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CROSS-NATIONAL STUDY OF ATTITUDES TOWARDS SEEKING PROFESSIONAL HELP: JORDAN, UNITED ARAB EMIRATES (UAE) AND ARABS IN ISRAEL

ALEAN AL-KRENAWI, JOHN R. GRAHAM, YASMIN Z. DEAN & NADA ELTAIBA

ABSTRACT

Background: Help-seeking processes provide critical links between the onset of mental health problems and the provision of professional care. But little is known about these processes in the Arab world, and still less in transnational, comparative terms. This is the first study to compare help-seeking processes among Muslim Arab female students in Jordan, the United Arab Emirates and Israel.

Aims: The present study compares the attitudes of Arab Muslim female students from Israel, Jordan and the United Arab Emirates (UAE) towards mental health treatment.

Method: A convenience sample of 262 female Muslim-Arab undergraduate university students from Jordan, United Arab Emirates (UAE) and Arab students in Israel completed a modified Orientation for Seeking Professional Help (OSPH) Questionnaire.

Results: Data revealed that nationality was not statistically significant as a variable in a positive attitude towards seeking professional help; year of study, marital status and age were found to be significant predictors of a positive attitude towards seeking help. High proportions of respondents among the nationalities referred to God through prayer during times of psychological distress.

Conclusions: The discussion considers implications for professional service delivery and programme development. Future research could extrapolate findings to other Arab countries and to Arab peoples living in the non-Arab world.

Help-seeking processes provide critical links between the onset of mental health problems and the provision of professional care. Lin *et al.* (1982) define the help-seeking process as those events occurring between the point of first recognising a problem (onset), and the point when a patient enters a mental health care system and stays in treatment for more than one session (treatment point). As recent research points out, there is variance in specific help-seeking practices by age, ethnoracial group, gender, nationality, religion and socio-economic status (Lin *et al.*, 1982; Bayer & Peay, 1997; Al-Krenawi & Graham, 1999, 2003; Okasha, 1999). A wide literature considers differences in utilisation and attitudes towards mental health treatment among diverse ethno-racial communities (Razali & Najib, 2000). Women, especially young adults, are found to have mental health needs that are often

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unmet (Ciarrochi & Deane, 2001; Krishnan *et al*., 2001; Raviv *et al*., 2000) and in some societies are high consumers of mental health services (D'Arcy & Schmitz, 1979). The present study contributes to a growing corpus of research on mental health help-seeking processes among Arab peoples (Al-Krenawi & Graham, 1999, 2000a; Al-Krenawi *et al*., 2000). It is the first to compare the attitudes of Arab Muslim female students from Israel, Jordan and the United Arab Emirates (UAE). Each group lives in significantly different economic, political and social contexts. Yet, as will be shown, the data reveal surprisingly similar attitudes towards helping seeking across the three nationalities.

ARAB SOCIETIES

Arab societies share many attributes, including a common physical and geographic environment and a collective memory of their place and role in history (Barakat, 1993). The Arab world is profoundly transitional, balancing modern phenomena such as oil exploration with traditional structures such as tribal castes (Barakat, 1993). Its economies remain largely dependent and underdeveloped, and its material and human resources have been harnessed for the benefit of a small segment of the population and on behalf of what are perceived to be antagonistic external forces (Barakat, 1993). Arab societies often consist of complementary patterns of family structures, patriarchy, primary group relations, spontaneity and expressiveness. They tend likewise to be high context, emphasising the collective over the individual, having a slower pace of societal change and a greater sense of social stability (Hall, 1976; Barakat, 1993; Lev-Wiesel & Al-Krenawi, 1999; Al-Krenawi & Graham, 2000a). The family, therefore, is important to the homologous interrelationship between the individual and group, as well as between the individual's social and economic status (Barakat, 1993). One of the most important parts of its kinship structure is the *hamula*, which includes a number of generations in a patrilineal line that have a common ancestor (Al-Haj, 1987; Al-Krenawi, 1998).

