patients should be explored. Crucial, also is the dissemination to doctors and social workers of more knowledge of the procedures used in Arab folk healing in order to broaden our repertoire of treatment modalities.

Summary

The process of using the traditional system did not vary according to social caste as did usage of the modern system, particularly among the men. It was found that patients also had greater ability to appreciate prognosis and etiology in the traditional system, as compared to the modern. Within the traditional system, patients also were less disappointed with the rate of change; this can be explained in terms of their underlying belief in God’s justice and goodness.

Religious factors, then, played a strong role in determining usage of the traditional system (Madsen, 1964; Umoren, 1990). Female patients, prior to the onset of the disease and during the course of treatment, tended to have been more religiously observant than their male counterparts; however, a significant increase in male religious observance over the course of the illness also was
noted (Al-Issawi, 1988; Al-Juhri, 1991; Al-Krenawi et al., 1995). Among both sexes, religious feelings, interpretations of distress and invocations were commonly expressed.

Present findings showed significant differences between male and female patterns of religious expression over the course of traditional treatment; for instance, males’ religiosity was often linked with expressed fears of death. Living in a patriarchal society, Bedouin males, it must be remembered, have a number of fears associated with loss of control or vulnerability. They tend, for instance, to be fearful of women’s magical powers as expressed by such forms of sorcery as magic beads and stones (Bar-Zvi, 1988; personal communication with amulet writer & fortune teller, 1994). The females also are more familiar with, and are more frequent users of, traditional Arab healing systems (Al-Issa, 1989; Al-Sabaie, 1989; Dickson, 1949; Nelson, 1974). Thus as patients they tended, more often than the men, to invoke traditional forms of assistance, and to be more familiar with them.

Men and women often had different perceptions of the causes of their ailments, during the course of traditional treatment. The educated men, and those with greater wealth, were apt to think of etiology in terms of Divine Will (Mn Allah) and Divine Punishment (El-Islam, 1994); the lesser educated and illiterate men, as well as those with less wealth, were more likely to focus on the spirits (Al-Jinn) as causes. The present male patients, like their counterparts in other Arab cultures, tended to show no association between levels of education and inclination to embrace supernatural
explanations of mental illness (Caliph, 1989; El-Islam & Malasi, 1985; Talat & Adli, 1982).

Women also emphasized the spirits' causes, but tended to frame these in the context of human agency. Many saw sorcery as an important etiology. Several patients experienced the evil eye; that is, they were the subject of another's envy, and consequently suffered psychiatric difficulties (El-Islam, 1978). Women also experienced another cause of distress, the Kabsa, a phenomenon common to Arab society (Boddy, 1989; Early, 1993; Inhorn, 1994); the term is literally translated as a "raid" or "surprise attack", in which a woman recipient is forced, by evil spirit possession due to another woman, into a state of infertility or sickness.

Although male patients were similarly minded, female patients were more inclined to believe that improvements in their situation were the result of the traditional intervention. For both sexes, traditional methods had particular effectiveness in their use of dream interpretation.

Another reason for the success of the traditional system was because the traditional healers' frames of reference are strongly ecological. They addressed virtually every aspect of a patient's life, since all were perceived to be connected with one's religious formation (Graham & Al-Krenawi, in press; Kiev, 1964a; Prince, 1976; Torrey, 1972b). The structure of traditional healing relationships is also based on the psychological needs of patients to submit to a parent figure (El-Islam, 1967).
Poor relationships between patients and psychiatrists vitiated the effectiveness of modern treatment. These relationships tended also to be formal; over the course of follow-up with the researcher, most of the examined women patients, and many of the male patients, could not even recollect their psychiatrist's name.

The modern system, one may conclude, was relatively incapable of gaining entry into the patient's culturally-derived frame of reference, which in turn inhibited patient communication to the psychiatrist, and the striking of a therapeutic alliance of a strength or depth comparable to that of the traditional healer-patient alliance.

Although it was not as successful as the modern system in addressing physical complaints, the traditional system nonetheless was more effective in improving non-physical symptoms such as nightmares and delusions.

In contrast to the modern system, the traditional system emphasized an external locus of control -- that is, a transcendent supernatural power; the healers did not, generally, suggest to the patients that their problems were their own fault (Grotberg, 1990). The psychiatrists' insistence of an internal locus of control (aside from accident and trauma), was not consistent with the patient's view of the modern system as being primarily oriented towards the medicinal treatment of somatic diseases. Patients were not receptive to being told they had personal, emotional or family problems.
In summary, there are a number of reasons for the patients' different beliefs and perceptions about the traditional system as compared with the modern:

1. Male patients perceived the modern system as treating the Al-Jisam (body), and the traditional treated the Al-Roah (spirit). The female patients perceived the modern as a system for the body, and they expected a medical examination; the traditional system was expected to deal with sorcery, the evil eye and spirits' action.

2. As the psychiatrists pointed out, the patients had no organically based physical problems. So the psychiatrists say, "You have no physical problems." The patients had already gotten this message from the GP, but hoped the doctors of the psychiatric clinic would find and address the physical problems.

3. The expectations of the Bedouin patients were thus not fulfilled by the modern system; this led to disappointment with the modern treatment.

4. As the patients reported, the nonphysical symptoms had been expelled or removed by the traditional system.

5. The patients and the traditional healers shared the same culture and the same perception of the diseases or problems.

6. The healers took into account and utilized cultural concepts that are vital in the Bedouin society, such as the honor of patients' families and extended families.
In addition, the healers' terminology was based on the patients' and the healers' culture (Al-Krenawi, 1992; Ruiz & Langrod, 1976a).

7. The patient-psychiatrist relationships were characterized as formal; there were different languages and cultures, leading to misunderstandings. The psychiatrists did not utilize Bedouin cultural concepts and their terminology was based on Western concepts with which the Bedouin patients were not familiar.

8. A third party (the translator) participated in the psychiatric treatment process, which of course disturbed the patients. This often happened in cases where the patient was female.

9. In the traditional system, females did not need the help of men; so they had a chance to meet the healers in groups or in individual conversation. Thus females could express their difficulties without disruption.

Finally, modern practitioners treating the Bedouin ought to consider traditional systems as one set of utilization choices within a broad spectrum of medical pluralism. There are, after all, numerous documented cases of psychiatrists referring patients who do not respond to western therapy to traditional healers, with positive effect (Jilek & Todd, 1974; Schwartz, 1985; Wessels, 1985). And more recently still, traditional and western medical epistemologies have been integrated in appropriate cultural context (Chi, 1994; Edwards, 1986; Suryani & Jensen, 1992). In particular,
where there are cultural differences between patients and modern practitioners, traditional system can be effectively used as an alternative to, or as a supplement with, the modern system.
Chapter Nine

CONCLUSION

Because the ethnographic data, their interpretation and discussion have been extensive, this concluding chapter begins with a summary. The findings regarding the perceptions, feelings, values, and approaches to treatment of the patients, psychiatrists and healers represent the main contribution of the present study. The next section outlines principles for modern practice with a Bedouin population, based on the preceding investigation. The role of social workers in a primary health care centre is argued in the third section. The links of Islam and social work are sketched in the fourth section, followed by directions for further research.

