Traditional versus Western perceptions of mental illness: women of Moroccan origin treated in an Israeli mental health center

Yael Latzer

Summary This paper focuses on the problems encountered in providing Westernized psychiatric treatment to a population with traditional healing beliefs. The sample comprised women of Moroccan origin living in Israel undergoing treatment for psychiatric disorders (N=38), and their treating psychiatrists (N=9). Ethnographic interviews were conducted among both groups. The results revealed that the symptoms, perceptions of the illness, and problems encountered in the therapeutic relationship differed across three age groups, young women (20–30 years), more mature women (31–42 years), and older women (43–60 years). While cultural conflict appeared to affect the development of mental illness in each group, this was most pronounced among women in the middle age range. Moreover, problems in the therapeutic alliance were greatest in this age group. The data from the therapists indicated that they maintained a Western perspective in both their understanding and diagnoses of these patients' illnesses. The different perspectives of the therapists and each of the three groups of women are discussed. It is concluded that professionals treating traditional populations must avoid imposing Western standards, and consider the treatment in the context of cultural beliefs. The developmental stages of the individual, and the stage of acculturation must also be taken into account if treatment is to be effective.

Introduction

When immigrants from non-Western countries are absorbed into a Western culture, their traditions concerning healing challenge Western medical systems. This paper reports a study carried out in Israel examining women of traditional Moroccan origin undergoing standard Western-style psychiatric treatment. The primary aim was to examine the conflicts encountered by these women and their biomedical-oriented therapists in terms of their perceptions of mental illness and its treatment. The main incentive for examining the issue was the recognition that the disparity between these two conceptions of mental health may affect the effectiveness of treatment.

Although this project concentrated on problems of a specific immigrant population in Israel with respect to the effects of contrasting views of mental health practices, it nevertheless mirrors similar conflicts experienced by immigrant populations and their doctors in other fields of medicine, both in Israel and in other countries. The issues associated with this difference in patient-therapist medical perspective have been widely discussed in the literature.

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(e.g. Alarcon, 1995; Arieli, 1970; Ben Ami, 1976; Bilu, 1977; Bilu & Witztum, 1993, 1994; Buhgra, 1997; Hes, 1963; Lukoff et al., 1995; Nilchaikovit et al., 1993; Palgi, 1963, 1966, 1978; Shokeid, 1971; Turbott, 1996). However to date, very little data has been reported in Israel regarding the potential effects of these differences from the mental health perspective. Examining this issue among specific populations is critical to the development of integrative, cross-cultural models of psychiatric treatment. By doing so, it may be possible to tease out both the similarities and differences in immigrants’ psychological adaptation to different cultures.

Cultures are complex, symbolic systems of both understanding and explanation (Gaines, 1995). A culture represents a particular worldview, whose logic explains that world and its animating forces. Culture not only affects adaptive and normative behaviors, it also finds expression in disease states such as psychopathological disorders (Yamamoto et al., 1997). For this reason, clinicians in multicultural settings are often faced with problems in the interpretation of the individual's theories about particular states or experiences (Gaines, 1995).

The conceptualization of symptomology as a complex system of cultural symbols has long been recognized by transcultural mental health professionals. While it is generally understood that as every culture develops its own concepts of mental health issues one must ascertain the mental health norms in each culture in order to adequately treat the individual (e.g. Goffman, 1961; Kiev, 1973), the translation of symptoms from one culture to another remains a subject of controversy (Yamamoto et al., 1997). Moreover, current research has shown that mental health professionals frequently receive insufficient ethnomethodological training. This issue is critical because when the cultural beliefs of therapists are embedded in the dominant local professional psychiatry, they may be in conflict with those of patients from minority cultures (Vega & Murphy, 1990). When the cultural perspectives of therapist and patient are at odds, communication problems are likely to ensue. In such situations, therapists may reach inappropriate conclusions and encounter problems in the therapeutic alliance (Marcus-Gonders, 1992).

These difficulties characterize many Israeli psychiatrists who treat members of minority cultures. The formal preparation of psychiatrists and psychologists in Israel does not typically include extensive ethnomethodological training. These professionals are usually trained in the biomedical and intrapsychic approaches characteristic of Western-oriented psychiatry. The Israeli psychiatrist is normally the head of a multidisciplinary therapeutic team, and carries the primary responsibility for the treatment of the patient. Typically, the psychiatrist evaluates the patient, prescribes medication if needed, refers the patient to social workers or psychologists in the event that social-rehabilitative treatment or psychotherapy are deemed necessary, and conducts the follow-up. Because the main duty of the psychiatrist centers on the biomedical treatment of the patient, a gap might be expected from the outset between the Israeli psychiatrist and the patient from a traditional ethnic background in terms of orientation and expectations from the therapeutic process.

While research conducted in Israel on the issue of immigrant mental health is relatively recent (Lerner et al., 1994), the results of clinical work on intra-Jewish ethnic diversity suggests that the idioms of distress vary among disturbed individuals from different regions such as Western Europe, Iran, Morocco, Ethiopia, and Russia (Bilu & Witztum, 1993, 1994, 1997; Latzer, 1996). Despite accumulating evidence from clinical reports, very little empirical work has been conducted directly examining this issue.