Arab societies are highly diverse and consist of heterogeneous systems of social differentiation based on ethnic, linguistic, sectarian, familial, tribal, regional, socioeconomic and national identities. On one level, therefore, Arab peoples may be perceived as having deep social and class distinctions and as being both disunited and politically fragmented transnationally and within national borders. Western norms have penetrated much of the Arab world although their impact has been differentially experienced within communities and across societies. Each society in the present article is overwhelmingly young. The United Arab Emirates (UAE) is a geographically small country, of 82,880 sq km. It had a population in 1998 of 2,759,000, with 1,844,000 (66%) men and 915,000 (33%) women.[1] A young country, the population growth rate is 1.59% (2001 est.) and fertility rate is an average of 3.23 children born/woman (2001 est.). It is more ethnically diverse than Jordan, with only 19% of the population local Emirati, the balance consisting of other Arab and Iranian 23%, South Asian 50% and other expatriates (includes westerners and East Asians) 8%.[2] Since 1973, oil has transformed the Emirates from an impoverished region of small desert principalities to an oil rich nation, albeit with high rates of economic stratification. The UAE's per capita GDP is not far below those of the leading West European nations. Its Gross Domestic Product (GDP) per capita is $22,800 (2000 est.) and its generosity with oil

revenues and its moderate foreign policy stance have allowed it to play a vital role in the affairs of the region. The unemployment rate is unspecified.[3]

Jordan is also a small country, of 92,300 sq km, sharing a long border with Israel. With a population of 5,153,378 (July 2001 est.), it is a young country; its growth rate is estimated to be 3% (2001 est.) and a total fertility rate 3.29 children born/woman (2001 est.). Jordan remains a diverse country with high rates of internal migration of Palestinian peoples since 1948 and, like the UAE, most of the population is Muslim (Al-Krenawi *et al.* 2000). With a high rate of internal migration, the majority of the population is Arab Palestinian, especially since 1948. About 98% of the country is Arab, and 92% are Suni Muslim, with the remainder Christian (6%) and other (2%). Jordan is a small Arab country with inadequate supplies of water and other natural resources such as oil. The Persian Gulf crisis, which began in August 1990, aggravated Jordan's already serious economic problems, forcing the government to stop most debt payments and suspend rescheduling negotiations. Aid from Gulf Arab states, worker remittances and trade revenues contracted. Refugees flooded the country, producing serious balance-of-payments problems, stunting GDP growth and straining government resources. Its GDP is estimated to be $17.3 billion (2000 est.), and its economy is being reformed, precipitating a GDP real growth rate of 2% (2000 est.). But unemployment remains high: the official rate is 15%, and the actual rate is estimated to be 25%–30% (1999 est.).[4]

With a geography of 20,770 sq km, Israel is a Jewish state, with a population of 6 million, and 2.57 children born/woman (2001 est.). Over 80% of the country is Jewish, approximately 15% is Muslim, 2% is Christian and the balance are Druze and other religious minorities. The Jewish population is racially diverse, with Europe/America-born 32.1%, Israel-born 20.8%, Africa-born 14.6%, and Asia-born 12.6%. Over 1 million Israeli citizens are of minority Arab background, practising Islam (the majority), Christianity or Druze. Official unemployment rates are 9% nationally but are higher among Arab peoples. Of the country's 1.2 million living below the poverty line 42% are of Arab background (Al-Krenawi & Graham, 1998; Poverty in Israel: factors and ways of coping, 2001); among Arab women, the occupational status has declined in absolute and relative terms between 1974 and 1994 (Semyonov *et al.*, 1999). The country's GDP is $110.2 billion (2000 est.) and its GDP per capita is $18,900 (2000).[5]

THE STATUS OF WOMEN IN THE ARAB WORLD

Within the three sample populations, gender differences in these Arab societies tend to remain strongly defined, and the social structure is male dominant. Arab women, particularly in a Muslim society, have been socially constructed by some as powerless, subservient and submissive (Al-Haj, 1987). Men tend to be leaders and the highest authority in the household, the economy and the polity (Morsy, 1993; Shalhoub-Kevorkian, 1999a). In many Arab societies, women's social status is strongly linked to being married and rearing children, especially boys (Al-Sadawi, 1995). Arranged marriages occur frequently, and women are expected to devote much of their time to the care of their family. Women commonly do not have careers outside the home. Many career women, even those attaining high levels of success, defer to their spouse or family for major decisions (Hoodfar, 1997; Shalhoub-Kevorkian, 1997).