Summary

This study has joined a small body of research on the dual use of traditional and modern healing systems. With Edwards (1986), it is one of the few examinations of how traditional populations actually go about using both systems. There is, of course, a wide concurrence that the modern system ought to incorporate aspects of the traditional (Meketon, 1982; Schwartz, 1985; Wessels, 1985), particularly in the context of treating traditional populations (Bilu & Wiztum, 1993; Bulus, 1989; Daise et al., 1992). But this study is one of the few pieces of research that has grappled with
the issue of how contemporary practitioners might begin to integrate the two mental health systems. Two aspects, as the study points out, that are particularly salient to a Bedouin population are the primacy of family involvement, and of a religious basis of healing.

The Bedouin patients in the present study utilized the traditional healing system in parallel with the modern psychiatric system. The patients developed strategies for dealing with both systems, and benefitted from both, regardless of their perceptions and explanations of the diseases or problems. In order to explain their illness, the patients provided several traditional explanations, such as sorcery, the evil eye, spirits' activities, or punishment from God for sins. Female patients connected their illness with supernatural and human agents, and the majority perceived their illness as a result of sorcery or the evil eye. In contrast, many male patients, especially the educated and wealthy, linked their illness to supernatural power, spirits' deeds, and/or God's will. These explanations helped patients understand their suffering and account for it in a lived world subject to the providence and will of Allah (Sia & Sia, 1994).

Religion played an important role in the lives of the patients as well as among their families. For many of the male patients, however, religion was not in the foreground of their everyday experience. Nevertheless, regardless of their social class or education, they all took up religion practices after the illness emerged. Female patients tended to practice their religion before
the illness appeared. In all cases, regardless of gender, religious observance helped the patients to feel close to the supernatural power represented by God, His Prophet and Holy Persons (healers and saints). When diseases emerge, a Muslim person feels that his or her life is threatened by death; this increases general death anxiety. The individual often also attempts to replace sins with good deeds because of the fear of punishment in the afterlife (Abdel-Khalek & Omar, 1988; Templer, 1991). Thus patients reported that religious rituals--reading the Koran, mentioning God, His Prophet and Holy Persons--were powerful resources assisting them to cope with their illness.

The patients perceived the traditional system as the best way to treat sorcery, the evil eye, spirits' activities, and spiritual treatment. According to psychiatric concepts, this system treats behavioral and emotional symptoms. In contrast, the modern system treats mental disorders and physical symptoms. When the patients referred to the psychiatric system, they perceived it as a continuation of primary medical care, providing specialized treatment for their symptoms. The patients initially had high expectations from the process of referral to the Soroka centre. Many patients, however, found that the professionals in the psychiatric system could not understand the full range of their needs; the system did not meet their expectations, and they were disappointed. The psychiatrists, facing a cultural chasm, were unable to address patients' expectations; hence there was a widespread failure to form therapeutic alliances leading to
successful outcomes. Some patients accordingly left this system, and others decided to utilize both systems concurrently.

The patients' perceptions of their diseases and symptoms were culturally and religious based. Physical complaints are a socially legitimized way of expressing personal and interpersonal problems. Consequently, the Bedouin patients with depression or anxiety commonly present in medical settings with a variety of somatic complaints, such as pain in all the body, fatigue, or shortness of breath; such symptoms are similar to those reported for other Arab mental health patients (Bazzouzi, 1970; El-Islam & Abu Dagga, 1992; Gorkin et al., 1985; Racy, 1980). If the psychiatrists were aware of such information, their training and the vast cultural and linguistic differences rendered them unable to act upon it, to investigate beyond symptoms. Gender differences also were identified, in terms of perceptions, familiarity with both mental health systems, and the way of managing both treatments simultaneously. In this regard, the patients' families played an important role in helping the male and female patients to undertake treatment in both systems.

The Bedouin patients expressed their emotional difficulties by powerful proverbs. The proverbs connected basic cultural and linguistic patterns with minute details of an ongoing social interaction (Briggs, 1985). These sayings are cultural tools through which the patients express their emotional and social distress, by way of story or maxim. Yet the power of a proverb is lost in a situation of cultural and linguistic disparities.
Patients also communicated through their body, by using hands, facial gestures, and body movements during their encounters with the psychiatrists. These non-verbal communications, as well as proverbs, have therapeutic aspects; both need to be taken into account in psychotherapy (Brant, 1993; Marsella, 1993; Rubin & Niemeier, 1992).

The Bedouin do not see themselves primarily as individuals but rather, as members of groups, especially family groups, extended family and tribe (Al-Krenawi et al., 1994). Bedouin adolescents shape themselves to fit their family environments on the basis of a cultural imperative that requires individuals to subordinate themselves to their families and tribes (Elkholy, 1977). Because of such familial relationships a patient's disease or problem becomes a concern of the whole family. Not surprisingly, the process of help-seeking almost always includes the patient's family (Meleis & La Fever, 1984).

The Bedouin culture is highly patriarchal. It is also characterized by authority, and a rigid structure of society, tribe, extended family, and nuclear family, systems which function under the will of a supernatural power (God). There is an Islamic tradition of raising children to respect parents and those who are in charge (Jamal, 1974). Islam emphasizes the importance of treating parents respectfully and of obeying their wishes (Koran, Al-Isra, v. 22-23); there is an expression among Muslims that the parents anger originates from the anger of God. The issue of authority is a particularly important factor for the person who
lives in such a society. The individual has to obey the rules determined by these structures. These strongly influence the individual's perceptions and explanations of the disease as connected with supernatural power, for the individual is dependent upon the above systems.

Muslims believe that the doctor's functioning depends upon the will of God; the human doctor is merely an agent; the real doctor is God as announced by the prophet Muhammad (Aomr, 1989).

From the patients' perspectives, and my participant observations in both systems during the treatments, practitioners in the traditional healing system generally shared cultural and religious perspectives with the Bedouin patients which the psychiatrists did not. The patients and healers, sharing the same world view, were able to communicate directly and to understand each other; the parties established a sort of familial relationship, and thereby a therapeutic alliance. In addition, the healers' orientation was not to blame the patients; the healers emphasized the issue of "external cause," an etiology of Divine will, as opposed to human agency. Such statements were often said in front of the patients, their families, relatives and other who were present. Once such an attribution was made the patient felt relief. Thus the healer as a respected authority is the one who can determine that something from outside causes the patient's disease or problem.