To date, the subject of how immigrants to Israel from traditional, non-Western societies respond to Western biomedical psychiatry remains a subject of speculation. To the best of my knowledge, there are two related studies. In one study, Gorkin (1985) examined the way in which cultural differences affect patient-therapist interactions among Israeli-born Arab
students. However, the target population in that study did not comprise immigrants. In another study, the effects of menopause on Israeli women from five subcultures (e.g. Israeli-born Moslem Arabs, and immigrant Jews born in North Africa, Iran, Turkey and Central Europe) was examined (Datan, 1990). It was found that psychiatrists were more likely to diagnose depression in women from cultures other than their own. While not the focus of the study, this finding suggests that the ethnic origins of the patient and therapist may influence diagnosis (and presumably, the subsequent treatment).

In light of the lack of applicable research, the study reported here was exploratory. The objective was twofold: (1) to identify areas of potential conflict between the traditional Moroccan and Western biomedical perspectives of mental health problems and their treatment; and (2) to determine how these views may be reconciled in order to develop a more effective therapeutic model for treatment of this population. It is hoped that an examination of these issues will contribute to an increased understanding of how cultural gaps between traditional approaches to mental health and Western-oriented biomedical psychotherapy might be bridged.

**Cultural transition and immigrant Moroccan women in Israel**

Anthropologists investigating social change have emphasized the hardship and difficulties experienced by traditional cultures when adjusting and adapting to more modern, Western cultures. The course of immigrants' adjustment to a new country, as well as their long-term psychological well-being, are influenced by both mitigating and risk factors (Grinberg & Grinberg, 1989; Berry et al., 1987). Both external and internal stressors must be considered in this context. Among the external factors held to be related to mental health are cultural diversity, language differences, socioeconomic status (SES), generational differences, reasons for migration, length of residency after migration and the existence of social networks. Internal stressors include factors such as level of expectation from the new culture, locus of control, and personality structure (Yamamoto et al., 1997).

Research indicates that assimilation within the host culture is enhanced when the individual's native cultural identity is valued and respected (Arthur, 1996; Comas-Diaz & Jacobsen, 1987; Richman et al., 1987). Among Moroccan Jews who began immigrating to secular Israeli society around the 1950s, the opposite was the case. National ideology during the early waves of immigration to Israel emphasized the relinquishment of prior cultural ties and the adoption of the 'new order'. While later Israeli society was to pay a heavy price for this ideology (Eisikovits & Beck, 1990; Lerner et al., 1994), the transition of Moroccan immigrant to Israel was often traumatic, frequently causing crises in the individual as well as the family (Palgi, 1963).

The gap between their former culture and that of the host country was large. In their country of origin, Moroccan Jews adhered tightly to religious traditions as the spiritual basis of day-to-day life (Ben-Ami, 1976; Shokeid, 1971; Vingroud, 1959). The family roles of this population were traditional: women functioned as caretakers of children and household, whereas the men supported the family and were the link to the outside world. In traditional Moroccan society, the family is the foundation of all social life. The family is broadly defined and includes extended kin, friendship, and patronage ties. It serves as an important support network, and functions as a central mediator between the individual and broader society.

Moroccan-born women were particularly vulnerable to the effects of cultural transition when entering secular Israeli society. Because of the paramount importance of family stability and family honor, Moroccan women are esteemed as preservers of the home and family on
the one hand, yet secluded in the home on the other. From this perspective, education and outside employment for women is viewed as threatening to core family values. The entry of women into the outside world is seen as threatening the ‘marital balance based on the husband’s/father’s dominance and on gender role complementarity’ (Walsh, 1985, p. 251).

Moroccan women who attempted to assimilate into Israeli culture were often rejected by members of their own society. Husbands tried to deny their wives access to the outside world in order to protect their own traditional position in the family hierarchy. These cultural conflicts resulted in a loss in these women’s self-esteem and sense of personal identity, and encouraged passivity and dependency. Mental stress among these women was often severe (Bilu, 1978), resulting in many referrals to mental health clinics. To a great extent, these women once again experienced a lack of understanding and rejection by their Western-trained therapists. In many cases, their mental condition deteriorated still further (Palgi, 1982).

**Cultural contrasts in explanatory models for mental disease**

Most Israeli psychiatrists maintain a biomedical, ‘internal causation’ approach to mental illness. This Western perspective holds that physiological causes are at the root of most mental diseases. According to this view, mental illness is seen primarily as a disturbance in the natural homeostasis of systems in the body (Young, 1976; Elizur, 1995). The ‘internalized’ view of mental disease is also apparent in the intrapsychic approaches to mental illness characteristic of Israel psychotherapists. While the emphasis is placed on psychological explanations for mental suffering, the focus is nevertheless on the individual.

