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IS PSYCHOTHERAPY REALLY NEEDED IN NONWESTERN CULTURES? THE CASE OF ARAB COUNTRIES[1]

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Summary.—Research has shown that mental health problems in Arab countries are of large proportion, with women and children probably the groups most at risk. Forms of psychological treatment are inadequate, making the need for such services a top priority.

The research on mental health issues in most Arab cultures is scattered. To our knowledge, no comprehensive epidemiological data on incidence of mental health problems in the Arab Middle Eastern countries are available. This may create the impression that mental health services in this part of the world are not warranted; however, there is evidence that mental health problems are of large proportion, and mental health care is inadequate. For example, Ibrahim (1971) found that Egyptians scored higher on neuroticism than Americans and British. Structural factors of extraversion, neuroticism, and psychoticism have been identified in Egypt and Saudi Arabia as noted in England (Farrag, 1985; Khalik & Eysenck, 1983). Ibrahim and Al-Nafie (1991) reported for a large number of university students in Saudi Arabia depressive symptoms and other related symptoms, including self-blame (64%), inability to concentrate well (54%), shyness (53%), shivering and shaking when somebody gets on their nerves (42%), problems related to school and study (33%), etc. Libyan students scored significantly higher on social anxiety and shyness scales than comparable cultural groups (Ibrahim, unpublished manuscript). While this article is too short to contemplate explanations, establishing solid policies of more mental health research and services should be encouraged in these cultures.

Within Arab cultures, mental health needs may vary from one group to another. For example, research showed that women are more prone to pressures than men, and, hence report more symptoms of anxiety (Ibrahim, 1976, 1991), neuroticism (Ibrahim, 1977; Khalik & Eysenck, 1983), and depression (Ibrahim, 1991; Ibrahim & Al-Nafie, 1991). Rufaie and Mediny (1991) studied all admissions to a psychiatric inpatient unit in Saudi Arabia, from 1988 through to 1989 and reported more women were admitted than men, with a ratio of 1.6 to 1. In an outpatient population, Saudi women, compared with Saudi men and Western women, reported higher rates of life

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stresses, especially marital, indicating that married women are even more at risk (Chaleby, 1986).

Children are also a risk group (Tuma, 1989). In our behavioral clinic, our initial data indicated that 65% of the outpatient visits are for children (Age 15 and below). Although it is difficult to get confirming data, almost 35% of our children clients showed psychiatric disturbances that warranted intensive care. For the rest, other emotional and behavioral problems (including disciplinary problems, toilet training, school problems, fears, speech and language difficulties) were noted, suggesting they were at risk and would benefit from behavior therapy and other mental health services.

In most Arab countries the most common interventions are by psychiatrists who mostly rely on drugs. The mental health treatment settings occur in two major kinds of professional systems, traditional mental hospitals and outpatient settings. Private psychiatric clinics are also an option for some. Various private corporations, universities, and religious organizations own and operate some health services that also provide psychiatric services. Some psychological services (e.g., psychometry, behavior therapy, family therapy) are provided through such settings but in most cases psychotherapy *per se* is not represented. Psychologists who are trained in any form of psychotherapy are rare, making the need for research on psychological health and training in therapy of high priority.

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