In the initial stage of the treatment in the traditional healing system, the healer often gave an explanation of the
patient's disease and "named" what was wrong with the patient. Such a situation increases the patient's trust and faith in the healer's supernatural ability, and creates for the patient an atmosphere of expectation of a cure (Bergman, 1981; Graham & Al-Krenawi, in press; Torrey, 1972b). The healers know how to deal with their patients based on the patients' perceptions, belief systems, culture and religion (Bulus, 1989; Hajal, 1987). The diagnosis process also enables individuals to manifest their conflicts and symptoms in culturally unstigmatized ways. While most Western techniques of psychotherapy attempt to establish a good rapport with the patient, this is not always the case in the traditional healing procedures. In the initial stage of many traditional treatments, the Bedouin patients expect an active, authoritarian role on the part of the healer, while the patient takes a passive, dependent stance (Al-Krenawi, 1992; Higginbotham, 1977).

All traditional healers under examination were family-oriented, seeing the patient as part of his or her family (Hajal, 1987); they treated the patients within their family and cultural context. It also should be noted that individual therapy often took place following the patient's request. At the group level, all patients who were present in the healer's house shared their difficulties and became supportive of each other. This led them to build a wide social network of supportive relatives. Another form of group intervention occurred when the healing rituals took place in the healer's house, for example the Dhikr or visiting a saint's
tomb. These strategies establish a therapeutic community for the patients, including his or her extended family and the tribe (Al-Krenawi & Graham, in press; Smale, Tuson, Cooper, Wardle & Crosbie, 1988).

Thus, from a psychiatric or psychotherapeutic standpoint, the traditional healing system is effective because it provides what the modern system labels as 'catharsis' and 'ventilation.' Moreover, several approaches of therapy such as individual, family, group and community were observed in the traditional healing system (LaDue, 1994). As we see throughout this study, the patients reported that the traditional system was effective and helped them to deal with their emotional difficulties. It was unfortunate that the mental health professionals generally ignored natural forms of social support.

As this study has emphasized, the psychiatric system has provided a potential opportunity for promoting co-existence between Arabs and Jews in the Negev. The patients have a common issue, this is the illness. However, the illness or the problems led the patients from both societies to share their difficulties and to help each other. Surely the treatment of mental problems in a modern context, but with a sensitivity to the Bedouin population and its traditional modes of helping, provides a very good opportunity for the Jewish and Arab cultures to learn about one another, and also about the nature and treatment of mental illness.

The phenomenon of dual use exists in numerous societies around the world, and even in modern countries such as the United States,
Canada and Israel (Al-Krenawi, 1992; Bilu & Witztum, 1994a, 1994b; Heilman & Witztum, 1994; Waldram, 1990). There is much evidence that it also is deeply rooted in the Arab culture (Abdul-Rahman, 1991; Al-Issa, 1990, 1989; Al-Juhri, 1991; El-Islam, 1994, 1982; Al-Rady & Al-Mahdy, 1989; El Sayed et al., 1986). According to the published reports, dual users rarely see any difficulties in such utilization patterns, even where both systems are inherently hostile to each other, as in North America (Waldram, 1990). The Bedouin patients in this sense faced difficulties in the first stages of the treatment, in both systems. However, their families helped them to manage both treatments.

In the present project, all subjects under examination utilized the traditional healing system during the course of disease(s) or problem(s). From the patients' perspective, the traditional system was both familiar, and potentially effective in responding to certain types of mental health problems. The patients, in like manner, were capable of respecting the modern system. Its use of medications, for an example, was widely sanctioned -- if not expected. The modern system is seen as particularly effective in treating somatic complaints; and the traditional system in treating problems relating to the spirits, sorcery, and the evil eye. However, the principal drawback of the modern system, however, was its lack of cultural sensitivity. And in like manner, the principal advantage of the traditional system was its cultural sensitivity. And so, in the paradigm of integration, is it not possible to harness the positive aspects of
both systems, in a process of dual use?

Taking into account this possibility, in the next section I propose principles of intervention with Bedouin patients, and in later sections discuss the role of the social worker as a cultural intermediary within a primary health care centre and a modern medical system. When a disease or problem emerges, the Bedouin patients, in my opinion, should have the opportunity to meet several practitioners, namely, GPs, healers, psychiatrists and social workers.

GPs often treat physical symptoms; they carry out the medical examinations to ascertain if the patients have physical disease, and whether they can be freed of it. GPs who work in the Bedouin primary health care often have no time to discuss the patient’s personal life; they focus nearly exclusively on physical symptoms. Such doctors become like their patients--somatically oriented--exacerbating a tendency to overlook issues of sociocultural awareness and gender sensitivity (El-Islam, 1982; Maoz et al., 1992; Walker, 1995). Since in a primary health care centre (hereafter, "PHC") somatic problems are the most common reasons for visits, there may not be sufficient opportunity for psychological problems to be discerned (Verhaak & Tijhuis, 1994). When both the doctor and patient share the same somatic definition of the situation, psychological problems are likely to be ignored and hence not treated (Verhaak & Wennink, 1990). The patients in this stage, when they became disappointed with the GPs’ treatment, seek help from the traditional healing system in parallel, until the
referral to the psychiatric system, if this in fact ever takes place.

In the psychiatric system, many patients terminated the treatment early. As well, there may be many patients who refused to refer to the psychiatric system when they realized its mental illness connection before the referral stage took place (Suleiman et al., 1989). In many countries, mental illness is regarded as a major social stigma that casts the sufferer and his or her family in a highly negative light (Brodsky, 1988; Fabrega, 1991; Gaines & Famer, 1986). This attitude is pervasive in the Arab world, in which psychiatric symptoms may be denied or attributed to such causes as "bad nerves" or "evil spirits" (Dubovsky, 1983; Zaior, 1978).

It must be noted that the traditional healing system continues to develop over centuries. The traditional system responds to changes which occur in the surroundings where they exist. It takes different modes of function but the principles are similar. In this sense, the system's evolution and development is similar to that of the medical profession. However, we also can see that the evolution of the healers who treat "mental illness" according to the Koran is a response to cultural change and the development of the modern health systems. Therefore, the traditional healing system continues to function as a vital answer to the patients' needs, but it takes different variations to fit with current social, political and cultural contexts (Waldman, 1990).

In sum, the conceptual framework on which healing systems are
formed is closely linked to cultural world views. Thus the modern-scientific orientation of the dominant culture (Western) supports a form of therapy including a long verbal investigation of the self with the goals of personal insight. Within the practice of the healers, there is an adherence to traditional Bedouin spiritual and religious beliefs. The goals of the treatment, relief of suffering and social integration, are therefore reached through manipulation in a religious realm.