This internal focus is not the norm for many cultures of the world. Research has shown that in countries such as Japan, India, China and the Mediterranean, somatization rather than psychologization is the norm (Gaines, 1995). Moroccan culture, like many non-Western, traditional cultures, perceives illness as primarily caused by factors external to the human body. According to this approach, the individual’s physical and mental symptoms are linked to disturbances in the family or society, or to acts carried out by the individual. Occasionally, illness is tied to supernatural causes such as the ‘Evil Eye’, ‘evil spirit’, or the magical influence of a person or an object (Arieli et al., 1994; Shilon, 1968; Wessels, 1985). While sometimes offering a physiological explanation for disease in conjunction with external explanations, greater weight is usually placed on the former.

Another difference between the traditional Moroccan and the Westernized Israeli psychiatric models of mental health care lies in the focus of treatment. The Israeli psychiatric model for instance, focuses on the development of patient self-awareness and insight, as well as the need to establish physical homeostasis through medication. Conversely, the traditional Moroccan view of mental illness usually focuses on the banishment of evil forces, the isolation and neutralization of a disruptive external influence, and the resolution of day-to-day problems.

One problem among traditional Moroccan immigrants is that they may be unable to reconcile two disparate belief systems regarding mental illness. Research carried out by Israeli investigators examining how traditional and Western medical approaches merge among different groups of traditional immigrants suggests that this may be the case (Hes, 1963; Shuval, 1970; Bilu, 1978). Those investigators found evidence of strong simultaneous belief in both systems. Other research on the effects of the penetration of the Western medical system into traditional societies indicates that with time, these two models eventually reach a level of acceptable integration (Beiser, 1985; Bilu & Witzum, 1994; Lewis-Fernandez & Kleinman, 1995; Kleinman, 1978; Kortmann, 1987; Moffic & Kinzie, 1996; Unschuld,
1976). However, given that acculturation is a lengthy process, it might be expected that full integration might encompass several generations.

Awareness of the problematic interactions between the two types of systems has prompted recommendations for integrative models of medicine (Bilu et al., 1990). The common feature of these models is the concern about the patient's cultural and social orientation as an important factor in the therapeutic process (Brickman, 1970; Buhgra, 1997; Frank, 1961; Gildwell, 1972; Igun, 1979; Levenson, 1977; Torrey, 1972). However, to date, no model provides general guidelines or specific recommendations for a particular culture. In addition, in order to delineate critical issues in the diagnosis and treatment of mental disorders among different cultures, the development of specific integrative models of mental health are needed. This study attempts to contribute to these aims by examining the perceptions of mental health and its treatment among a specific population of immigrants, as well as their treating psychiatrists. It is hoped that such an endeavor will not only provide information regarding the particular problems of this population and how best to address them, but will contribute to the development of integrative, transcultural models of mental health.

Because acculturation may be a prolonged process and encompass several generations, it might be expected that immigrants of different age groups would perceive and react to the gap in the traditional and Western explanatory models of illness in different ways. To assess this possibility, three subsets of Moroccan women were examined: immigrants who were middle-aged at the time of immigration; immigrants who were adolescents at the time of immigration; and second-generation women. It was hoped that by examining a wide age range, it would be possible to tease out the ways in which traditional and Western biomedical approaches to mental illness and treatment are integrated over time.

**Methodology**

**Participants**

*Patients.* The patient population included 38 women of Moroccan origin (ages 20–60 years) who were treated for psychiatric disorders in the Mental Health Outpatient Clinic of Rambam Hospital in Haifa, Israel. This large clinic is part of the national health system and serves the general public in northern Israel. Of 43 patients selected from the hospital's psychiatric archives answering the criteria of having been born in Morocco or being second generation to Moroccan immigrants, two refused to be interviewed, and three were not active participants for other reasons. The remaining sample included all patients who agreed to participate.

The patient sample was divided into three age groups *a-posteriori*, following an analysis of the data. These different age groups were characterized by similarities in demographic characteristics, symptomatology, and perception of the illness. The general demographic profile for each group of women was as follows:

- **Young age range (20–30 years; N=13):** young women were typically native Israelis born to Moroccan parents, had completed about nine years of formal education, and had some clerical training. The young woman was typically married, had two children, and did not work outside the home.
- **Middle age range (31–42 years; N=18):** women in the middle age range were typically born in Morocco, and had immigrated to Israel in their teens. They had completed an average of eight years of formal schooling, and had trained for professions such as a seamstress or hairdresser, but did not work outside the home. These women were usually married and had an average of five children.
Older range (43–60 years; N=7): women in the older age range were born in Morocco and had immigrated to Israel as adults. They usually had about five years of schooling, no formal profession and did not work outside the home. These women were usually married or widowed and had six children on average.

Tables 1 and 2 present demographic information for the patient population. As is evident from the tables, all women were from a low socioeconomic background. This may be attributed to the fact that individuals who seek psychiatric treatment in public clinics may be those who are unable to afford private treatment.

