Arab Americans

What Is the Cultural Impact on Healthcare?

by Amel Al Awami, MD, and Barbara A. Bernhard, MA

"Too much freedom is spoiling him."

"He should stand still."

"She must sit upright."

These comments are frequently heard in Arab-American households. Throughout the Arab culture, there is an emphasis on the upbringing of a polite child who respects elders and obeys orders. But at the same time, there is great tolerance for children to be active and noisy.

Families with traditional Arabic backgrounds expect boys to be energetic, outgoing, know how to defend themselves, and protect their belongings. Girls are expected to be quiet and follow the rules without talking back to adults. If there is any deviation from the expected cultural norms, it is believed to be a fault of upbringing and not a disorder. That can delay diagnosis and acceptance for healthcare providers working with Arab-American communities.

In Arab cultures, as in many others, raising children remains the mother's responsibility, and she is blamed for any perceived problems with a child's upbringing. She can face criticism for her parenting style from her immediate family, her in-laws, and the community. Fathers are expected to secure the financial future of their children.

Many Arab-American families still feel their worth is based on the way the community and the "tribe" perceive them and their children. Therefore, when a child has a developmental delay, learning difficulties, or any mental illness, the family can experience enormous stress as well as social stigma and rejection. This adds to the reluctance of many families to pursue medical assistance and management.

Let's examine just a few of the cultural barriers families and healthcare providers face regarding the diagnosis of ADHD in Arab communities.

Community awareness

ADHD is viewed as a Western-created "illness." In Arab-American communities, children are supposed to be active and curious; it is acceptable that at times children act irresponsibly or are forgetful. In these communities, these kids are perceived as simply being "naughty," that "they will grow out of the activity." Since there is the feeling that this condition is related to life in the West, clinicians may hear comments like, "The upbringing style in the West puts too many demands on children and the fast pace of living makes adults less tolerant of behaviors that are actually normal for kids." You can also hear the feeling expressed that, "The modern society tends to look for quick fixes and rush to medicate children to see quick results." This perception can create resistance to treatment. The idea in many of these families is that ADHD is a consequence of children spending more time indoors, in front of computers or TV, choosing sedentary activities instead of other opportunities to vent their energy. That is often seen as the reason their child might fidget or be less focused.

The prevalence of ADHD among Arab populations is variable according to published studies, ranging from 6-16 percent. That is more or less equivalent to the occurrence in the United States, where the prevalence is reported from 5-10 percent. (Refer to the following studies listed in the Additional Reading: Al Hamad, Tashkandi, and Al Qahtani.)

The mental health literacy in Arab communities is seen by a number of researchers and providers as sub-optimal (as mentioned by

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and ADHD

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Odeh, see below). In particular, there is a lack of awareness, as well as many misconceptions, about neurobehavioral disorders. Language is one of the major challenges seen in developing a successful medical partnership between the family and the healthcare provider. English may be a second language; parents and patients may not be fluent and even if they are, practitioners must keep in mind that fluency may be in conversational English only. There may be no understanding of the language of medicine and medical diagnosis and treatment. Adding to the communication problem is the issue of embarrassment and reluctance of most individuals to admit they do not understand.

In addition, just the possibility of a mental or neurological issue can provoke mixed feelings for a family. Some still don't believe that mental illness or neurological conditions exist. The belief is still held that these symptoms are caused by a superpower-related to the "jin" and/or evil eye (see the study by Al-Habeeb).

The acculturation effect in Arab-American communities can modify these challenges, writes Ahlam A. Jadalla in his research. While this can improve communication between family and physician, it can also create tensions within families, where elders are still seen to know best.

Asking for help

For Arab families, this means the need to overcome the stigma and the overwhelming misery of feeling they have failed as parents. Most would rather ask for help from a family member or a friend than turn to healthcare providers. Many in Arab-American communities are reluctant to share personal and family information; there is an overall mistrust and fear of being exposed to another person, particularly a stranger or an unknown authority figure.

Building bridges of trust and open channels of communication are important to get more insight into the family and key to taking a good history for the optimum treatment of the child. This may require that healthcare providers find ways to promote more community outreach, so clinicians and practitioners can become more familiar with the community.

Accepting the diagnosis

It is difficult for many families to accept the diagnosis of ADHD and that is certainly true in Arab-American communities. Families may remain in denial for a long time. Healthcare providers need to explore the reasons behind a family's fear and resistance to management to modify their counseling approach.