Divorced women in Arab societies suffer emotionally and socially. A divorced woman's marital prospects can be poor in many Muslim societies; they are usually restricted to becoming the second wife of a married man or the wife of a widower or older man (Brhoom, 1987; Chaleby *et al.*, 1989; Tamush, 1989; Al-Krenawi & Graham, 1998). Mothers are known to endure years of marital problems in order to avoid the stigma of divorce or the prospect of losing their children (Al-Krenawi & Graham, 1998). Throughout the Arab world, since the 1980s, many gains for younger and working women have become endangered by changing demographics, privatisation, unemployment, urbanisation, and the spread of Islamism as the ideology of the young. With some of their numbers suspicious of the other, secularists are afraid Islamism will take away the limited rights they have gained and Islamists are committed to the rights of women defined by Islam. This polarisation has reduced the possibility of developing a participatory society. Furthermore, although liberal, radical and Islamist perspectives differ on the role of women, they all continue to subordinate women's needs to that of men and society, notwithstanding the efforts of activists in each society (Hatem, 1995).

The study analyses attitudes towards help-seeking processes with respect to such demographic variables as age, year of study, marital status and nationality (Arab peoples in Israel, Jordanians and United Arab Emirates) (see Table 1). It hypothesises that nationality will be a statistically significant variable in predicting attitudes towards seeking professional help.

METHODOLOGY

Participants

The sample consists of three groups: Israeli-Arab, Jordanian and United Arab Emirate. The total sample was 262 Muslim-Arab undergraduate University students; 84 were from Amman, Jordan, 76 from Dubai, UAE and 102 from Ben-Gurion University, Beer-Sheva,

Table 1
The sociodemographic characteristics of the sample

Variable	Values	Total sample	Jordan	Dubai	Arabs in Israel
Nationality		$N = 262$	$N = 84$	$N = 76$	$N = 102$
Age	19 years	35%	67%	39%	6%
	20	18%	18%	31%	9%
	21	15%	12%	25%	10%
	22	9%	2%	4%	18%
	more than 22	23%	1%	1%	57%
Year of studies	1st	31%	69%	16%	13%
	2nd	31%	14%	49%	30%
	3rd	26%	10%	35%	32%
	more than three	12%	7%		25%
Marital status	Married	16%	2%	12%	30%
	Single	84%	98%	88%	70%

Israel. A convenience snowball method was used to select participants. Ages ranged from 19 to 24; the majority were under 21 (53%). The questionnaire included a question on ethno-racial background, religion and gender; any subject who self-reported as not being a Muslim, female or of Arab background was excluded from the analysis. For purposes of this study, Arab students in their first year of studies made up 31% of participants, 31% were in their second year and 38% were in their third year or more. Married participants comprised 16% of the sample and 5% of participants had at least one child. All subjects from the UAE and Jordan were studying family sciences, education, communication or art in the faculties of social sciences. While 90% of the Israeli-Arabs were in the faculty of social sciences and humanities, the remaining 10% were in the faculty of health sciences, studying such disciplines as nursing, physiotherapy, pharmacology or laboratory studies.