**Table 1. Patients’ country of birth vs. age**

<table>
<thead>
<tr>
<th>Age range</th>
<th>Morocco</th>
<th>Country of birth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger (20–30 years)</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Middle (31–42 years)</td>
<td>17</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Older (43–60 years)</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>10</td>
<td>38</td>
</tr>
</tbody>
</table>

**Table 2. General demographics of the patient population by age group**

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>Older (43–60 years)</th>
<th>Age group</th>
<th>Young (20–30 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Middle (31–42 years)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young (20–30 years)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4+</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Educational attainment (years)</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1–5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6–9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>10+</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Professional status</td>
<td>Professional</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Employed</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>18</td>
<td>13</td>
</tr>
</tbody>
</table>

**Therapists.** The therapist population included nine psychiatrists (three men and six women) treating the patients at the time of this study. The therapists, all part of the same professional unit, agreed to participate following a request by the present investigator (also a member of the team). Cooperation was full because each member of the team faced a similar problem in daily work. Specifically, many of the patients were not taking their medication, but continued to appear at follow-up, a circumstance which was frustrating to the psychiatric team. On their part, the psychiatrists sought answers to this enigma. As indicated in Table 3, the treating psychiatrists were all of Ashkenazi background and were aged between 32 and 36 years. The majority were married and had an average of two children.
Table 3. Demographic characteristics of the therapist population

<table>
<thead>
<tr>
<th>Therapist no.</th>
<th>Country of birth</th>
<th>Age at immigration (years)</th>
<th>Age at assessment (years)</th>
<th>No. of children</th>
<th>Familial status</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Romania</td>
<td>26</td>
<td>35</td>
<td>2</td>
<td>Married</td>
<td>M</td>
</tr>
<tr>
<td>2</td>
<td>Romania</td>
<td>13</td>
<td>34</td>
<td>2</td>
<td>Married</td>
<td>M</td>
</tr>
<tr>
<td>3</td>
<td>Russia</td>
<td>25</td>
<td>34</td>
<td>2</td>
<td>Married</td>
<td>F</td>
</tr>
<tr>
<td>4</td>
<td>Poland</td>
<td>12</td>
<td>34</td>
<td></td>
<td>Divorced</td>
<td>F</td>
</tr>
<tr>
<td>5</td>
<td>Israel</td>
<td>33</td>
<td>32</td>
<td>3</td>
<td>Married</td>
<td>M</td>
</tr>
<tr>
<td>6</td>
<td>Romania</td>
<td>13</td>
<td>32</td>
<td>2</td>
<td>Married</td>
<td>F</td>
</tr>
<tr>
<td>7</td>
<td>Argentina</td>
<td>30</td>
<td>32</td>
<td>2</td>
<td>Married</td>
<td>F</td>
</tr>
<tr>
<td>8</td>
<td>Israel</td>
<td>31</td>
<td>32</td>
<td>2</td>
<td>Married</td>
<td>F</td>
</tr>
</tbody>
</table>

Procedure

This study was based on the 'Emic approach' (Weiss, 1997). As such, it represents qualitative research carried out from a phenomenological perspective (i.e. from the patients’ and therapists’ respective points of view: Becker et al., 1961; Becker, 1963; Deutcher, 1973; Douglas, 1970; Pelto, 1970; Scheff, 1967; Weiss et al., 1988). This approach, also called ‘domain analysis’, was adopted as the method of choice because while it considers basic questions that emerge from the literature, it also admits new questions and new approaches based on the results. Furthermore, it is characterized by flexibility and lack of predetermined positions (Bogdan & Taylor, 1975; Spradley, 1979).

In line with this approach, data were gathered in semi-structured interviews with the therapists and the patients. Both groups were asked open-ended questions regarding the nature of the illness, its initial symptoms, subsequent development, the time and circumstances of referral for medical treatment, the course of treatment, and its success. Supplementary data were obtained from the patients’ existing treatment records. All interviews were recorded on audiotape with permission from the participants, and then transcribed verbatim.

The researcher conducted interviews with patients in their homes. Interviews typically lasted between two and four hours, depending on the participant’s level of cooperation and ability to express herself. All interviews were conducted in Hebrew, although terms from the patients’ mother tongue were used sporadically.

Interviews with the therapists were carried out by the researcher subsequent to the patient interviews, and took place at the psychiatric clinic. In the interviews with the therapists, each patient was discussed individually. The interviews lasted about two hours.

Data analysis

A content analysis of the interview protocols was conducted. In line with the emic approach (Pelto, 1970; Spradley, 1979; Weiss, 1997), the analysis was carried out as follows: first, the responses to the open-ended questions in each interview were reread several times, and repeating motifs were identified. The main themes identified were: descriptions of the disease, explanations of the disease, perceived reasons for its occurrence, the course of its development, the attitudes of ‘significant others’ toward the illness, and the ‘psychiatrist–patient’ interaction during therapy. These motifs were used as the basis to construct several categories of response. Similar responses were tallied across respondents according to the categories identified.
Findings and discussion

The results of the data analysis revealed significant differences between the perceptions of female patients from a traditional Moroccan background and their Western-trained psychiatrists with regard to their perceptions of mental illness and the therapeutic process. These differences in perception appeared to reflect the respective cultural origins of these two groups, namely, the European background and Western training of the therapists, and the traditional Moroccan background of the patients.