New Principles for Modern Practice with a Bedouin Population

Many aspects of modern mental health practice with a Bedouin population, it must be stressed, require improvement. The first of these is the striking of a therapeutic alliance. The psychiatrist has considerable potential for making in-roads by way of medications. Medications, as a modern form of treatment, it must be stressed, have considerable sanction in Bedouin culture (Al-Krenawi et al., 1994). Patients enter modern therapy with the expectation of being treated medicinally. Just as medications foster therapeutic alliances with Western patients (Burgess, 1993; Sarwer-Foner, 1993; Southwick & Yehuda, 1993), prescriptions in a Bedouin context furnish an excellent basis for striking a therapeutically beneficial relationship between the clinician and the patient.

Secondly, in order to maintain the alliance, modern health and social services practitioners need to gain a greater knowledge of,
and sensitivity towards, traditional modes of helping and the Bedouin culture (Foulks, 1980). Doctors and social workers need to learn more about informal community resources, cultural perceptions, belief systems, and practices (Beiser, Gill, & Edwards, 1993; Rankin & Kappy, 1993). This knowledge would provide a clinical basis for mutual trust, understanding, and respect. It is also an important potential tool for gaining entry into the patient's main problems or conflicts, as frequently expressed by way of bodily symptoms, proverbs, and non-verbal language. The specifics of intercultural training, however, are not the subject of the present research.

The third step, the clinician's need to develop their contextual understanding of patients, their ability to read patients' ecological maps, involving ineffably subtle aspects of Bedouin culture: power relationships within family structures, the implications of familial interdependency in all aspects of patient illness (Al-Krenawi et al., 1994; Bott & Hodes, 1989; Kim, 1995), and the implications of illness labels for family honor, to cite several examples. In several instances, the observed patients fell ill as a reflection of dysfunctional family patterns. The "sick" label, as an example, is known to have provided the patient with greater familial attention and in some cases indicated such emotional issues as avoiding an arranged marriage (Al-Krenawi et al., 1994). It is essential for modern clinicians to appreciate the cultural nuances behind these family patterns. The mental health practitioner's task, in this sense, is to determine the real
problem behind the somatization.

This leads to a fourth step, namely the clinician’s making contacts and links into the Bedouin community. Striking an alliance with powerful member’s of the patient’s family undoubtedly furthers treatment goals of the helping process itself (Heilman & Witztum, 1994). As an example, clinicians can help strengthen instrumental family support systems by writing letters of support regarding social service applications. Or, as another example, clinicians’ alliance with the patient’s family can promote more effective use of prescribed medications (Bassett, Remick, & Beiser, 1986). On another level, such clinician-family work also allows the modern system to gain greater community acceptance.

Finally, modern clinicians must develop awareness of the cultural meaning of traditional practices (Al-Krenawi & Graham, in press; Atkinson, 1987; Grotberg, 1990; Sanua, 1979; Van der Hart et al., 1988; Ward, 1984), and be open to acknowledging their potential therapeutic effectiveness. This knowledge not only promotes a stronger therapeutic alliance; it also allows the modern clinician to learn from the patient, since he or she is an excellent information source regarding traditional practices and Bedouin culture.

Yet, as the data indicate, the modern practitioners under investigation tended to be less aware of traditional practices, less apparently respectful of them, and willing to learn from them. Again, it must be stressed that most of the psychiatrists were themselves faced with understanding and adjusting to Israeli
culture; the confrontation with Arab culture, especially language, placed an almost impossible, additional demand on them. In contrast, the traditional healers had considerable knowledge of the modern system, were willing to integrate the two systems, and to respect aspects of modern practices. As this study emphasizes, in several respects, practitioners within both models have much to learn from one another.

There are, as we have seen, numerous benefits of the concurrent use of modern and traditional treatment models. Those patients under examination who used the two systems simultaneously, benefitted from the modern system’s medications and follow-up. They also were helped by the introduction to social support networks consisting of individuals from different Bedouin tribes and from Jewish society, neither of which might have been accessed via traditional modes. Exposure to modern patients provided important forms of instrumental support, especially regarding access to welfare services. Female patients in particular, in being allowed to leave their homes, were exposed to a wide network of people under the modern system.

Exposure to the psychiatric system, even if for only one session, provided the opportunity for the present patients to relinquish several misconceptions: that psychiatric services are for "crazy people" only; that patients ought to be blamed for their mental illness; that medications work virtually instantaneously. The traditional model’s insistence on intense and continuous use of the family ought to be an important clue for the modern
practitioners of the benefits of developing forms of strategic family therapy with this population (Al-Krènawi et al., 1994; Napoliello & Sweet, 1992).

The Role of Social Workers in a Primary Health Care Centre

A large body of evidence suggests that general practitioners participate in the long-term care of over 90% of neurotic patients and a sizable portion of those with major disorders (Hess, 1985; Maoz, et al., 1992; Shepherd, Cooper, Brown, & Kalton, 1981). Only a small number (about 10%) of patients with psychological problems are referred to and treated by psychiatric services. All the others are treated, if at all, by primary health care physicians only (Verhaak & Wennink, 1990). As Hendryx, Deobbeling and Kearns (1994) state, primary care physicians may fail to recognize mental illness in their patients in 45-90% of cases. This situation suggests the likely benefits of having social workers in the PHC, functioning side by side with the PHC team, namely the welfare of the PHC’s consumers (Devore & Schlesinger, 1991).

The PHC is a legitimate place in the Bedouin society where every person has the right to visit. Moreover, females in this society are allowed to visit this system without breaching the cultural norms and without their families’ interference (Al-Krenawi, 1993). The PHC is the main place that Bedouin females can present their emotional difficulties by bodily ailments. Also, this system serves as a social club for Bedouin female (Mass & Al-
Krenawi, 1994). It appears that the PHC is the central junction where the physical, mental and social problems are located (Gross, Gross, & Eisenstien-Naveh, 1983; Halbreich, 1994; Laden, Oehlers, Waddell, & Miller, 1983; Lennox, 1983; Zola, 1973).

There are several good reasons for including social workers in the PHC:

1. An increasing recognition of the holistic nature of the world whereby the individual interacts with a number of different systems. For our purposes we must recognize that the individual is constantly affected by physical, emotional and environmental factors, and therefore if we are to provide appropriate services to the users of the health care services, we must be prepared to treat the physical, emotional, and environmental factors which influence the patient.

2. The place of the PHC as an important community resource for dealing with a variety of problems. The community clinic is a centre which services a cross-section of the entire population, including those who do not utilize other social services. This fact makes the PHC clinic an important focal point for the early detection and prevention of problems, in addition to its role as a place for treating problems (Walker, 1995).