Measures

The Orientations for Seeking Professional Help (OSPH) Questionnaire

The OSPH scale, created by Fischer and Turner (1970), is a 29-item scale that assesses attitudes associated with seeking professional help for psychological problems. The scale has a four-point Likert format, with responses ranging from 'strongly agree' to 'strongly disagree'. This scale has four dimensions: recognition of need for psychological help, stigma tolerance, interpersonal openness and confidence in mental health professionals. Factor 1 identifies recognition of personal need for psychotherapeutic support. Scoring low (negative) on this subscale means seeing little necessity for professional help for emotional problems, believing that psychological conflicts resolve themselves. In contrast, high scores (positive) on this scale indicate the individual does not see value in suffering alone through a period of emotional stress, and is acknowledging the possibility of seeking professional help in the future. In Factor 2, which assesses opinions about threat of stigmatisation as a result of a psychiatric treatment, low scores indicate sensitivity to others' opinions regarding the need to visit a psychiatrist. High scores express freedom from such concerns. Factor 3, a measure of interpersonal openness, perhaps comes closest of the four subscales to being a personality measure. An apparent hypothesis would be that people scoring high on this scale disclose important aspects of themselves more readily than low scorers do. Finally, Factor 4 refers to confidence in mental health professionals and practitioners. Scoring high on this subscale is indicative of faith in psychotherapeutic techniques and in mental health professionals.

The scale reliably distinguished persons who had experienced prior psychotherapeutic help from those without such professional contact. The internal reliability of the scale is moderately good (Cronbach alpha = 0.83–0.86), and its test–retest reliability ranges from $r = 0.86$ ($N = 26$) for a five-day interval, to $r = 0.84$ ($N = 20$) for a two-month interval. In this study the Cronbach alpha was 0.85, indicating high reliability.

FINDINGS

A hierarchical multiple regression analysis of the sum total of the scores from the OSPH was performed in order to examine whether nationality was a predicator of a positive attitude towards seeking professional help for psychological problems. This is the rationale behind the inclusion of particular variables in the logistical regression analysis. The demographic

Table 2
Nationality as a predictor of a positive attitude to seeking professional help for psychological problems, results of a hierarchical multiple regression analysis of the sum total of the scores from the orientation for seeking professional help (OSHP) questionnaire

	β	*β*	*T*
Age	0.79	0.09	2.35*
Year of study	3.30	0.15	2.25*
Marital status	2.15	0.18	3.52***
Nationality	0.45	0.04	−0.68

$F = 8.90$***; $R = 0.31$; $R^2 = 0.10$

*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$

variables entered in this analysis were age, year of study, marital status and nationality. Data revealed that nationality was not statistically significant as a variable in a positive attitude towards seeking professional help (see Table 2).

Year of study, marital status and age were found to be significant predictors of a positive attitude towards seeking help. Means indicated that those in advanced years of study, in the third year or more ($M = 134.4$, SD = 21.5), had more positive attitudes than those in the first and second year ($M = 126.2$, SD = 16.4). Single women ($M = 124.3$, SD = 18.4) had less positive attitudes to seeking professional help than married women ($M = 135.8$, SD = 23.5). The findings also revealed that the younger respondents, those from age 19 to 20, have less positive attitudes towards seeking professional help (younger $M = 123.3$, SD = 21.2) than those older, from age 21 to more than 22 ($M = 125.4$, SD = 19.2). In addition to the 29 questions of the scale, we added one more question that asked: If you experience a psychological problem do you refer to God through prayer? Eighty-five per cent of Jordanians, 78% from the UAE and 70% of the Arabs in Israel responded affirmatively.

DISCUSSION

The findings revealed differences in attitudes and knowledge varying by age. Younger respondents had less positive attitudes than those aged 21 and more. It is possible that younger respondents had less awareness about available mental health services and of mental health problems. Previous exposure to mental health services has been shown to be associated with positive attitudes towards mental health help-seeking processes (Yoo, 1996).

Single women in our study had less positive attitudes towards seeking mental health services than married women. Being married may change attitudes in several respects. Married respondents may have been older than their single counterparts, and so marriage could be a partial artefact of age. Being married – particularly in an unhappy marriage – may occasion more reasons for considering the use of mental health services (Hall, 2000; Williams, 2001). Predisposing factors such as marital status or age, however, are contingent upon the presence of need to seek mental health services (Leaf *et al.*, 1988). Some research points out that women, not men, are differentially excluded from marriage following onset

of a psychiatric disorder (Hall, 2000), and marital status reduces the potential stigma, as elaborated later, of seeking mental health services.

