

27 Cultural Diversity and Clinical Neuropsychology in Israel

Neuropsychological Rehabilitation within a Cultural, Religious, and Political Melting Pot

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Section I: Background Information

Perspective and Overview

We, the authors of this chapter, when asked by the editor of this book to write a chapter on Israel's cultural diversity and clinical neuropsychology, did not have to dig deep in search of representations of the subject. Our own nuclear families immigrated to Palestine and later to Israel from two remote corners of the world during the first half of the 20th century. They brought with them their rich and diverse cultural backgrounds and added them to the melting pot of Israel's evolving culture. For us, personally, clinical neuropsychology acted and still acts as that melting pot. Israeli clinical neuropsychology brought us together.

Israel is one of the smallest states in the world, with a long and rich history of cultural diversity, affecting all aspects of life. Here we refer to the following three major aspects of the impact of Israel's cultural diversity on the practice of clinical neuropsychology:

- a Cultural and religious diversity and geopolitical tension as integral parts of Israel's social DNA.
- b Israel's welfare policy and the ethics of social solidarity.
- c The consideration of the above aspects and the strong emphasis on treatment and rehabilitation rather than assessment in the development of clinical neuropsychology in Israel.

We then continue by describing four neuropsychological rehabilitation cases that, in our minds, demonstrate the effects of these characteristics on the practice of clinical neuropsychology in Israel. The first two cases demonstrate how the ethic of social solidarity within the patients' specific communities (A Kibbutz and a governmental security agency) assisted their rehabilitation. The other two cases demonstrate how the involvement of spiritual beliefs and religion (in the Hasidic and in the Jewish Yemenite communities) were harnessed to enhance the process of treatment.

Geography/Geopolitics

The state of Israel, the declared homeland of the Jewish people, and the holy land for all three monotheistic religions measures 22,100 km², approximately a quarter of the size of the larger New York metropolitan area. Of Israel's 9 million citizens, 75% are Jews, 20% are Arabs, and 5% are of other origins.¹ Located on the eastern shores of the Mediterranean Sea, Israel is surrounded

by Arab countries, many of them still object its legitimate existence. Hence, the area has suffered decades of political tensions, conflicts, terror, and wars.

Geopolitical tension is "the name of the game" in Israel, affecting all aspects of life, including clinical neuropsychology's strong emphasis on the rehabilitation of brain-injured army veterans and civilians. However, political and cultural conflicts are not new to this area.

History

During the long period between 1500 BC and the mid-20th century, the area of Biblical Canaan and later Palestine was conquered by at least 14 empires. Each of these transitions left its cultural fingerprints on the land. Hence, cultural diversity is rooted in Israel's DNA.

During this long history, the Israelites and later the Jews were forcefully deported three times. The last deportation (1st century AD) lasted approximately 2000 years, during which the Jews were integrated in Western and Eastern countries all around the world. Only during the second half of the 19th century, with the establishment of the Zionist movement, and especially in the aftermath of the WWII Holocaust, did Jews start to reinhabit their sacred homeland, bringing with them a diversity of Western and Eastern cultural influences from the diaspora. The current Israeli cultural melting pot is the direct result of the waves of Jewish immigration to Zion (as the region was called prior to official statehood in 1948) and later to the state of Israel until the present day. In 1948, the year of its establishment, the state was inhabited by close to 800,000 citizens. Seventy years later, this number has multiplied to approximately 9.1 million citizens, a growth largely accounted for by Jewish immigration.

People

Among the Jewish population, 43% define themselves as secular, 33% as partly observant, 11% as observant, and 10% as Orthodox, which, among themselves, are divided into approximately a dozen different subgroups.² For country of origin, 10% of the Jews emigrated from Asia (mainly from Iraq, Yemen, and Iran); 13% from Africa (mainly from Morocco, Tunisia, Algeria, and Ethiopia); 13% from Russia and the former USSR; and 15% from Europe and America (mainly from the United States, Poland, Romania, and France). The remaining 49% were born in Israel.³ Among the Arab population, approximately 85% are Muslims, 7.5% are Christians, and 7.5% are Druses. Israel's past and current cultural diversity affects all aspects of life, including the focus and quality of clinical neuropsychology services.