3. The collaboration of social workers will help other mental health professionals recognize the emotional component of physical illness and offer the often overextended physicians an opportunity to provide a service for which the physicians
may not be adequately trained, nor have the time to provide (Devore & Schlesinger, 1991).

4. Patients benefit by receiving treatment in a familiar setting from the social worker and the GP.

It is primarily the physician who acts as gatekeeper. Without the physician's understanding of the role of the social worker and commitment to the social worker's success, the role of the social worker in the clinic is at best peripheral. Much of the literature underscores the importance of physicians and gives evidence of their negative attitudes toward social workers (Katherine, Oslen, & Oslen, 1967). The physicians' centrality in determining the role of the social worker requires a strategy that would bring physicians and social workers together in an effective, collaborative effort. In this sense physicians need to be part of the planning of such programmes and to be convinced that the social worker's role is to help the physicians to provide another service for the benefit of the patients (see Gross, Gross, & Eisenstein-Naveh, 1982).

Social workers in the PHC will provide information about the patients' background and will work along with the GPs and the consultant psychiatrists. Such a situation will avoid the stigma that the patients are concerned about when they are referred to the mental health system. Many of the patients under examination can be treated by a clinical social worker, and/or with a consultant psychiatrist in PHC. Such a programme would help make the GPs more aware of their patients' problems, as it will the consultant
psychiatrists as well.

Social workers have the potential of teaching the other medical practitioners how to be more culturally sensitive. Social work as a systemic profession, considers all the systems with which the individual interacts (Kim, 1995). One of these systems is the traditional healing system as a model of helping. In such a setting the social worker will function as a cultural consultant (cultural broker) who can mediate between the patient’s culture and the other professions involved in the treatment process, including GPs and psychiatrists (Budman et al., 1992; Fandetti & Goldmeir, 1988; Weidman, 1975).

In sum, the PHC is a focal junction for the patients who have problems at different levels. This setting is often the first step in seeking medical help (Halbreich, 1994). Social worker can organize the cases needing consultation with the consultant psychiatrists once a week. In the consultation meetings the GPs, psychiatrist and the social worker discuss the cases. The social worker is the coordinator of the consultation sessions; he or she brings the relevant data related the case in question. In such a situation a social worker functions as an intermediary between the patients and the medical practitioners, emphasizing the patient’s background, including belief systems, religion and the traditional healing system in the patient’s community. Moreover, the social worker will help the multi-disciplinary team to read the ecological map of the patient and determine how and when to intervene.

The social work profession is well situated in the PHC,
wherein the psychosocial problems came to light. Moreover, social work intervention in the PHC can reduce the frequency of the patients' visits to the physicians. Many problems can be treated in the patient's community by the team of GP, social worker and consultant psychiatrist. It will reduce the rate of referral to the psychiatric system, for personal, social and economic reasons (Maoz et al., 1992). The modern therapy will be available and useful because it will be culturally based. Psychiatric consultation in the PHC is also strongly recommended by Maoz et al. (1992) and Meeuwesen, Huyse, Meiland, Koopmans, and Donker (1994); they stated that such consultation will promote the GPs' awareness of all aspects of the disease—the so-called "psychosocial problems."

In addition, there is a place for the social worker in the psychiatric system where the psychiatrists treat multi-ethnic groups. The social worker's task in such a situation is to act as a cultural consultant and intermediary, to provide the psychiatrists with relevant information. The social worker can help resolve misunderstandings between the psychiatrists and the patients' and their families, not only translating exchanges between the patients and their families and the psychiatrists, but by interacting with them in a culturally accepting manner, and conveying information in an understandable way. Social workers can provide psychiatric assessments from a perspective that acknowledges the credibility of different cultural expressions of illness, and they can recommend specific management strategies that
take into account the patient’s culture, and how it might affect his or her capacity to understand and respond to his or her illness.

Social workers also can provide the psychiatric staff with relevant information about the traditional healing in the patient’s community and its therapeutic significance from the patient’s perspective, and about the degree of religiosity of the patient. In doing so, it is hoped the treatment will be more effective.

The reasons for wishing to co-operate with and learn from traditional healers are not entirely altruistic. We as modern practitioners have much to learn about humanity in our relationships with one another. In many respects we are just emerging from the emotional and spiritual dark ages. We seem to be struggling towards a social ideal of community which allows for individuality; of a social responsibility while respecting personal growth and freedom. As always, we believe we are developing these concepts for the first time. Yet holistic medicine, mind/body unity, self-help groups, environmental issues, as well as psychological concepts, such as catharsis, ventilation, and self-expression, are values which the traditional healing systems have had for thousand of years.

Finally, based on this study, clinicians who are working with different cultures from their own, need to be familiar with their patients’ cultures. They have to bridge the gap between the "we" and "they," to create a situation of trust. They must learn to appreciate patients’ perspectives, values, and life worlds (Sue,
Mental health professionals ought to be prepared, under certain circumstances, to work concurrently with traditional healers. This will be achieved through orientation and education concerning the populations served and by providing approaches and techniques for dealing with the specialized concerns of a culturally diverse patient population. It is time to develop and practice a model for productive dual use of the two systems.

Social Work and Islam

Social work has been significantly influenced by religion. Throughout its history, religious teachings, devout individuals and religious institutions have contributed to the elaboration of social work concepts, and values, the founding of social work educational facilities, and the extension of opportunities for professional practice (Canda, 1988; Cox, 1983; Joseph, 1988; Timberlake & Cook, 1984; Young & Ashton, 1956). Although the Jewish and Christian roots of social work ethics are often recognized, seldom have researchers addressed the question of how values from other major religions are congruent with or potentially useful to social workers. Hence this section deals with congruencies between Islamic teachings and social work.

There are analogies of many social-work concepts in the Islamic religion (Azmi, 1991; Stillman, 1975). The Prophet Muhammad recommended visiting ill people; he stated that visiting supports the patients and brings them relief (Farsy, 1964). In
fact one of the "five pillars of Islam" is alms giving. The Prophet Muhammad said, according to traditional Hadith, "A giver of maintenance to widows and to poor is like a bestower in the way of God, an utterer of prayers all the night, and a keeper of constant fast." Generosity to the less fortunate is believed to be preventive against guilty feelings and crime (El Azayem & Hedayat, 1994). It also should be noted that the prophet of Islam recommended what we call today group work: "Those who interact with people and tolerate their hardships are better than those who do not interact with people and do not tolerate their pains" (quoted in Banawi & Stockton, 1993, p. 151). Such Hadith recognizes the benefits of what we call "group process."

Since the root of social work goes back to religion, it is argued that social workers need to consider religion as a dimension in social work intervention because religion reflects the tradition of the people we serve (Abdul-Hadi, 1989; Al-Dabbagh, 1993). All religions, including Islam, are understood to be cultural systems (Geertz, 1973; Tibi, 1990). Social work deals with person as a total organism, so how can we ignore religion and culture in Western-style intervention?