In this study, three patient groups were examined: young women, women in the middle age range, and older women. The analysis of the data obtained for each group indicated that the symptoms, perceptions of illness, and treatment needs differed in each. Conflicts in the patient–psychiatrist interaction were evident across the age groups, but were most pronounced among women in the middle age range. In the following section, these group differences will be discussed.

Patients’ symptoms and attribution of cause

Women in the middle age range

Among women in the middle age range, symptoms were mainly somatic and typically appeared for the first time following the birth of a baby. Fifty percent of the patients in this group described somatic symptoms such as lack of appetite, weight loss, pressure in the head, pain and pressure in the chest, feelings of suffocation and dyspnea, weakness, palpitations, and abdominal pain. Some also complained of tremors, paralysis, back pain, pressure in the eyes, dizziness, inability to speak, vomiting, diarrhea, and nausea.

Diagnostic confusion on the part of the psychiatrists was very evident regarding women in the middle age range. Several diagnoses were often given to one patient, which occasionally contradicted each other. The range of diagnoses typically included hysterical personality disorder, depressive and paranoid personality traits, and depressive reactions. The therapists found these patients ‘enigmatic’. As one psychiatrist said, these women’s diagnoses:

... Changed [at different assessment times], and ranged from pseudo-neurotic schizophrenia to personality disorders (B.12).

Women in the middle age range also appeared to be perplexed regarding the source of their problems. This confusion seemed to be associated with their attempt to maintain a traditional belief system while at the same time wishing to assimilate. They used both Western and traditional terms to describe their illness. To quote one woman:

I have depression and weakness. It’s not nerves. It doesn’t go away. ‘Tsira’ [light demonic possession—Bilu, 1978], ‘Tkiaa’, I just got stuck. Like having indigestion, I have a mental disturbance, not a mental illness. It’s actually shock and alarm (B.13).

It appeared that although these women held a deep internal belief in the traditional explanatory model, externally they tended to conform to the Western model. For example, one patient (B.18) gives three explanations for her condition: a Westernized explanation relating to stress and stress reactions; a second, more traditional explanation which focused on the doctors’ malevolent intentions; and a third explanation in which she stated that her husband and mother-in-law had a spell cast on her to cause her to become insane:

Look, the reasons for all these illnesses is troubles, troubles, troubles. A person who has a lot of troubles collects them until he goes crazy.
All the spells they cast on me didn’t do anything to me. What made me crazy was the prescription the doctor gave me ... Like we Moroccans have spells, you doctors have pills.

My husband fixed up some spell with his mother against me ... My husband and his mother gave me all of this—they spend their money and soul on spells and s’hurs [In Moroccan, a hex—Bilu, 1978]. He used to say—I’ll kill her, I’ll make her crazy—and he did it ... (B.18).

The therapists were not aware of this ambivalence. In fact, they were either not even familiar with the traditional explanatory model, or did not think their patients believed in it. When the therapists were asked if they thought there was a causal link between the patients’ culture and their condition, the typical responses were: ‘I’m not familiar with the subject, so I couldn’t say ...’; ‘I don’t think so. Maybe?’; ‘I don’t know—I don’t know her well enough ...’.

When asked if she thought a patient had accepted the psychiatric explanation offered to her, one therapist had this to say:

She accepts that she is sick ... I think she accepts my perception ... I partially explained to her the importance of pharmacotherapy, and the nature of her illness—she accepted what was said—accepted my view.

Her patient however, had a different explanation for her illness:

It’s probably the Evil Eye ... Look, sometimes I think it happened to me because I’m being punished for bad things I did—that’s what religious people believe ... I think it might have something to do with a curse on my family—my mother said someone cursed our family (B.16).

These findings support the view that the outward Western behavior of these women was merely superficial, whereas their real convictions were traditional. These women had not integrated the Western concept of ‘autonomy of the self’ as part of their personality, and so perceived their illnesses as being the result of external factors. For instance, many explained the crisis after childbirth as being caused by supernatural spirits and the ‘Evil Eye’. Typically, they also maintained that their present illness was the result of an accumulation of traumatic events. Thus, these patients did not consider themselves mentally ill in Western terms. This may have been due not only to their awareness of the stigma attached to such illness in Israeli societies, but because their conception of the source of their problems differed.

These women’s view that external factors accounted for their illnesses had a basis in reality. Typically, intense stress occurred after key events, particularly events related to childbearing. Among most of the women in the middle age range, the trigger for their illness was related to pregnancy, abortion, or birth itself.