The data in the present study show that students in the first and second year had less positive attitudes towards psychological help. These attitudes, likewise, might have changed with more experience in academia and in growing older. We can see similar results among married and single respondents. Cultural factors may create a significant barrier. Women in Arab societies are stigmatised if they utilise mental health services, and may perceive utilisation as jeopardising marital prospects or of increasing the likelihood of separation or divorce. Among Muslims in the Arab world, a husband or his family could use seeking treatment as leverage for obtaining a second wife. Women represent a family's honour; and so they may be highly reluctant to divulge personal issues to anyone outside the family, for fear of hurting their family status or their own status within it. Moreover, women respondents may worry whether help seeking could lead the family to withdraw her from studies, or invoke other sanctions that may negatively influence her life.

In the Arab world, stigma is attached to mental health services (Savaya, 1995; Al-Krenawi & Graham, 2000a) and may have influenced respondent attitudes towards seeking psychological help. Indeed one study of Arab women's help seeking indicates that medical general practitioners, rather than psychologists, psychiatrists or other mental health professionals, tend to be the targeted treatment source of choice (Savaya, 1995). Similarly, the utilisation of services may variously be interpreted, or perceive to be interpreted as reflecting, inability to cope on one's own, personal weakness or the socially unsanctioned need to involve those outside of the family in resolving a problem (Al-Krenawi *et al.*, 2000). Moreover, the status of being a post-secondary student may create a higher social prestige, reinforcing norms of being able to cope on one's own. Some research associates liberal attitudes towards women with positive help-seeking attitudes in men and women (Zeldow & Greenberg, 1979). The patriarchal norms in the Arab societies under examination may have a negative impact on attitudes towards mental health services among men and women.

At the same time, the mental health needs of women in Arab communities may be considerable. Arab patriarchy limits women's choice-making agencies and their geographic mobility, both of which negatively impact help-seeking abilities, which is further exacerbated by the stigma of mental health services as discussed below (Al-Krenawi & Graham, 1999). Cultural practices in Arab societies assert control over women: domestic violence, polygamy and in some societies genital mutilation occur. The perceived need to keep silent about such experiences as rape, to preserve the image of female virginity and safeguard family honour and reputation revictimises and weakens the victim (Shalhoub-Kevorkian, 1999b). In domestic assault in the Arab world, where legal structures are involved, the law has had the paradoxical effect of further victimising those very women seeking to rely on it (Shalhoub-Kevorkian, 2000). Women in the Arab world may be killed in order to protect family honour (Attir, 1994). Previous research on women in Palestine discusses the considerable trauma associated with family violence and sexual assault; in one study, disclosure of assault in approximately 10% of the cases led to killing of the victim (Shalhoub-Kevorkian, 1999a).

The findings indicate that nationality was not a significant predictor of attitudes towards seeking professional help. These results go against the prediction that the Arabs in Israel would have more positive attitudes towards seeking professional help for psychological problems than the other two groups. We assumed that living in Israel, a country more modern and

western, might have engendered more positive attitudes towards professional helping. Moreover, the Arab-Israeli respondents studied at a mainstream Israeli university, regularly interacted with students of Jewish background and with the broader Israeli society, and as such would be influenced further by western norms. Recent research on South Asian women associates level of acculturation to positive attitudes towards seeking psychological help (Sheikh, 2001). Other research on Aboriginal peoples in North America revealed more negative attitudes towards mental health services among those with higher commitment to tribal than mainstream culture (Price & McNeill, 1992). These findings may be potentially extrapolated to the Arab subjects in the present study. Those respondents with strong identification to Arab culture, including its religion, may have less favourable attitudes towards utilising mental health services.