Language and Therapy in a Culturally Diversified Society

For approximately 50% of Israel's population, Hebrew, the formal language of the state of Israel, is not their native language. Various dialects of Arabic, Russian, Amharic, Yiddish, English, and French are commonly used. As will be detailed later in this chapter, this has strongly affected, and not positively, the use of assessment tools in general and of neuropsychological tests in particular.

Israel's clinical neuropsychologists are educated and trained to pay special attention to cultural and ethnic habits, sensitivities, and customs (e.g., a female therapist should not close her office door when treating an Orthodox Jewish patient or shake his hand. Among persons of Ethiopian origin, especially females, eye contact is regarded as impolite. A lack of eye contact is not a sign of anxiety or shyness as it would usually be referred to). In fact, many neuropsychologists specialize in the treatment of individuals from specific cultural communities compatible with their own origins and backgrounds. Non-Hebrew-speaking Arab-Israelis and newcomers from the former

USSR are usually treated by psychologists of the same origin. There are no formal interpretation services for other non-Hebrew-speaking patients.

Socioeconomics

Another important feature of the state of Israel to be considered in the context of this chapter is Israel's welfare policy. Since its establishment, the state has emphasized social solidarity in principle and in its laws. Education is free up to the 12th grade. The average year of education is 13 years, with a little less than 2% of illiteracy; an obligatory progressive social security tax covers various kinds of benefits and compensations, including retirement, disability, rehabilitation, and more.

Within this frame of reference, special consideration is given to the armed forces. Service in the Israel Defense Forces (IDF) for two-and-a-half years, and later in reserve units, is obligatory for men and women aged 18. Since the establishment of its armed forces, the state has declared its utmost responsibility in cases of disability due to service. As part of that, the rehabilitation services of the defense ministry have made tremendous contributions to the development of local clinical and neuropsychological rehabilitation services, strongly emphasizing the development of neuropsychological rehabilitation programs and methods.

Health Status

Excellent public medical services are available for all Israeli citizens for a relatively cheap obligatory medical insurance tax. Both physical and mental health services are delivered by four public health services which are regulated by law in terms of type and extent of eligibility. Long-term neuropsychological rehabilitation services are fully covered by the Social Security or by the Defense Ministry's rehabilitation department.

Neuropsychological Approach

The development of clinical neuropsychology in Israel since the early 1970s has been influenced to a large degree by the three aspects described in the previous sections: the state's prolonged existence under the pressures of geopolitical violence, its existence as a cultural melting pot, and its welfare and social solidarity policies, especially regarding army veterans. In two previous articles,^{4,5} we described in detail how these aspects affected Israeli neuropsychology.

Compared with clinical neuropsychologists in other Western countries, Israeli clinical neuropsychologists specialize much more in treatment and rehabilitation than in assessment. Most of the professionals in this field are licensed rehabilitation psychologists (or interns) who specialize in the treatment of patients with pediatric and adult traumatic brain injuries (TBIs) and various other neurological disabilities. Based on a professional survey we conducted in our 2016 papers,^{4,5} we reported that only 8% of Israeli clinical neuropsychologists are primarily involved in clinical or forensic assessments. As mentioned above, rehabilitation and disability compensations are fully covered by various state agencies. Thus, compensation claims and neuropsychological assessments as part of them are less needed, relative to what is common in nonwelfare countries. This trend is also manifested in the four cases we present later—they are all rehabilitation case studies rather than assessments. The strong emphasis on neuropsychological treatment and rehabilitation rather than assessment is probably one of the reasons why the development of locally adapted assessment tools has been underdeveloped. Some Intelligence, memory and executive functions assessment batteries have been wholly or partly translated but only a few of them were adequately validated. The relative lack of local norms in Hebrew, Arabic, and other local languages raises

questions about their clinical applications. The Appendix includes a short list of the tests that have been translated or psychometrically validated for local use in Hebrew.

Section II: Case Presentations

Note: Possible identifying information and several aspects of history and presentation have been changed to protect patient identity and privacy.