One explanation for this lies in cultural discontinuity. In traditional society, childbirth is considered weakening for women. Therefore, the postpartum woman must beware of supernatural, superhuman and human dangers. The adage, ‘The grave is open until a month after delivery’ reflects the perception of the woman’s proximity to death during this period, and the need to guard her. In Morocco, the mother is waited on for a month following labor: her food was prepared, her children taken care of, and her house cleaned. In this perception of childbirth, a crisis occurring in the postpartum period is legitimate, understandable, and requires help and support. The finding that the appearance of symptoms closely followed childbirth suggests that the woman’s feeling of solitude and lack of support at this critical time may have played a critical role in their development.
Women in this age range typically experienced a collapse of family structure following immigration to Israel. Most of these women were raised in an extended and multigenerational family, which frequently lived within a single household. Upon their arrival in Israel, their families became more nuclear. When these girls grew older and eventually married, they lived separately from their extended families. Thus, their family structure became even more nuclear, and they became more dependent on their husbands for support. As was common among many non-Western immigrants to Israel from traditional, patriarchal societies, their husbands did not assume the supportive role usually taken on by the female members of the extended family. This lack of support may have served as a precipitating factor for the development of somatic symptoms. Physical symptoms may have allowed them to receive some measure of support in a socially and culturally acceptable way. As suggested by Eisdikovits (1983), the ‘patient role’ may have allowed the woman to obtain support from her husband, but also entrapped her in a vicious cycle.

when I delivered my first daughter, the troubles began, my husband didn’t come to visit me, I was in my mother’s in law home, like a dog, he cheated on me ... and after every birth I felt bad and hospitalized. There was nobody around to help me ... (B.18).

Another aspect of the specific problems of women in this age group is that most had immigrated to Israel during adolescence. Therefore, they may have suffered a double identity crisis; one due to the cultural transition, and another due to the developmental stage at which a search for identity normally occurs. The idea that adolescence is a particularly critical period in terms of the effects of immigration has been forwarded previously by Mirsky (1997).

Perhaps more than the other two groups, these women were caught ‘between two worlds’. Not only did they face a double identity crisis, but they entered a society which, although pressuring them to adopt modern Western values, treated immigrants from Middle Eastern countries condescendingly, viewing them as ‘primitive’ and ‘backward’. At the same time, members of their own ethnic community saw the adoption of the new ways as threatening, and in the case of women, often immoral. Thus, these women may have felt doubly rejected.

Among women in the middle age range, cooperation with the medical treatment was minimal. Only a small minority took their medication as prescribed. The majority did not take their medication at all, a fact they concealed from their psychiatrists. All the women in this group also sought traditional treatment during the course of therapy, another fact they concealed from the psychiatrists. This finding suggests that these women were dissatisfied with the medical treatment, yet did not wish to displease their psychiatrists.

Interestingly, all the patients in this group attributed any improvement in their condition to the simultaneous use of both methods. It appeared that these women felt that the combination of treatments gave them the best of both worlds: the traditional methods answered a need to be protected from external dangers, while the psychiatric clinic provided them with a framework for social and emotional support. The patients considered the clinic to be a setting for entertainment, ventilation, security, and maintenance of their patient role. The clinic served as a social gathering place and an occasional hospitalization offered a respite from day-to-day pressures. The patients say:

My only fun is coming here—I talk and vent a little (B.19).

Coming here is like a holiday from home. I dress up, and forget about my chores ... (B.21).
I come here only because of my fear that if I stop coming, my illness will no longer be acknowledged. This is better—I come to the doctors every two months, and in between continue with the rabbis’ treatments (B.24).

Whatever my fate will be, I don’t believe in doctors. They can’t make me crazier, but they can’t make me healthy either. I come here so they won’t close my file (B.30).

Another factor that may have contributed to the ineffectiveness of psychiatric biomedical therapy among Moroccan women in the middle age range was that the psychiatrists often failed to explain their diagnostic conclusions in detail. One reason these women may have sought traditional explanations for their diseases was because the psychiatrists gave only limited information to the patients. A common claim among the psychiatrists was that verbal explanation was not needed because the patients were not used to, and could not understand, the psychiatric perspective. As put by the psychiatrists;

She lacks the insight and introspection required for successful Western-oriented psychotherapy (B.21).

She can’t understand in the sophisticated sense. She has a limited ability to understand due to her educational background and low mental capacity (B.18).

Despite this view on the part of the therapists, the patients themselves felt a need for verbal interaction and explanation. To quote the patients:

My opinion is that talk therapy is better than just taking medications and poisoning the body. If they just gave me a touch, encouragement, a smile, that would be enough (B.32).

All day long it’s just pills, pills, pills. I don’t think I need any. I want someone to sit with me, understand me, hear me, give me advice, so I know what I’m doing wrong. But here, only 5 to 10 minutes—‘take your pills and leave’ (B.12).

I think if there were Moroccan doctors it would have been better—they would understand me (B.16).

Young adult women

The psychiatrists generally felt little diagnostic confusion in the case of younger women. The most common diagnoses among young women were hebephrenic schizophrenia and personality disorders. These women shared a common referential terminology with their therapists, and discussed their illnesses in terms of intrapsychic conflict. Thus, young women tended to use Western phrases to describe their illnesses, and viewed them as emotional problems. This Western perspective on the part of the patients is apparently due to the fact that they had been born and raised in Israel. As one woman described her illness:

Maybe its depression like the doctor says. I don’t know what to think anymore. I thought I had something physical, a physical illness. I had tests done, and they didn’t find anything. My husband says I’m crazy, and the children hear him and they call it craziness too. So I have depression. I know what I have is a problem with my nerves. I’m always nervous ... (Z.7).