This study investigated a traditional model of helping. And there are similarities and analogies between modern and traditional models of helping. The traditional model of helping has a cultural legitimacy, as well as therapeutic components at different levels. The purpose of this model is to heal and to help people who suffer from what Westerners call "mental illness." Thus social workers
need to learn about traditional healing in the communities they serve.

Those from different ethnic groups refer disturbed people to traditional healers or spiritual-religious leaders, for instance, priests, rabbis and sheiks, before, during and after they refer them to modern system. In many cultures around the globe, the social work profession operates side by side with the traditional healing system. This phenomenon suggests that social workers should consider how to deal with clients who have different backgrounds, religious belief systems and different perception of their disease or problems (Burgest, 1982; Devore & Schlesinger, 1991; Green, 1990; Kim, 1995; Lum, 1986, 1982; McQuaide, 1989; Smith, 1963; Timms, 1983); ignorance, even if well intentioned, is no longer defensible.

Social Work Practice with Clients of Diverse Cultures; Dual Use of Systems

There are contradictions between the modern model of helping and the traditional one and clients who belong to traditional ethnic groups know that the modern professions reject the traditional model, and its reliance upon supernatural power. Our task as social workers is to eliminate our biases, to show clients that social workers accept and respect clients' cultures and belief systems. Moreover, we have to consider how we can use traditional models of helping, such as rituals, and how we can
learn from the traditional healers, especially the terminology used when labelling and "classifying" the degree of a problem (Al-Krenawi, 1992; Hes, 1975).

To gain the essential information about clients from diverse ethnic groups, social workers should address the following issues and questions in their interventions.

1. We should seek to understand the client's culture, religion, values and belief system;

2. In obtaining the family history we need to learn more about the client's nuclear and extended family: we should read the socio-ecological map of the client's family. What are the relationships among the family members? In which circumstances do they meet? Who is the powerful person in the nuclear and the extended family? What are the family rituals?

3. We should investigate the relationships with the community: who are the respected and powerful spiritual persons in the community, Rabbis, Priests, Sheikhs and traditional healers? Are there any community rituals, and what is the purpose of these rituals?

4. We must consider symptomatology, the degree of severity, especially the client's explanation and interpretation of the symptoms.

5. We need to investigate self-treatment: Does the client understand the symptoms? How does the client cope with his/her symptoms. What sources has he/she consulted such as the family or community, religious-spiritual leaders and
6. We should find out how the people in the client's family and community evaluate the symptoms (tentative diagnosis). What is the etiological explanation, according to the client and the traditional sources that he/she has consulted?

7. We should find out what treatment has been suggested by the traditional healers? What does the diagnosis mean from the client’s perspective?

8. We need to investigate the social construction (and legitimacy) of the sick role in the client’s family and community (including the patient’s rights and obligations).

By knowing this information about the client’s background, we can select the appropriate techniques of intervention. For example, by knowing who are the powerful persons in the client’s family and extended family or the community, we can consider these powerful people as partners in our intervention (Al-Krenawi et al., 1994; Lum, 1982; Madanes, 1981). Social workers need to allow the clients to practise their own healing rituals appropriate to their belief system and cultural canon (Al-Krenawi & Graham, in press).

The Western and traditional systems are complementary and should be constructed to function alongside one another (Chi, 1994; Green & Makhulu, 1979; New, 1977; Rappaport & Rappaport, 1981). For example, I once conducted a group for Bedouin widows in primary health care; the frame was modern, while the content of the group was traditional (Al-Krenawi, 1993). Those with bad dreams had to do "Rahamah" (memorial ritual for the dead), which in direct
translation means "to obtain food for the dead person's soul and to invite people to eat the food." Afterwards, they read verses from the Koran. This action is intended to prevent the soul of the dead from re-appearing. I allowed the group members to practise this ritual and I even shared with them its effect at the personal and the group levels (Al-Krenawi, 1993; Al-Krenawi & Graham, in press). The effectiveness of the combination between modern and traditional approaches is corroborated by several investigators in diverse settings (Bokan & Campbell, 1984; Edwards, 1986; Jilek, 1994; Lambo, 1978; Lefely, 1986; New, 1977; Ruiz & Langrod, 1976a, 1976b; Rudy & Thomas, 1983; Yoder, 1982).

In sum, the model of traditional healing must be considered an important source of support for those who engage people of diverse cultures. Because social work intervention is often based on intuitive as well as empirical knowledge, the role of traditional healing can readily be integrated into interpersonal practice with people of various cultures (Castellano, Stalwick, & Wien, 1986; Gutheil, 1993; Kissman, 1990; Laird, 1984; Morrissette, McKenzie, & Morrissette, 1993; Schindler, 1993).

Finally, the mental health practitioner does well to respect and accept the client as representative of his/her culture. It is time that social workers and mental health workers for the benefit of their clients, become aware of the essential connections between modern and traditional healing approaches.
Directions for Further Research

The study opens up broad areas for future research. Follow-up research might determine:

1. The frequency of visits to the modern and the traditional mental health systems, utilized by the research population;

2. The duration of stays in the modern or traditional mental health systems by the research population; the quality of outcomes in the two systems, separately and jointly;

3. Comparison analysis between patients who utilize just the modern psychiatric system with patients who utilize the traditional healing system;

4. The variation among the types of healers in terms of perceptions and treatment of mental illness;

5. The attitudes of the Arab people toward emotional and personal problems we label as "mental illness";

6. The impact of the structure of Bedouin society upon individual perceptions and explanations of disease(s) or psychosocial problems.

It is entirely appropriate that we as social workers reaffirm our systems orientation. In this effort, we can start by listening to our clients. The fact that medication and surgery often fail and traditional methods sometimes succeed should always be kept in mind. The end of the age of "cultural imperialism" is dawning in social work, as have non-universalistic and cultural contextual approaches in other disciplines. Is it possible that we are on the
threshold of a new, integrative approach, embracing Western knowledge yet holding to cultural values is now being developed in social work and mental health practice? Might social work lead the way in this eminently significant effort?
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Appendix A

Questionnaire (for all the new referrals)

Pre-contact with the psychiatrist

1. The patient's background:
   a) The patient's name....................
   b) Identity card number (I.D.)...........
   c) birth date................
   d) sex male female.
   e) Which Qabilh (nation) do you belong to:
      Tayaha.
      Azazmeh.
      Gderat.
      Zullam.
      Tarabeen.
      Flahin.
      Abid.
   f) relationship status:
      Married.
      Single
      Widow/er.
      Divorce/Separate.
   (for male) How many wives have you married?.............
   (for female) Is your husband married to more than one wife? If
   yes which number are you.............
   g) How many children do you have, boys --- girls----
   h) Education
      Elementary school, years....
      High school, years........
      College..............
      University...........
      Illiterate.
   i) Place of living
      Village.
      Outside the villages.
j) In which type of house do you live?