The Case of BR—Communal Social Solidarity and Neuropsychological Rehabilitation in a Kibbutz Community (Therapist EV)

A kibbutz is a type of settlement that is unique to Israel. It is a collective community (the word kibbutz means "gathering"). The residents of the community share everything and work as members of a collective. Kibbutzim were founded in the 1920s on the ideology of combined socialism/communism and Zionism. Currently, approximately 100,000 people live in 270 kibbutzim in Israel (approximately 1.1% of the population). The principles of equality and solidarity are taken extremely seriously, and they are expressed in the principle of "give what you can, take what you need." Only in this context can the rehabilitation process of BR, a kibbutz member, be understood.

BR was born and raised in a kibbutz in the northern part of Israel. BR served as an officer in the IDF and then returned to the kibbutz. Although kibbutz occupations were traditionally based on agriculture, his kibbutz, like many other kibbutzim, branched out into industry. More specifically, the kibbutz built a large plastic factory that produces all kinds of plastic pipes. About a year after returning from the army, BR asked the kibbutz to allow him to study mechanical engineering (and to pay his tuition). The kibbutz approved his application under the condition that when BR graduated as an engineer, he would join the kibbutz's factory. At the age of 28, BR graduated from a very prestigious institute of technology in Israel as a mechanical engineer, and as planned, he started to work at the kibbutz's factory. He did very well in the factory and was consistently promoted, up to the level of a manager in one of the factory's wings. He got married in the kibbutz and has three children, two boys and a girl.

At the age of 52, BR was hospitalized after suffering from a severe cerebrovascular accident (CVA) affecting some parts of his right temporal and parietal lobes. After two weeks in a general hospital, he was transferred to a rehabilitation center where he was hospitalized for approximately three months. During these months, he received primarily physical and occupational therapy. The medical report issued upon his discharge indicated that BR had a weak left arm. From a cognitive perspective, based on previous neuropsychological assessment, there were no language problems, but he had impaired spatial orientation, visual memory, and some attentional difficulties. In terms of his behavior, he was described as impatient and tending toward impulsivity. After approximately a month of medical leave he insisted on going back to his previous job in the factory. His intact language was apparently very misleading regarding his abilities, so he returned to his job. However, very soon, it was apparent that the job was beyond his capabilities, and his performance at the factory was described by one of his colleagues as a disaster.

BR was referred to me at the age of 54, approximately two years after his discharge from the hospital. I met with him on a weekly basis; he came to my clinic in the center of Israel from his kibbutz (almost an hour and a half each direction). He was always escorted by a kibbutz member who drove him in a kibbutz car. At the first visit, he arrived with the kibbutz's financial manager, who assured me that the kibbutz was committed to BR's rehabilitation and that they were willing to do what it took to get him better. It was clear on the one hand that BR lacked awareness of the full consequences of his injury and, on the other hand, that he was still mourning the losses he was

experiencing, although he did not always have a clear understanding as to what they were. Thus, the first sessions were dedicated to addressing these issues, supporting him in the mourning process, and helping him accept what he had lost but at the same time recognize what was preserved.

In the next phase, I felt that we were ready to deal with the issue of his occupation. I asked his permission to visit the kibbutz and the factory and meet with his colleagues which is acceptable among kibbutz members. During the visit, he explained to me exactly what his job involved. In addition, I met with some of his coworkers in an attempt to understand what BR's difficulties were in resuming his job. The conclusions we reached were that his technical skills were well preserved and that he could make good decisions regarding specific professional issues. However, there were more problems at the managerial and interpersonal levels. BR's coworkers described him as being impatient and impulsive and as having difficulties listening to others. He had difficulties prioritizing the tasks at hand. He was not successful at assigning the right people to the right tasks.

Following these sessions, it became clear to BR that if he wanted to succeed, he could not return to his job as a manager. He agreed to work under the supervision of a colleague with whom he felt there was mutual respect. The supervisor/colleague and BR were asked to discuss difficulties encountered with BR and me possible solutions. With time, BR showed gradual adjustment to the new position. The frequency of our meetings was reduced gradually until the meetings ended approximately a year later. Occasionally BR called me to ask for advice, but that too gradually stopped, which indicated to me that BR finally accepted his new situation.