Yet despite the use of a common explanatory model, young women exhibited a lack of compliance with the biomedical treatment. They refused to take their medication as directed, and usually appeared at the clinic only as a result of family pressure (typically by the mother).
This may have derived, in part, from understanding the stigma of mental illness, and their unwillingness to be thus stigmatized. These women had no desire to be placed in the patient role, nor to be relieved of the role and demands of the homemaker. These women saw themselves as ‘modern’, and sought to avoid being seen as ‘primitive’. Thus, they also did not seek traditional therapy. Because they did not see themselves as mentally ill, they refused any form of treatment.

Once they (the psychiatrists) set up a meeting with psychologist, he asked me to draw picture, I don’t like it. They want to prove that I’m crazy ... (Z.37).

Among young women, symptoms of mental illness were typically characterized by ‘acting out’ behaviors and multiple suicide attempts. It should be noted here that in traditional Jewish culture, suicide is prohibited. Apparently, women in both the middle and the older age ranges acceded to that taboo, as suicide attempts were nonexistent among those age groups.

The young women attempted suicide primarily by drastic means such as suffocation and fire. This finding suggests that they considered death the only solution for their suffering, and were not merely crying out for help. This phenomenon may reflect feelings of helplessness due, in part, to feeling caught between the demands and expectations of their traditional family and those of modern Israeli society. This interpretation is supported by the finding that among most of the young women, symptoms of mental illness first appeared during adolescence. On the basis of the information obtained in the interviews, it would appear that one of the precipitating factors for the suicide attempts was that older members of the family perceived the desire for independence and sexual experience as threatening to family homeostasis and the preservation of traditional values. One young woman expressed her distress thus:

Everything starts at home, especially in my case ... If I let my hair down, they called me a whore. Same thing if I came home half an hour late, they would call me that too. That’s why I got the stabbing pain attack ... My father was very strict about religion and tradition, and it was more important for him than family relationships (Z.2).

The data from the interviews suggests that while they felt themselves to be a part of modern Western society, young women experienced a great deal of internal conflict due to their traditional background. The fact that they shared a common terminology with their therapists may have served to conceal this, such that the psychiatrists were unaware of the full significance of this factor. The therapeutic interaction was further undermined by these women’s denial that they were mentally ill and refusal to seek much-needed therapy.

Older Moroccan women

As for the younger group of women, the psychiatrists had little difficulty reaching diagnoses. Older women were usually diagnosed as having neurotic ailments such as adjustment disorder, or as having a ‘primitive’ personality. Among the women in the older age group, the most prevalent symptoms were withdrawal, fear, and anxiety. These women described their illness in the strictly traditional terms of their culture of origin.

I was scared of my sister’s scream, I got left in the air, ‘Machluaa’ [scared], ‘Dhesha’ [dumbfounded]. I was scared of the fire. I was just shocked, ‘Hatfa’ [a fright ...(M.16).
Unlike the other two groups of women, older women took their medication. This high level of cooperation may be due to the high value traditional Moroccan culture places on the healer. The traditional healer is typically an older, experienced and dignified individual, and is accorded great respect. However, one of the more obvious differences between the women in the older age group and their psychiatrists was in terms of age; while the psychiatrists were all of higher socioeconomic status, they were also younger than the patients. Moreover, the psychiatrists were all of European background. Consequently, while the high social status of the therapists appeared to be respected, the psychiatrists’ age and cultural background may have created a distance in terms of the therapeutic alliance.

I don’t take any medication (psychotropic) but lets keep it between us. If I will take this medication, that’s the end for me, if I will take them I will not cook anything ... I have my faith that’s the best ... (M.24).

While they cooperated with the medical treatment, older women displayed an ambivalent attitude towards the psychiatric interaction. Like women in the middle age range, they sought simultaneous traditional treatment. However unlike their younger counterparts, they did not try to hide this from their therapists. The older patients spoke freely about obtaining traditional treatment:

The rabbis told me I got depression because I stepped on something bad [demonic]. What they wrote on my amulet is that someone gave me the Evil Eye. The rabbi told me that this Evil Eye was made for someone else, but I stepped on it accidentally instead of her, so I got her depression. Now nothing will help, it will never go away. I believe this with all my heart (M.37).

My mother-in-law cast a hex on me. Since then, I have no more strength. Before, I was like an ox, working from morning till night (M.18).

When someone is caught [by a demonic force], that’s it—he can never get out of it (M.17).

The ambivalence on the part of older women towards the psychiatric interaction also appeared to be associated with the lack of verbal interaction, as well as the lack of understanding on the part of the therapists regarding the significance of the loss of their former status and support from their extended family. This idea has been put forward in the context of previous work on immigrants (e.g. Comaroff, 1978; Youngman et al., 1999).