As a minority within Israel, the Arab Israeli respondents may have had a particular bias to rely on religion as a form of self-identity as a minority. A minority among a majority, they may feel a threat to their culture and return to their religious roots in order to protect their culture. How, then, to explain the high reference to God in help seeking among the three nationalities? All respondents were Muslim, and women are perceived to represent the honour of a family and may internalise the more conservative aspects of retaining Islamic identity and autonomy (Haj, 1992). This compulsion to retain Islamic identity may be a particularly strong countervailing response to the media and cultural hegemony of globalisation, which imparts western norms within and beyond these countries (Ahmad, 1992, cited in Shalhoub-Kevorkian, 1997). Still, there are radically different contexts between the nationalities. Respondents in Jordan and the UAE, in contrast to the Arab in Israel respondents, attend more conservative universities, live as majority Muslim Arab members of society and hold religious views that reflect these societies.

Not surprisingly, among the three national groups, the high rates of referring to God through prayer reflects widespread interpretations of the causes and possible solutions to mental health problems; women in Arab society may be especially religious and conservative (Ahmad, 1992, cited in Shalhoub-Kevorkian, 1997). A growing literature examines the influence of Islam as a basis for interpreting and responding to mental health problems (Chaleby, 1985; Al-Issa, 2000). Religion imparts explanatory mechanisms, including meaning, purpose and specific aetiologies (the supernatural world, the Divine). It also affords such healing-based coping mechanisms as Koranic healers, and various informal providers of support who conceive of and respond to problems religiously. Islam provides a prism through which one experiences mutual interactions, validation, the venting of problems and explanatory mechanisms. Islam likewise provides various faith-based healing practices such as the Pillars of Islam (Al-Krenawi & Graham, 2000b; Sheikh, 2001). Al-Subaie and Alhamed (2000) point out that Arab patients believe that mental illness can only be treated through traditional or religious therapy such as daily prayer or other religious rituals.

Religiosity within a Judeo-Christian context has been demonstrated to be conducive to better mental health (Byrd, 1988; Al-Issa, 2000). But current scholarship remains unclear as to either a positive or negative conclusion about the relationship between Muslim religion and psychopathology (Al-Issa, 2000). Under favourable circumstances, religion and good health can be mutually reinforcing. Belief may provide behavioural constraints that contribute to good health, a sense of belonging and community that reinforce it and hope – all of which can be beneficial to mental health treatment (Mitchell & Baker, 2000). But recent

research on African American women's help seeking found self-directing religious coping style to be positively related to perceived stress and depression, and negatively to favourable professional psychological help-seeking attitudes (Corbett, 1999).

Reference to God invariably leads to the informal mental health systems in each country. In Arab societies, where the range of treatment for mental health problems has traditionally been more pluralistic than the West, positive attitudes to treatment could cover a variety of pathways to treatment – including treatment systems that are referenced to religion. Moreover, these systems sometimes function in place of the biomedical system (Sue & Zane, 1987; Jilek, 1994; Al-Krenawi & Graham, 1999). Islam likewise influences patient perception of aetiology; the influence of divine punishment, or the presence of angels, are commonplace (Denny, 1988). It is not unusual for people of Arab background to attribute mental health problems to one, two or three of the following causes: the biomedical, human or supernatural. Arab peoples may tend not to see the origins of problems and illnesses biomedically, but rather as resting with an external locus of control (Chaleby, 1987; Al-Krenawi, 1999; Al-Issa, 2000). For example, physical or mental sickness, or family or marital problems, could result from several external causes. These include the intervention of supernatural elements such as spirits or the participation of other people with the supernatural via such avenues as the evil eye or sorcery (Sanua, 1979; El Islam, 1982; West, 1987; Morsy, 1993; Al-Krenawi *et al.*, 1996, 2000, 2001; Al-Issa, 2000).

The implications for helping professional practice are myriad. A practitioner should appreciate the aetiology of the problem or illness from the perspectives of the patients, their family and the society to which they belong. Their explanatory model, derived from their cultural and religious realities is, in this sense, an informal theory. The practitioner's knowledge and skills are a formal theory (Al-Krenawi, 1999). The practitioner could bridge the gap between formal and informal theories, as the informal theories have strong resonance with patients and their families. Such bridging could include using patients' idioms of distress in the intervention process (Bilu & Witztum, 1995). It could include traditional healing with the modern helping process, and could incorporate the patient's perception of aetiologies. Similarly, on epistemological grounds, consideration must be given to the role of religion. Mental health practitioners should be aware of how religion relates to subjects deemed by some patients to have everything to do with mental health – such as spirits, sorcery or the devil (Al-Krenawi & Graham, 1999; Al-Issa, 2000). Typical of non-western societies, requested (Hunte & Sultana, 1992) medicinal treatment is often an expectation of Arab mental health patients (Al-Krenawi & Graham, 2000a).