The take-home message is as follows: this case report demonstrated the pivotal role of BR's kibbutz in his rehabilitation process, which was expressed by the declaration of the kibbutz's financial manager in committing that the kibbutz was willing to do whatever it took to help BR get better. This commitment was expressed financially by choosing the therapist they wanted even if it was far from the kibbutz and driving BR to the meetings with the kibbutz's car. Second, it was expressed by their involvement in BR's work placement and their willingness to make the needed adjustments to enable his success, including assignment of a colleague to supervise him. However, above all, the readiness of the kibbutz representatives to collaborate with the therapist enabled the success of the rehabilitation process for BR. Thus, this case presentation exemplified how the value of civil social solidarity was applied to its extreme in the kibbutz community.

The Case of GV—Social Solidarity within the Armed and Security Forces (Therapist EV)

Due to its complicated security situation, Israel has developed several highly specialized security and intelligence agencies in addition to the IDF. Men and women are employed by these organizations in intense life-long careers that form and foster an "institutional family" atmosphere with a very strong emphasis on interorganizational solidarity.

GV was born in Tel Aviv to parents who had immigrated to Israel from one of the Arab countries three years earlier. His native language was Arabic. In high school, he studied Arabic as a second language. He served as an officer in one of the IDF's intelligence units for six years. Upon discharge, he went to school and graduated with a degree in Middle East studies. At the age of 27, he was recruited to one of Israel's intelligence agencies. He was very successful in his job as an interrogator and was rapidly promoted. At the age of 49, he suffered a severe CVA to his left temporal and frontal lobes, including to the Broca area. The major consequence of the stroke was expressive aphasia. The neuropsychological evaluation upon his discharge two months later indicated that GV had above-average intelligence and that his spatial and perceptual skills were well preserved. Expressive aphasia was his most pronounced impairment following his stroke, but it was emphasized that GV's receptive language was intact. In addition, the report indicated mild attentional difficulties, a low frustration threshold and a tendency toward impulsivity.

Despite GV's enthusiasm to return to the intelligence agency, he realized he could not return to his previous position as an interrogator because of his severe language deficit. The agency was committed to its employees and decided not to lay off GV and gave him a paid leave of absence for a year with the hope that GV's condition would improve. During this year, his friends from work visited him on a regular basis, and he also visited his workplace (a classified complex) several times but was also very frustrated with his condition. Speech therapy was the major therapy he received that year in addition to sporadic meetings with the agency's social worker. He refused to receive psychotherapy because he did not feel that he had emotional problems.

Toward the end of the year, the agency's social worker contacted me to consult about rehabilitation options for GV. At first, I was very skeptical about whether I would be able to communicate with a person with such an expressive language deficit. The social worker made it clear that the agency was dedicated to helping GV through his rehabilitation process. The agency was willing to accept him back into the agency in any job that he could perform or helping him find a job outside of the agency if necessary. The agency was also committed to paying for all the necessary expenses, including the therapy. After several meetings, it was clear to me that GV understood well what we discussed, and with the help of his wife, I was able to obtain meaningful responses from GV, which was very encouraging. The most frequent feeling expressed by GV was frustration with the fact that he could not return to his previous position. Thus, the next phase of the therapy was to help him through his mourning phase, i.e., help him accept that he was unable to pick up where he left off because of his injury. It was a very slow and painful process for him to give up a role that had in many ways defined him for the last four decades. My working assumptions were that GV had the potential to be employed, he was very motivated to go out and work, and obtaining employment would be a critical move in his rehabilitation process. The goal in the next step was to try and identify preserved skills that could be utilized in a new, gratifying occupation. I received an indication of GV's preserved skills from his wife's description of him as a talented handyman at home. At that stage, I asked the social worker whether there was a maintenance job in their classified complex that could be suitable for GV. The option to work in maintenance was immediately rejected by the social worker as being inadequate for a person with his status in such a hierarchal organization. I was convinced that GV's only chance to succeed in a new job at the agency was to find a job with workers at his level of clearance, which would reflect the status to which he belonged. The next step was asking the social worker to share with me the various jobs that people with his clearance rank were doing other than interrogations. One of the possible options was for GV to work in the photo laboratory, in which photos and videos were processed and analyzed. GV was very enthusiastic to join the laboratory, as he knew most people there and they knew him. In addition, he felt that his experience in looking for the right information could serve him well in his new job. I recommended appointing a senior colleague to mentor GV. We had a joint meeting with his mentor to discuss potential difficulties that might arise, such as frustration learning new skills at his advanced stage of his career. I continued to meet with GV once a week for a few months, and gradually, we reduced the frequency of the meetings. When necessary, his mentor asked to join the sessions (with GV's approval) to raise and discuss some issues that came up at work and for which he needed guidance on handling. The sessions ended approximately a year later, when GV seemed very satisfied and rewarded by his new job. His wife, who joined us occasionally, reported how his mood and behavior had significantly improved since he went back to work.