House
House + Tent
Tent
Other

k) What is your job?

Teacher
Public service employee
Housewife
Shepherd
Driver
Factory employee
Other, what
Unemployed

l) What is your occupation

m) Do you practice the Islamic principles, fully or partly?
Could you explain please.

Testimony
Prayer
Fasting
Almsgiving
Pilgrimage

n) Do you read verses from the Koran, and mention God's name and His Prophet Muhammad; when you do that?

2. How do you understand your problem from your point of view, what is the cause of your problem or disease?

3. Why do you refer to the mental health clinic? Do you know what this service involves?

4. How referred you to the psychiatric clinic (Soroka)?

5. Do you have any idea about your diagnosis?

6. Did the family's doctor gave you any information about your situation; what did he/she said to you?

7. Have you consulted a traditional healer about your problem or disease?

8. Have you consulted your family about your problem or disease, and what did they suggest that you do?
9. Do you know what psychiatrists do?

10. Do you think the psychiatrist will help you with your disease or problem; could you please explain and give an example about how does the psychiatrist going to help you?
نوع ج - لكل المتجهين للعلاج - (قبل الاتصال مع الطبيب النفسي).

1. خلفية المريض.

أ) اسم المريض ........................................

ب) رقم الهوية ........................................

ج) تاريخ الولادة ....................................

د) الجنس: ذكر، أنثى ................................

ه) إلى أي قبيلة من القبائل تتنتمي تنصب؟

القبيلة

 Arabian

التقاليد

قريات

أعمال

التاريخ

فلاحون

عبد

و) الحالة الشخصية:

مترأة

عازبة

أرملة

مطلقه

منفصلة

للذكور: كم زوجة لذا؟

للإناث: هل زوجك متزوج بكثر من امرأة واحدة؟

إذا كان الجواب نعم فأي رقم جنت؟

ز) كم عدد أطفالك؟ ذكور............................

ج) تفقت: مدرسة ابتدائية: عدد السنوات

مدة ثانوية: عدد السنوات

كلياً، عدد السنوات

جامعة: عدد السنوات

أمي..............................................
1. ما هو لنغك الحالي؟
2. موظف خدمات عامة
3. ربة بيت
4. راع
5. سائق
6. عامل في مصنع
7. آخر. ما هو؟
8. عاطل عن العمل

(ما هي مهنتك؟)

- هل تطبق قوانين الإسلام؟ جزئياً أو بشكل كامل. تشرح.
- الشهادات
- الصلاة
- الصوم
- الزكاة
- الحج

1. هل تقرا ليات قرآنية وتذكر اسم ربك ونبيه محمد (صلى الله عليه وسلم) في أي حالة؟
2. هل تعرف ما هي مشكلتك وما هو سبب هذه المشكلة أو المرض حسب رأيك؟
3. لماذا توجهت إلى عيادة الأمراض النفسية؟ هل تعرف ماذا تحتوي هذه العيادة؟
4. من وجهة إلى هذه العيادة النفسية؟ (سورة)
5. هل لديك فكرة عن تشخيص حالتك؟
6. هل أعطاك طبيبك العائلة فكرة عن وضعك حالتك وماذا قال لك؟
7. هل استشترطت معالجات تقليدية (درويش، خيط، شيخ..الخ) حول مشكلتك أو مرضك؟
8. هل استشترطت عالتك حول مشكلتك أو مرضك وماذا اقترحوا عليك أن تعمل؟
9. هل تعرف ما هو عمل الطبيب النفسي؟
10. هل تظن أن الطبيب النفسي سوف يساعدك في مرضك أو مشكلتك. هل تستطيع أن تعطي لنا مثالاً كيف من الممكن أن يساعدك الطبيب النفسي؟
Second interview (after the patient has contact with the psychiatrist)

1. Who is your psychiatrist (name)..............................

2. What is the psychiatric diagnosis, do you know what the diagnosis means?

3. How did you present your difficulties (symptoms) to the psychiatrist?

4. What is the psychiatric treatment?

5. Do you feel any improvement in your situation in the mental health clinic?

6. Do you think that the psychiatrist understands your difficulties?

7. How is your relationship with the psychiatrist, and how does the psychiatrist treat you?

8. Does the psychiatric treatment help you, and how does it help?

9. Do you think the psychiatric service helps you indirectly? Do you meet friends and visit relatives who are hospitalised in the Soroka hospital?

10. Do you want to continue the treatment in the psychiatric system would you explain pleas?

11. Do you go to a traditional healer? (The healers name and location)

12. Who is the healer, is she/he a Bedouin and familiar with the Bedouin culture?

13. What is the diagnosis according the healer?

14. Do you understand the healer's diagnosis, and what does the diagnosis mean for you?

15. How did you explain your problems (symptoms) to the healer?

16. What is the healer's treatment?

17. What did the healer suggest for you to do?

18. How do you describe your relationship with the healer, how does the healer treat you?

19. Why do you chose to go to the healer? Is it your choice or your family and relatives suggestion?
20. Do you practice cultural and religious healing rituals to cope with your difficulties, in addition to the psychiatric treatment?

21. Do your family or other relative help you to practice these rituals?

22. Do you think these rituals help you?

23. In what way do these rituals help you to cope with your problems?

24. How do you feel before and after the rituals take place?

25. Which treatment is more effective according to your opinion and why?

26. Why do you use both systems simultaneously (the modern and traditional)?

27. How do you perceive the two systems?

28. How do you manage the use of both systems?

29. What do you gain from each system?

30. Which type of treatment is more appropriate for you and why?
المقابلة الثانية (بعد أن يكون المريض قد قابل الطبيب النفسي)

1. من هو طبيبك النفسي؟ (الاسم)

2. ما هو تشخيص المرض حسب العادة النفسية؟ هل تعرف ماذا يعني هذا التشخيص؟

3. كيف تعرض صعوباتك (الأعراض) للطبيب النفسي؟

4. ما هو العلاج النفسي؟

5. هل تشعر بأي تحسين طرأ على حالتك في العادة النفسية؟

6. هل تظن أن الطبيب النفسي فهم حالتك؟

7. كيف تصف علاقةك مع الطبيب النفسي. كيف يتمتع معك؟

8. هل تظن أن العلاج النفسي يساعدك. كيف؟

9. هل تظن أن الخدمات النفسية تساعدك بشكل غير مباشر؟ هل تتلقى بصدق؟ أو تقرر أقرب يقتلون