The geographic location of mental health and psychological services is important. Stigma may be avoided or reduced by integrating mental health services into non-stigmatising frameworks, or physical settings, such as general medical clinics (Al-Krenawi, 1996). Likewise, since mental health services may be stigmatising to family pride, especially, it may be helpful to deliver services in sensitive and flexible modes. A family, as an example, may decline to show up for an appointment if it is anticipated that a different family of Arab background may notice them entering a social service or mental health clinic, with the stigma that this entry implies (Al-Krenawi & Graham, 2003). But delivering the service in a non-stigmatising general medical setting may facilitate access for some. Mental health service delivery is known to be of low reputational value among Muslim (Azmi, 1991) and Arab women (Al-Issa, 2000; Al-Krenawi, 2000). As argued in relation to criminal justice services in one Arab community,

professional interventions need to be understood as complementing rather than substituting for more culturally sensitive community responses (Shalhoub-Kevorkian, 2000); the same aptly applies to mental health service delivery.

But, to emphasise an important point, accessing mental health services can be seen as an important societal goal in reducing psychological distress (Bergin & Garfield, 1994). In western cultures, to say nothing of the Arab world, few people that experience significant psychological distress seek psychological help. For example, a recent survey of over 10,600 persons in Australia pointed out that while more than one in five adults meet the criteria for a mental health disorder, 62% of the subjects with a mental disorder did not seek any professional help for mental health problems (Bayer & Peay, 1997). There are cultural and gendered contexts in which help seeking occurs or is precluded. For the Arab communities studied here, they are myriad.

In summary, as this paper argues, attitudes towards help-seeking processes among young Arab women are strongly influenced by such factors as age, educational attainment and marital status. Practitioners, those who plan educational services and those who promote mental health awareness policies, should be aware of the significance of post-secondary education to young women's attitudes to help seeking, as the present research conveys. So too might the same personnel appreciate the significant differences in attitudes among married versus non-married women. Our research provides considerable basis therefore for changing negative attitudes towards mental health services and for helping to render them more culturally appropriate.

The present findings suggest the potential for common experiences across national boundaries. Given the commonalities of trans-national migration of peoples, there is the potential for considerable implications to practice in countries where people of Arab background are in the minority. For example, people of Arab background constitute a significant – and growing – proportion within such western countries as Australia (210,000), Canada (144,050), France (2 million), Britain (210,000), Israel (1 million) and the United States (700,000) (Al-Krenawi & Graham, 2003). Issues of acculturation, re-acculturation, assimilation, discrimination and intergenerational issues as experienced by these and other things create considerably different experienced contexts – to say nothing of the varying sociopolitical contexts in which these are played out, one community, country and one region to the next. The implications for countries other than the present countries under analysis, are best left to future research. While beyond the parameters of the present article, further research could profitably extrapolate findings and implications of the present article, to other Arab countries and to Arab peoples living in the non-Arab world.

We are aware of the limitations of this study with respect to sampling and sample bias – as a result of convenience sampling from a female, undergraduate university population, and a relatively small sample size. External generalisations are therefore limited. But as a first study in this area, the findings have implications that could influence both subsequent research and practice and policy innovations for helping professional practice for women of Arab background. Future research could fruitfully examine the experiences of a comparable subset of male undergraduate students, as well as samplings of non-university students and older subjects.

NOTES

1. http://www.uae.gov.ae/2
2. http://www.cia.gov/cia/publications/factbook
3. http://www.cia.gov/cia/publications/factbook
4. http://www.cia.gov/cia/publications/factbook
5. http://www.cia.gov/cia/publications/factbook

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