The take-home message is as follows: this rehabilitation process would not have been successful without the dedication and support of the agency GV came from. The role of the agency's social worker as the liaison between the agency, GV, and me was critical. She was authorized to choose the therapist and act upon my recommendation. The agency's commitment to GV was evident

when it declared that it was willing to reemploy him when he was ready. The agency showed great flexibility and the willingness to adjust the workplace according to GV's needs.

The Case of SK—The Effect of Extreme Hasidic Religious Obedience on Neuropsychological Rehabilitation (Therapist DH)

Hasidic Judaism arose as a spiritual movement during the 18th century in Eastern Europe. Today, most Hasidic groups live in Israel and the United States, and their members account for approximately 140,000 households and are regarded as ultraorthodox Jews. The Hasidim are organized in many "courts," each spiritually led by a "Rebbe" to whom members adhere and bond to gain optimal closeness to God. Hasidic courts differ in religious practices, customs, family and personal habits, and even dress. The affiliation to a specific court is hereditary.

SK was one of my first patients at the neuropsychological rehabilitation day center. The center was a therapeutic-milieu group program for patients with TBI.

SK was a big, heavy man in his mid-30s. He and his family were members of an orthodox Hasidic group. Their spiritual leader lived in the United States and was admired by his followers for being able to foresee the future. His blessings were believed to determine personal fates. SK, his wife, and their five children lived in a small community of his congregation in the northern part of the country. In addition to his orthodox education, SK acquired a license in accounting and served in the Israeli army as a clerk. At the age of 18, he married YK, who maintained their household and took care of their children until late night while SK worked and observed his orthodox practice. Life seemed to flow smoothly except that from time to time, mainly in the springtime, SK suffered from manic attacks. He spent excessive amounts of money and was extremely restless. He was never violent toward his wife, but their relations were never warm.

During the *Yom Kippur War (1973)*, SK was drafted to his reserve unit. A week later, he was involved in a car accident as a passenger. He suffered a mild-moderate TBI confined to the right prefrontal lobe, with no significant motor, language, or intellectual deficiencies. Upon his release from the hospital, he returned home and tried to resume his work but was released due to minor errors he made. Close to that time, he was referred to our clinic to help him regain his professional abilities. He was more restless than usual and had difficulties falling asleep but somehow managed his daily routines and religious practice, although with less enthusiasm.

In spring, chaos ensued (i.e., a vicious comorbid combination of mania and orbitofrontal lobe syndrome). SK became extremely agitated both physically and emotionally. In group sessions, he could not sit down for more than a few minutes and burst into uncontrolled and unrelated attacks of laughter and tears. In group and individual sessions, he repeatedly quoted religious commandments, beliefs, and sayings, supposedly quoting his Hasidic Rebbe. His wife told us that SK had become verbally and physically violent, mainly toward her but also toward his elder children. When confronted during treatment with the worsening of his condition, he developed a negativistic attitude, repeatedly quoting religious commandments that he supposedly obeyed. To my bewilderment when I tried to confront him about his violent behavior toward his wife, he said, "You know that unlike you (secular) guys, we respect our mothers and wives as queens... You'll never be able to understand that ..." For a couple of weeks, we tried to calm him down through relaxation and behavioral techniques and finally through psychiatric treatment, which he refused, claiming that "... it's all in the hands of the Lord ..." We were very close to dismissing him from the program, as his behavior became a serious nuisance for other patients. As a final step, we decided, with his permission, to consult his local Rebbe, who was unaware of the situation and was very eager to cooperate. We invited him to a staff meeting with SK. In came a tall, respectful-looking young man wearing an elegant business suit. In the presence of his Rebbe, SK underwent a complete transformation. He

sat quietly and participated seriously in the discussion. At the end of the meeting, the Rebbe faced SK and said, "Listen very carefully ... from now on these good guys are my delegates ... everything they advise you to do is my command, and you know very well that my command is our Rebbe's command ... I need you to take full responsibility for your misdoings, especially at home and here at the program ... I urge you to do so as there is no other way I or our Rebbe will be able to help you."