Women in the older group had immigrated to Israel despite their feelings of deep cultural roots and attachment to their native land. They made no pretence of exchanging the old for the new. However, despite their adherence to traditional beliefs and values, their role and status had been altered by changes in the family structure upon immigration to Israel. These women had spent most of their lives within an extended family, and enjoyed the respect and the venerated role of an elder. As with the women in the middle age group, these women intensely felt the lack of a social support network, perhaps more so because of their loss of status and the length of time they had spent in their former cultural milieu. Upon immigration to Israel, they no longer enjoyed their former vantages and felt left alone in an empty nest. Many had to cope with senescence on their own, and as well as feeling useless to their community. Moreover, as the extended family disintegrated and the nuclear family emerged, the remaining family’s ability to render support in cases of illness was diminished. In a sense, these women perceived psychiatric treatment as an alternative to the family support they had been accustomed to.
my only treat is to come here (to the clinic), I'm talking a little bit and feel relieved ... my children forced me to stay there (psychiatric hospitalization), I thought it's like a hotel, I will get some rest and than it's over. But I came, I saw people in very severe state, I never have been in a state like this ... I wanted to come home so I was about to take a cub and then my daughter in law came and convinced me to wait ... (M.17).

### Problematic psychiatrist–patient junctures

The results of this study revealed that in each of the three groups of women examined, issues of cultural conflict were central to the development of their emotional problems. However, the focus of these issues and the manifestations of cultural-based conflict differed in each. The psychiatrists appeared unaware of the significance of these issues to the development and maintenance of their patients' illnesses. The consequence of this was confusion regarding psychiatric diagnoses, and largely ineffective psychiatric treatment.

One of the central problems for the patients in the middle and older age groups was that because they held a primarily traditional model of illness and healing, they did not view their illnesses as resulting from intrapsychic conflict, but from external, often magical factors. In this context, the psychiatrist was considered an omnipotent healer, and the patients largely expected healing to occur without being actively involved in it themselves. These patients also desired warmth, personal involvement, and devotion on the part of the psychiatrist. This in essence, reflects a transfer of expectations from traditional healers to the Western setting. When healing did not automatically occur as the result of taking their medication, and they did not obtain the verbal explanations, sympathy and support they sought from their psychiatrists, these women were disappointed. It is clear that what these women sought from the therapeutic interaction was primarily social and emotional support, rather than medical treatment.

Younger women appeared to share a similar perception of the source of their illness with their doctors, namely, that their illness was the result of intrapsychic conflict. Despite this, they viewed the precipitating conditions to be cultural conflict between the demands of their traditional upbringing versus their desire to live as modern, Western women. In this sense they were similar to women in the middle age range. As this age group appeared most resistant to receiving any form of treatment, alternative methods of encouraging them to obtain treatment must be considered.

The psychiatrists, in keeping with their position as head of a multidisciplinary therapeutic team who held mainly the responsibility for the medical aspects of treatment, kept their patients at a distance. In line with their Western training, they expected cooperation, involvement, responsibility and insight on the part of their patients. The results of this study suggest that this approach is unsuitable for the treatment of traditional patient populations of Moroccan origin. As suggested by Biliú (1978), as long as modern psychiatry does not allow for the importance of 'life problems' in the development of mental illness among traditional populations, the efficacy of biomedical treatment, as well as intrapsychic therapy, may be ineffective.

### Conclusion

The results indicate that the effectiveness of the treatment is closely linked to the patient-therapist relationship. Clearly, there is a need for greater communication with their patients on the part of the psychiatrists, both in terms of explaining their diagnostic conclusions, and in terms of understanding the patients' own viewpoint. While the psychiatrists may have rightly concluded that Western psychotherapeutic treatment was unsuitable for this population, there is a definite need for emotional and social support.
FIGURE 1. Integrative model of the patient-therapist relationship

In view of these needs, it is suggested that the effectiveness of the treatment may be improved through increased psychotherapy by a member of the treatment team, support groups, and greater personal interaction on the part of the psychiatrist. Because mental illness carries a stigma in most societies, another way in which to provide emotional and social support for immigrants is through involving the general family practitioner. The trained GP, in association with community mental health clinics, may prove an effective mediator in the processes of obtaining the appropriate emotional and social support for immigrants. This may be particularly critical in cases in which there is resistance to obtaining therapy.

In the illustration above (Figure 1), a model is proposed which suggests ways in which the gap between the traditional and biomedical approaches may be bridged through increased
patient–psychiatrist communication. According to this model, psychiatrists trained in Western biomedical approaches may be better equipped to help patients from traditional backgrounds by adopting an integrative approach. When therapists become better acquainted with the cultural perspectives of their patients, and explain their own perspectives to their patients, the gap between these two internal models of mental illness may be narrowed.

In a multicultural society such as Israel, in which continuous immigration is the norm, such training is a necessity. Immigrants comprise a vulnerable population and so are at high risk for mental illness. As therapists may play a vital role in the successful adjustment of such individuals, it is critical to achieve a greater understanding of the patients’ backgrounds and to examine their illness in the context of their cultural history. As the process of acculturation is a continuous one, often across generations, psychiatrists must also be aware of the differences among individuals at different stages of this process. Thus, as suggested by the data in the present study, immigrants at different stages may have varying treatment needs and the therapeutic emphasis must reflect this.

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