علاجًا في مستشفى سوريك؟

10. هل تريد أن تواصل العلاج في إطار العادة النفسية؟ شرح

11. هل توجه حاليا إلى معمل تقليدي (اسم المعمل وعنوانه)؟

12. من هو المعمل التقليدي. هل هو بديع. لديه معرفة عن الحضارة البدوية؟

13. ما هو تشخيص المعمل التقليدي؟

14. هل تفهم تشخيص المعمل التقليدي وماذا يعني لك تشخيصه؟

15. كيف تشرح مشكلتك (الأعراض) للمعمل التقليدي؟

16. ما هو علاج المعمل التقليدي؟

17. لماذا أقترح المعمل التقليدي أن تعمل؟

18. كيف تصف علاقةك مع المعمل التقليدي وكيف يتعامل معك؟

19. لم تأتهر الطقس دينياً وحضارية للتقب على صعوبتك بالإضافة إلى العلاج النفسي؟

20. هل تمارس طقوسًا دينية وحضارية للتقب على صعوبتك بالإضافة إلى العلاج النفسي؟

21. هل يساعدك عائلتك أو قريبك أن تمارس هذه الطقوس وتقوم بها؟

22. هل تظن أن هذه الطقوس تساعده؟

23. كيف تستوعب هذه الطقوس بالتقرب على مشاكلك؟

24. كيف تشعر قبل وبعد القيام بجراحة الطقوس؟

25. أي من العلاجين تعتبره لنجاح حسب رأيك ولماذا؟

26. لماذا أخترت أن تتعالج حسب الطريقتين في أن واحد؟ (الحديثة والتقليدية)

27. كيف تستوعب كل من الطريقتين في العلاج؟

28. كيف تلاقين في استعمال الطريقتين؟

29. لماذا تستفيد من كل طريقة؟

30. أي من العلاجين مناسب لك أكثر ولماذا؟
The Interview with the Psychiatrists

The interview focuses on the following issues:

The psychiatrist's background:

Sex: Male ---- Female-----

Ethnic......................

1. What is the patient's diagnosis.
2. The etiological explanation for the patient's problem or disease.
3. The degree of severity (what is the prognosis).
4. Which approach of treatment do you use, medication or psychotherapy; would you explain that please?
5. The relationship between you and the patient, what is your perspective. For example, is there empathy, closeness, friendliness and understanding.
6. How do you treat educated Bedouin patients, could you please explain.
7. Do you find any different between females and males during the treatment process.
8. Which type of rituals do your patients practice; do you think they practice religious principals.
9. Do you think the cultural diversity of your Bedouin patients makes it hard for you to understand their problems?
10. Do you think the healer's treatment will have impact on what you are doing.
_appendix_b_in_hebrew

ראיות על הפיסיקאים

חרות חומק וינושם הבהיה:

הקרקד של הפיסיקאים:

מרחוי - נבובה

מיד: זכר - נבובה

ארץ מגורים:

1. מה היא ההבהיה של התוכנה?
2. התוכנאות של בעיית וא Manitou של התוכנה?
3. מה היא הפרוגרסיה?
4. מה היא שיטת הס subparagraph של התוכנה משמש בה?
5. תואר בקשת את מעורכת יסודות עם התוכנה למחלק האיסור בעיקרה
6. קרבה וידידה בין עולים ונשים
7. איך אתה מתפל ל التابعة בדואים משיכולים או לписать בקשת
8. האם אתה מרצה سوريا? סופות בין ברניק על.CASCADEים חזרה
9. איך אתה תשוב לשירותי? התוכנות של المحليةibbean עם אכות
10. האם אתה תשוב לשירותי? עם הסיסמה משיכולים על טיפוכי התוכנה?
Appendix C

The Interview with the Traditional Healers

The interview focuses on the following issues:

The healer's background:

Sex: Male ---- Female-----

Which Qabilah do you belong to?..............
Which type of healer are you?..............

1. What is the patient's diagnosis.
2. The etiological explanation for the patient's problem or disease.
3. The degree of severity (what is the prognosis).
4. The treatment techniques
5. The relationship between the you and the patient, from your perspective. For example, is there empathy, closeness, friendliness and understanding.
6. How do you treat educated Bedouin patients, would you please explain
7. Do you find any different between females and males during the treatment process.
8. Do you think the psychiatrist's treatment will have impact on what you are doing.
مقابلة مع المعالجين التقليديين

المقابلة ستتركز في المواضيع التالية:

- خلفية المعالج التقليدي
- الجنس : ذكر أو أنثى
- إلى أي قبيلة تنتمي؟
- أي نوع من المعالجين التقليديين تعتبر؟
- 1. ما هو تشخيص المريض؟
- 2. ما هي أسباب المشكلة أو المرض عند المريض؟
- 3. ما هي درجة خطورة المرض (ما هي دلالة المرض)؟
- 4. ما هي طريقة العلاج؟
- 5. ما هي العلاقة بينك وبين الطبيب. من منظورك على سبيل المثال هل هناك تعاطف، قرب، صداقه، ود.
- 6. كيف تعالج المريض المثقفين أضرح من فضلك؟
- 7. هل تجد فروقًا بين النساء والرجال من خلال العلاج؟
- 8. هل تظن أن علاج الطبيب التقليدي يؤثر على ما تقوم به؟
CONSENT FORM

Title of Research Project: A Study of Dual Use of Modern and Traditional Mental Health systems by the Bedouin of the Negev.

Investigators: Alean Al-Krenawi, M.S.W., Ph.D. Candidate, Faculty of Social Work, University of Toronto.

I acknowledge that the research procedures have been explained to me and that any questions that I have asked have been answered to my satisfaction. I also understand the benefits of joining the research study. The possible risk and discomforts have been explained to me. I know that I may ask now, or in the future, any questions I have about the study or the research procedures. No information will be released or printed that would disclose my personal identity without my permission.

I understand that my participation in this study is completely voluntary and, I further understand that I am free to withdraw my participation from the study at any time.

I hereby consent to participate

___________________________________________________________
Name

___________________________________________________________
Signature of Psychiatrist

___________________________________________________________
Witness

___________________________________________________________
Date
TO WHOM IT MAY CONCERN

Mr. Alean Al-Krenawi, a Ph.D. student, Faculty of Social Work, University of Toronto, conducted a study in which he interviewed Bedouin patients of our Psychiatric Outpatient Clinic at the Soroka Medical Center, Beer-Sheva, Israel. He also interviewed a number of psychiatrists belonging to our staff, who treat these Bedouin patients.

Mr. Al-Krenawi assured me that no names or personal details of the interviewed persons will be published in his Ph.D. thesis.

I happily agreed with this scientific cooperation.

Prof. Dr. Benjamin Maoz, Head of Psychiatric Department

Alean Al-Krenawi, Ph.D. candidate