As expected, SK's frontal lobe syndrome was not resolved solely by persuasion. It took us another couple of months to stabilize SK's behavior and teach him to overcome his impulsive urges to react physically or violently. What made the change occur was his willingness to take responsibility, which left us with the mission to teach him how to do that. From time to time, we kept in touch with the Rebbe, who ultimately helped us integrate SK into a part-time clerical job at one of his community's offices and took care of SK's family.

The take-home messages are as follows: the case of SK demonstrates how consideration of cultural/religious diversity may significantly affect the outcomes of neuropsychological rehabilitation. If we had not involved SK's Rebbe in the rehabilitation process, we never would have been able to manage the vicious combination of premorbid manic tendencies and frontal lobe syndrome that precluded SK's cooperation at the beginning of the treatment. Spiritual leaders have tremendous powers of persuasion that may be harnessed as an integral part of treatment. SK overcame his negativistic attitude not through psychological change, but through religious obedience. These are different mental processes; the result is the same.

The Case of YE—Religious and Cultural Jewish-Yemenite Practices as an Existential Solution in Neuropsychological Rehabilitation (Therapist DH)

Yemenite Jews are Jews who immigrated to Israel during the early 1950s from Yemen. At the time, they were unique (and many of them still are) in religious and cultural practices, in mentality, in look (complexion), and in dress (Eastern). All of them were originally observant or orthodox but adopted more secular practices once integrated in the then-dominant Ashkenazi culture, which considered them to be culturally inferior. They are considered hard workers and scholars.

At the age of 28, YE was a junior commander in the northern border police corps when his car was hit by a truck on a foggy winter morning as he was on the way to his base. He suffered from a mild left frontotemporal injury, which left him with moderate attention and verbal memory deficits. He tried to resume his commanding position but failed and was ultimately released from the police corps to his deep frustration. At that time, he was referred to our center. In addition to his cognitive impairments, we observed that he was severely depressed and suffering from post-traumatic reactions in the form of restlessness, avoidant behavior, zoophobia (especially of pets and insects), and even mild paranoid ideation. These were accompanied by physical symptoms of irritable bowel and sleep disturbances.

YE is the fourth of six siblings. His parents were born in a small village in Yemen, married there and immigrated to Israel in the late 1940s. The family settled in a small village in the south desert zone of the country. Traditionally, Jewish-Yemen families were patriarchal. With much resentment, YE described his father as rigid, authoritative, and at times even rude. However, his father was apparently very smart, as he managed to develop a very successful agriculture services business, which made them wealthy and enabled all his children except for YE to be employed in the family business. YE described his mother as naïve. From a very young age, YE was designated by his father to be the family's bridge to the Israeli mainstream. He was the only child who was sent to study at the "heder" (room), a Yemenite system of advanced language and tradition studies for toddlers and young children. Indeed, YE had perfect linguistic abilities and deep knowledge of biblical and religious literature. He was the only child who graduated high school and was then

drafted to a prestigious police unit where he successfully finished the combat officers' course and served as a commander. YE described himself as a very successful and charismatic commander, admired by his soldiers and highly appreciated by his superiors. His father's aspirations for him were to be realized. YE's postinjury deep depression and posttraumatic reactions could be understood in this context. As the designated and successful "ambassador" of his family to the Israeli mainstream, he developed narcissistic perceptions of himself, which deprived him of the ability to cope with personal hardships and failure. There was no way he could cope with the breakdown of his dream or with his father's and family's disappointment.