Arabs learn from an early age to respect authority figures and not to question their judgments. Nowadays, there are more efforts to encourage families to become involved in healthcare decision-making. Some Arab-American families are not used to this style. It can cause confusion when practitioners considered authority figures are not making decisions for them.

Accepting medical management

The healthcare management steps should be explained thoroughly and in simple words that are culturally sensitive. Every family is different, so the simple way is to ask each family about their own beliefs and understanding and what works best for them. Many Arab-American families are reluctant to start their children on medication, but that issue is not peculiar to this culture. These families may express fear of addiction, as well as concerns about side effects and long-term effects.

Living with the diagnosis

Raising a child to flourish and be successful is a challenge that all families face. ADHD creates additional challenges for both child and family in the search for that success. Rejection and stigma can affect every member of the family. Some Arab-American families are reluctant to marry into a family that includes a person with any sort of disability. They can be particularly negative about a person with a neurobehavioral disorder. It can add to the sense of shame, guilt and isolation of both patient and parents, and that adds to the challenges for healthcare providers.

The need for a cultural interpreter

Having an Arabic translator in medical settings is crucial; not only to translate the conversation but also to act as a "cultural interpreter" who can explain cultural nuances to each of the participants. Cultural competency training should be part of the medical interpreters' certification process. Until that time however, a cultural interpreter is something healthcare providers may consider adding to their practice. Cultural issues can hinder or aid practitioners; cultural insight can bridge cultural gaps and smooth over misunderstandings to improve overall compliance.

Religious issues

It's estimated that as many as 3.7 million Americans of Arab descent live in this country, with connections to 22 Arab nations. In those countries, Muslims make up 95 percent of the population. Many of those nations follow

Guidance for Treatment Providers

1. When faced with a family from a different cultural background, ask them about their understanding of the diagnosis, their fears, and worries. Using the motivational interview to meet the family where they are works best to bridge cultural differences.
2. Explain the diagnosis and management in the simplest way possible. Avoid medical jargon.
3. Remember not all Arabs are Muslims and not all Muslims are Arab. Be sensitive to the concerns of all the religions found in Arab-American communities.
4. Acculturation levels can be different from one family to another. You need to understand where each family stands during every step of the management.
5. Stigma related to mental illness and neurobehavioral conditions can be a serious concern in Arab-American communities.
6. Remember that the father can be the decisionmaker, although the mother is the direct caregiver.
7. The need for a cultural interpreter is important to explain the cultural nuances to all parties in a medical conversation.

Sharia law, derived from the religious precepts of Islam. Only 24 percent of Arab Americans are Muslims (statistics based on the Pew research and demographic collection by the Arab American Institute). Most in the United States are Christian, with smaller populations including Jews, Druze, and Bahá'í. However, Muslims make up the majority of Arabs who emigrated to the US in the last two decades, so healthcare workers may be seeing many more young patients from Muslim households that adhere to Sharia rules.

Religious conventions can present their own challenges to diagnosis and treatment. The Arab culture across religions can dominate certain areas, such as who makes decisions in the household. In the Arab communities, it is the father's responsibility to make family decisions, but the mother is considered the caregiver. In other words, the father has to be convinced of the diagnosis and treatment for the management plan to see the light.

In Islam, parents are advised to play with their children in the first seven years of life, discipline them in the second seven years, and be their friends in the third seven years. Islamic scholars say the discipline can include light corporal punishment, but they have also outlined conditions: smacking should not be on the face, and it should not be harsh; it should be with the intention to discipline and not be in anger; it should not include insults or verbally abusive, degrading language. Addressing this issue with parents of children with ADHD is particularly crucial, since discipline can all too easily escalate into anger and even abuse. In cultures where physical discipline has been considered a norm, this may call for culturally sensitive discussions from healthcare providers.

Religious observances can also raise issues about medication and treatment. The month-long fast during the Muslim holy month of Ramadan is one example. There are rules of the fast that deal with medical concerns and with children. Physicians and providers can reach out to the community for details and insight to develop proper medical management that also addresses religious needs.

In all these matters, the key is clear and culturally sensitive communication to foster trust and form a successful provider-patient-family relationship.

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ADDITIONAL READING

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