The beginning of the treatment was impacted by YE's emotional and psychosomatic reactions. Most of the time, he stayed in his place—a mobile caravan attached to his parents' home—entirely preoccupied by anxieties and pain. He rarely left his room, except to have meals with his family, which he resented. A combination of supportive psychotherapy, psychoeducation, and psychiatric treatment was employed to ease and "normalize" his reactions and inspire hope in his ability to overcome the hardships. Indeed, within a couple of months, his depression and fears eased, replaced by boredom and a sense of worthlessness. We then searched for focuses of personal interest that could potentially fill the current void in his life. YE decided to virtually "go back" to the "heder." With my support and encouragement, he decided to relearn by heart all the prayers and biblical chapters that are read in synagogues during Sabbath ceremonies. According to the Yemenite tradition, there are two versions of these chapters, so he rehearsed both. He also decided to publish the two versions for local use. YE approached the mission with typical scholastic motivation and diligence. He used his excellent preserved executive functions to plan his work through daily missions and progress reports for the months ahead. Rehearsing was organized in a repetitive order (e.g., learn chapter A, rehearse chapter A, learn chapter B, rehearse chapters A and B, and so on). He published the booklets and even managed to sell a couple of them. Within a year from the beginning of treatment, his mood improved, and he overcame most of the posttraumatic anxieties. Having achieved that, the next phase of the treatment focused on work reentry and age-related social involvement. His father pressed hard for YE to join the family business. Knowing his father's personality, YE refused and intended to start a business of his own in the food industry, producing traditional Yemenite food. He took two academic courses in economics but lost interest and decided to approach the mission more practically. YE's personal strengths were his good social relations, charm, and financial wit. I suggested that we employ these assets by examining his ability as a salesman. With the help of our center's vocational counselor, YE started to work as a salesman in an electrical appliances store and succeeded. However, YE was very lonely. He was still feeling socially inferior and like less of a "man" than he felt before. At the same time, he was especially attracted to young female foreign workers from Russia and Eastern Europe who were employed in Israel as caretakers for elderly people. However, the language barrier prevented any attempt to realize his desires. Therefore, YE decided to learn the Russian language by himself. For this purpose, he harnessed the same typical "Jewish-Yemenite" scholastic aptitudes and exceptional linguistic aptitudes that he harnessed for learning the two versions of the Sabbath prayers. Within less than a year, he acquired a good command of the Russian language. He managed to have a couple of relationships in which conversations were held in Russian, but unfortunately, neither of them developed into a serious, long-term relationship. YE is most likely the only Jewish-Yemenite man who has good command of the Russian language.

The take-home message is as follows: the case of YE demonstrates how his deep involvement in his ethnical sub-culture was harnessed to existentially fill the void in his life and induce meaning and control of his fate. Religious practices and interests were adopted, in this case, less for their spiritual influence than for their "organizing" effect. Indeed, we have met many young men and women who in the face of a disastrous brain injury began to practice strict religious

commands for the commands' organizing effects on their lives in addition to the commands' spiritual effects.

Section III: Lessons Learned

There are three lessons to be learned from our experience as neuropsychologists in Israel:

- **Cultural diversity and neuropsychological rehabilitation:** Approximately 50% of Israel's Jewish citizens are not native to Israel, originating from more than a dozen different cultures from all parts of the world. Thus, as a clinical neuropsychologist, one can expect that one of every two patients will come from a different origin and culture, not to mention the large community of Arab citizens. Israeli neuropsychologists are educated to be especially attentive to cultural differences. Cultural traditions and religious customs are frequently embraced to improve the effects of treatment.
- **Social solidarity and neuropsychological rehabilitation:** With more than 2000 years of living in the diaspora in small segregated communities, and the horrific effects of the holocaust at their historical background, Israelis put a strong emphasis on social solidarity. As part of it, health and medical services in general and neuropsychological rehabilitation in particular, are fully covered by several state-agencies. In addition, social and professional sub-communities tend to take responsibility of their members in the face of personal disasters, a trend that is frequently harnessed to enhance vocational and social reintegration of our patients.
- **Clinical neuropsychology in a regional conflict zone:** In face of constant regional conflicts, wars, and terror attacks, Israeli clinical neuropsychologists are primarily involved in treatment and rehabilitation of patients with various kinds of brain injuries, less so in forensic and clinical assessment. This is probably the reason for the paucity of locally and culturally adapted assessment tools in Hebrew and especially in Arabic.

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